Health Services
LOS ANGELES COUNTY

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 288-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

November 13, 2018

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL OF VARIOUS CONTRACT ACTIONS
FOR MY HEALTH LOS ANGELES PROGRAM ENHANCEMENTS
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

SUBJECT

Request for approval of delegated authority to amend the My Health LA program services agreements with Community Partner clinics to effectuate program enhancements related to patient care, annual audits, Monthly Grant Funding rate and payments; and approval of delegated authority to enter into new agreements with all qualified Community Partners upon the conclusion of a solicitation process.

IT IS RECOMMENDED THAT THE BOARD:

1. Delegate authority to the Director of Health Services (Director), or her designee to execute an amendment to My Health LA (MHLA) agreements with the Community Partners (CPs) listed in Attachment A, effective upon date of execution or January 1, 2019, whichever is later to make enhancements in the following MHLA Program areas: patient care; annual audits; and Monthly Grant Funding (MGF) rate and payments.

2. Delegate authority to the Director, or her designee to execute MHLA agreements, with additional qualified CPs after completion of a solicitation process, effective July 1, 2019 through June 30, 2020, with an option to extend the term of the agreements for up to four additional one-year periods through June 30, 2024, to be coterminous with the existing MHLA agreements; subject to approval as to form by County Counsel, with notice to the Board of

Supervisors (Board) and the Chief Executive Office (CEO).

3. Direct the CEO to work with the Director, or her designee, to submit budget actions to the Board for their consideration that accounts for changes to the MHLA base budget allocation, utilizing tobacco settlement funds set aside as obligated fund balance, that satisfy the contractual obligations of the MHLA program for Fiscal Years (FY) 2018-19 and 2019-20.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Background

MHLA is a no-cost health care program for low income individuals and families who live in the County of Los Angeles (County) and do not have or cannot get health insurance, such as Full-Scope Medi-Cal.

The Department of Health Services (DHS) has dedicated its efforts to work collaboratively with 50 non-profit CPs that collectively provide primary care services at over 200 clinic sites throughout the County. DHS and CPs have long-established partnership goals which include: (a) preserving access to primary and preventative health care for uninsured residents of Los Angeles County; (b) encouraging coordinated, whole-person care; and (c) encouraging health collaboration and appropriate utilization of health care services. To this end, DHS is seeking approval of the recommendations above to implement program enhancements, and to enter into new MHLA agreements with all qualified CPs that respond to an expedited solicitation to enable DHS and CPs to continue to meet the MHLA participants' needs.

First Recommendation

Approval of the first recommendation will allow the Director, or her designee, to execute new amendments to the MHLA agreements, substantially similar to Exhibit I, with current CPs to implement program enhancements in the following areas:

Patient Care and Access Standards

The amendment to the existing MHLA agreements will provide for new patient access standards for MHLA enrolled participants such that all participants must be provided with an appointment within 21 days, instead of 90 days, for routine primary care and within 96 hours for urgent primary care services.

Annual Audits

In order to ensure quality patient care, the MHLA agreement language is also being amended to include monetary assessments ("liquidated damages") for non-compliance with certain performance standards, as found during the annual audits. A CP can be assessed liquidated damages if the CP's clinic: (a) has a score under 80% for Facility Site Review or Medical Record Review and does not implement an acceptable Corrective Action Plan (CAP) or does not remediate the deficiencies; (b) is non-responsive to DHS' request for an acceptable CAP; (c) beginning with the FY 2018 – 19 annual audits, has five or more of the same repeat deficiencies for three subsequent years, with no improvement between the first and third year; and/or (d) does not comply with licensing or credentialing obligations. In addition, the MHLA agreements are being amended to implement audit procedures established by the National Committee for Quality Assurance whereby if 40 medical records are pulled during an audit review and the first eight meet or exceed audit standards, no

additional medical record reviews are required until the following year. The amendment also provides definition for Repeat Deficiencies, makes changes to when a CP must file a CAP, and gives the Department authority to transfer patients to another dental or CP clinic in the event of significant adverse audit or patient care-related findings.

The amendment to the MHLA agreements also provides for other changes related to patient care, including but not limited to giving the Department authority to impose liquidated damages for clinics that do not comply with the New Empanelment Request Form process within 30 days, clarifying CP obligations with regard to the provision of medical supplies and Durable Medical Equipment for MHLA enrolled participants, and allowing for reimbursement of dispensary and pharmacy payments in accordance with the MHLA formulary.

MGF, Dental, and other and CP Payments

In order to ensure that MHLA program funds are utilized on those patients who receive a health benefit from the program, the MHLA agreements are being amended to implement new MGF payment rules such that the MGF will commence only once the participant has received a MHLA covered service from the CP. Once the MGF payment commences, it will continue through the end of the 24th month. If a MHLA participant has not had another a face to face encounter with the CP's professional staff person before the beginning of the 25th month, the MGF will cease to be paid to the CP for that participant (but the participant will remain enrolled if otherwise eligible) until such time that the participant returns to the CP for another MHLA covered service.

Currently, DHS pays for dental services in accordance with Denti-Cal rates. The terms of the MHLA agreements are being amended to clarify that the Department will only pay CPs the Denti-Cal Schedule of Maximum Allowances rate, without regard to any supplemental payments that the California Department of Health Care Services (DHCS) may authorize for the Denti-Cal program. In addition, the MHLA agreements are being amended to authorize the Department to freeze dental payments to CPs at then-current levels in the event that a Denti-Cal increase by DHCS would result in anticipated MHLA budget shortfall. The MHLA agreement related to the Dental program is further revised to change the current process for enrolling MHLA dental patients, which allows for the use of an Ability To Pay form, by requiring that all MHLA-eligible patients seeking dental care services enroll in MHLA, as necessitated by the Department's Membership Administration and Payment Linkage Environment system.

In recognition of the potential financial impact of the above referenced new patient care requirements, DHS has worked collaboratively with the CPs to determine a MGF rate that will support the CPs transition to the new requirements. Accordingly, with the approval of the amendment to the MHLA agreements, the MGF rate will be increased from $28.50 to $32.00 effective January 1, 2019. Furthermore, the MHLA agreements are being amended to allow that surplus program funds, if any, from prior years may be used to augment MGF up to 10% to support the creation of a quality incentives program. Surplus program funds are unspent amounts from the base allocation appropriated in each FY, but do not include unspent amounts from any supplemental funding in accordance with third recommendation above.

The amendment to the MHLA agreements makes a few other clarifying and administrative changes, including the addition of several new standard County provisions.

Second Recommendation

Approval of the second recommendation will delegate authority to the Director, or her designee, to

enter into agreements with additional qualified CPs that are selected as a result of a solicitation, effective July 1, 2019 through June 30, 2020; with an option to extend the term of the agreements for up to four additional one-year periods through June 30, 2024; subject to approval as to form by County Counsel and with notice to the Board and CEO.

Third Recommendation

The MHLA base budget allocation for FY 2018-19 is $64.788 million. Based on the FYs 2018-19 and 2019-20 funding requirement projections, additional Tobacco Tax Reserve funding will be required to allow the Department to satisfy its contractual obligations to the CPs.

Approval of the third recommendation will direct the CEO to work with the Director, or her designee, to submit any budget actions to the Board for their consideration that account for changes to the MHLA base budget allocation that satisfy the contractual obligations of the MHLA program for FYs 2018-19 and 2019-20 utilizing tobacco settlement funds set aside as obligated fund balance.

Implementation of Strategic Plan Goals

The recommended actions support Strategy II.2, “Support the Wellness of Our Communities” and III.3 “Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability”, of the County’s Strategic Plan.

FISCAL IMPACT/FINANCING

The total FY 2018-19 Final Budget allocation for MHLA is $64.788 million, which includes $4.305 million funded by the Tobacco Reserve Fund. DHS anticipates that this amount will be inadequate for FYs 2018-19 and 2019-20. Increases in enrollment rates, the addition of new CP sites, and increases in the number of “active” participants, as well as increases in the number of approved CPs in FY 2019-20 as a result of a solicitation (which could result in the addition of up to 20,000 new enrollees), are projected to add to the shortfall in the MHLA program.

The recommendations provide for budget actions to be taken and submitted to the Board to account for changes to the MHLA base budget allocation, utilizing tobacco funds set aside as obligated fund balance to satisfy the contractual obligations in any new or amended MHLA agreements for FYs 2018-19 and 2019-20. The additional tobacco tax reserve funds are only to be utilized after a budget allocation of $64.788 million is exhausted in each FY.

DHS will return to the Board for approval of a FY 2018-19 appropriation adjustment should the MHLA program exceed the FY 2018-19 Final Budget allocation of $64.788 million. DHS will request full and complete funding for the MHLA program for FY 2019-20, including the use of additional tobacco tax reserve funds as part of the regular budget process. For future FYs, DHS will work with the Board and CEO to determine the MHLA program's direction and request a sufficient budget allocation consistent with that direction.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The MHLA agreements provide for their periodic amendment. The MHLA agreements include the provision that agreements may be terminated or suspended for convenience, in whole or in part, by the County upon 30 days prior written notice and also includes a mutual termination for convenience

clause as requested by the CPs.

The amendment to the MHLA agreements also includes a change to the existing Cost of Living Adjustment (COLA) language, so that the COLA adjustment can be triggered at DHS' discretion without requiring a request by the CPs. If a COLA is granted by DHS, it will be effective at the beginning of the applicable FY.

The MHLA agreements that are entered into with additional CPs, as a result of a solicitation, will generally have terms and conditions consistent with the current amended MHLA agreements.

CONTRACTING PROCESS

The first recommendation will amend MHLA agreements with current CPs that were selected through a Request for Statement of Qualifications in 2014. The second recommendation will enable DHS to refresh the original solicitation to select additional CPs that will also serve the MHLA program's low-income, uninsured participants.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommended actions will ensure continued program enhancements and continued accessibility to health care services, including dental care services, for low-income, uninsured residents throughout the County.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

CRG:sd

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

ATTACHMENT A

2018 MHLA CORPORATE NAMES AND CONTRACT NUMBERS

	MY HEALTH LA, CONTRACTOR:	MHLA CONTRACT NO.:
1.	ALL FOR HEALTH, HEALTH FOR ALL, INC.	H-706170
2	ALL-INCLUSIVE COMMUNITY HEALTH CENTER	H-706171
3	ALTAMED HEALTH SERVICES CORPORATION	H-706172
4	ANTELOPE VALLEY COMMUNITY CLINIC	H-706173
5	APLA HEALTH & WELLNESS	H-706448
6	ARROYO VISTA FAMILY HEALTH FOUNDATION	H-706174
7	ASIAN PACIFIC HEALTH CARE VENTURE, INC.	H-706175
8	BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	H-706176
9	BENEVOLENCE INDUSTRIES INCORPORATED	H-706177
10	CENTRAL CITY COMMUNITY HEALTH CENTER, INC.	H-706179
11	CENTRAL NEIGHBORHOOD HEALTH FOUNDATION	H-706180
12	CHINATOWN SERVICE CENTER	H-706181
13	CLINICA MSR. OSCAR A. ROMERO (RFSQ #2)	H-706362
14	COMMUNITY HEALTH ALLIANCE OF PASADENA	H-706182
15	COMPLETE CARE COMMUNITY HEALTH CENTER, INC.	H-706183
16	COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.	H-706184
17	EAST VALLEY COMMUNITY HEALTH CENTER, INC.	H-706185
18	EL PROYECTO DEL BARRIO, INC.	H-706186
19	FAMILY HEALTH CARE CENTERS OF GREATER LOS ANGELES, INC.	H-706187
20	GARFIELD HEALTH CENTER	H-706188
21	HARBOR COMMUNITY CLINIC	H-706189

ATTACHMENT A

2018 MHLA CORPORATE NAMES AND CONTRACT NUMBERS

	MY HEALTH LA, CONTRACTOR:	MHLA CONTRACT NO.:
22	HERALD CHRISTIAN HEALTH CENTER	H-706190
23	JWCH INSTITUTE, INC.	H-706191
24	KEDREN COMMUNITY HEALTH CENTER, INC.	H-706192
25	KOREAN HEALTH, EDUCATION, INFORMATION AND RESEARCH CENTER	H-706193
26	LOS ANGELES CHRISTIAN HEALTH CENTERS	H-706194
27	LOS ANGELES LGBT CENTER	H-706195
28	MISSION CITY COMMUNITY NETWORK, INC.	H-706196
29	NORTHEAST VALLEY HEALTH CORPORATION	H-706197
30	PEDIATRIC & FAMILY MEDICAL CENTER, DBA EISNER PEDIATRIC & FAMILY MEDICAL CENTER	H-706198
31	POMONA COMMUNITY HEALTH CENTER	H-706199
32	QUEENSCARE HEALTH CENTERS	H-706200
33	SAMUEL DIXON FAMILY HEALTH CENTER, INC.	H-706201
34	SOUTH BAY FAMILY HEALTH CARE	H-706202
35	SOUTH CENTRAL FAMILY HEALTH CENTER (RFSQ #2)	H-706364
36	ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.	H-706204
37	THE CLINIC, INC.	H-706205
38	TARZANA TREATMENT CENTERS, INC. (Non-FQHC)	H-706206
39	THE ACHIEVABLE FOUNDATION	H-706207
40	THE CHILDREN'S CLINIC 'SERVING CHILDREN AND THEIR FAMILIES'	H-706208
41	THE LOS ANGELES FREE CLINIC, DBA SABAN COMMUNITY CLINIC	H-706209
42	THE NORTHEAST COMMUNITY CLINIC	H-706210

ATTACHMENT A

2018 MHLA CORPORATE NAMES AND CONTRACT NUMBERS

	MY HEALTH LA, CONTRACTOR:	MHLA CONTRACT NO.:
43	UNIVERSAL COMMUNITY HEALTH CENTER	H-706211
44	UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC.	H-706213
45	VALLEY COMMUNITY HEALTHCARE	H-706214
46	VENICE FAMILY CLINIC	H-706215
47	VIA CARE COMMUNITY HEALTH CENTER, INC. (effective 11/28/16 formerly known as BIENVENIDOS COMMUNITY HEALTH CENTER)	H-706178
48	WATTS HEALTHCARE CORPORATION	H-706216
49	WESTSIDE FAMILY HEALTH CENTER	H-706217
50	WILMINGTON COMMUNITY CLINIC	H-706218

EXHIBIT I

Agreement No. H-706XXX-X

MY HEALTH LA PROGRAM SERVICES

AMENDMENT NO. X

THIS AMENDMENT is made and entered into this _____ day of _____, 2018,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and

(hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "MY HEALTH LA PROGRAM SERVICES", dated October XX, 2014, and any amendments thereto, all further identified as Agreement No. H-706XXX (all hereafter "Agreement"); and

WHEREAS, on September 23, 2014, the County's Board of Supervisors ("Board") approved delegated authority to the Director of Health Services, or her designee, to execute amendments to address programmatic and administrative changes necessary for the continued implementation of My Health LA; and

WHEREAS, on November 13, 2018, the Board approved delegated authority to the Director of Health Services, or her designee, to amend the Agreement to make program enhancements to the My Health LA Program, and other necessary administrative changes; and

WHEREAS; County desires to address these necessary changes by making revisions to MHLA Agreement within Paragraphs 2.0, Definitions, 5.0, Payment and Billing, 7.0, Administration of Agreement-Contractor, 8.0, Standard Terms and Conditions, and 9.0 Unique Terms and Conditions; and replacing Agreement Exhibit A-1, Statement of Work; Exhibit B.2a, My Health LA Pricing Schedule, and Exhibit K (K-1 or K-2, as applicable), My Health LA Dental Care Services, Description of Services, Funding, Billing, and Payment; and

WHEREAS, Agreement provides that changes in accordance with Paragraph 8.1, AMENDMENTS AND CHANGE NOTICES, may be made in the form of an amendment which is formally approved and executed by the parties; and

WHEREAS, Contractor warrants that it possesses the competence, expertise and personnel necessary to provide services consistent with the requirements of this Agreement and consistent with the professional standard of care for these services.

NOW, THEREFORE, the parties hereby agree as follows:

1. This Amendment shall be effective _____, 2018.

2. Agreement Paragraph **2.0, DEFINITIONS**, subparagraph **2.19, DHS Facility**, is hereby deleted in its entirety and replaced as follows:

"2.19 DHS Facility includes Medical Centers, Health Centers, or Outpatient Centers all within Department of Health Services."

3. Agreement Paragraph **2.0, DEFINITIONS**, subparagraph **2.33, Medically Necessary**, is hereby deleted in its entirety and replaced as follows:

"2.33 Medically Necessary services or supplies, which include Durable Medical Equipment as defined by the Department in a PIN, are ones that meet the following criteria: a category of services required to be provided under this contract, and not specifically excluded, and recommended by the treating clinician to be (a) for the purpose of diagnosing or treating a medical condition; (b) the most appropriate supply or level of service, considering potential benefits and harm to the Participant, (c) not furnished primarily for the convenience of the Participant; (d) not required solely for custodial or comfort reasons; (e) consistent with Department policies and furnished in the most appropriate place of service; and (f) known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that a physician or other provider may prescribe, order, recommend or approve a service, or supply does not, in itself, make it Medically Necessary. The Department shall have the final authority for determining whether a treatment, service or supply is Medically Necessary, in its sole discretion."

4. Agreement Paragraph **2.0, DEFINITIONS**, subparagraph **2.35, Monthly Grant Funding (MFG)**, is hereby deleted in its entirety and replaced as follows:

"2.35 Monthly Grant Funding (MGF) is a method of payment for Included Services in which Contractor is paid a fixed amount, on a monthly basis, for each Participant assigned to Contractor. The MGF payment for periods beginning after December 31, 2018 will only be paid for such Participants who in a prior 24-month period had an Included Service for which Encounter Data is required to be submitted."

5. Agreement Paragraph **5.0, PAYMENT AND BILLING**, is hereby revised and the following is added:

"5.0 MHLA PROGRAM EXPENDITURES - PAYMENT AND BILLING

The Department will monitor the MHLA Program expenditures on a monthly basis. In the event that the Department determines that there will be insufficient appropriation to continue to fund MHLA through the end of any Fiscal Year, assuming enrollment of a minimum of 146,000 Participants, the Department may, at the sole discretion of the Department, freeze MHLA dental payments under Exhibit K at the established Denti-Cal Schedule of Maximum Allowances (SMA) rate, without regard to any supplemental payments, in effect at the time of notice of the freeze.

At the Department's discretion, surplus program funds from any prior Fiscal Year may be used to augment the MGF by up to 10% to support quality improvement activities the details of which shall be outlined through the Provider Information Notice (PIN) process."

6. Agreement Paragraph **5.0, PAYMENT AND BILLING**, subparagraph 5.2.1, is hereby deleted in its entirety and replaced as follows:

"5.2.1 Contractor shall be paid the MGF monthly, in arrears, in accordance with paragraph 5.5 hereunder, for each Participant who has selected the Clinic as his or her Medical Home as of the last day of each month.

The MGF payment for periods beginning after December 31, 2018 will only be paid for such Participants who in a prior 24-month period had an Included Service for which Encounter Data is required to be submitted."

7. Agreement Paragraph **5.0, PAYMENT AND BILLING**, subparagraphs 5.5.1 and 5.5.2, Payment Due Date, are hereby deleted in its entirety and replaced as follows:

"5.5.1 Beginning on the commencement date of the MGF period, County shall pay Contractor the MGF and, during Pharmacy Phase One, the Pharmacy MGF, for the Participants specified in paragraph 5.2 above, monthly, in arrears. Effective January 1, 2019, the Department shall determine the MGF based on a combination of enrollment data in the Enrollment System as of the last day of the calendar month for which the MGF is being calculated and Encounter Data required to be submitted to the Department.

5.5.2 Payment Due Date

The Department shall remit the MGF and Pharmacy MGF within 80 days following the month to which the MGF relates. If the 80th day is a weekend

or bank holiday, payment shall be remitted on the immediately following weekday."

8. Agreement Paragraph **5.0 PAYMENT AND BILLING**, subparagraph **5.5.3** Suspension of Payment, is hereby deleted in its entirety and replaced as follows:

"5.5.3 Suspension of Payment/Liquidated Damages

Payment shall only be made to the extent Contractor has met all of its service deliverables, including the obligations related to the submission of medical encounter data due during that month; is not in default under the terms of this or any other agreement with the County; and has met all financial obligations under the terms of this and any prior agreements with the County. If such conditions have not been met, the Department may suspend payment of the MGF in accordance with Section III.M. of the Statement of Work, Exhibit A-2.

Further, the Department may assess liquidated damages under the circumstances and in such amounts as specified in Attachment II-B, Table of Liquidated Damages, and in accordance with Exhibit A-2, Statement of Work, Section III.N. Liquidated Damages. Such liquidated damage may be assessed addition to, or in lieu of, other remedies provided in this Agreement."

9. Agreement Paragraph **5.0, PAYMENT AND BILLING**, subparagraph **5.8, Cost of Living Adjustments (COLA's)**, is hereby deleted in its entirety and replaced as follows:

"5.8 Cost of Living Adjustments (COLA's)

The MGF may be increased annually, at the sole discretion of the County, based on the most recently published percentage change in U.S. Department of Labor, Bureau of Labor Statistics' Consumer Price Index (CPI) for the Los Angeles-Riverside-Orange County Area for the 12-month period prior to each July 1. If a COLA is provided, the COLA shall become effective at the beginning of the applicable Fiscal Year. However, any increase shall not exceed the general salary movement granted to County employees as determined by the Chief Executive Officer as of each July 1 for the prior 12-month period. Furthermore, should fiscal circumstances ultimately prevent the Board from approving any increase in County employee salaries, no COLA will be granted."

10. Subparagraph **5.9, Default Method of Payment: Direct Deposit or Electronic Funds Transfer**, shall be added to the Agreement as follows:

"5.9 Default Method of Payment: Direct Deposit or Electronic Funds Transfer

5.9.1 The County, at its sole discretion, has determined that the most efficient and secure default form of payment for goods and/or services provided under an agreement/ contract with the County shall be Electronic Funds Transfer (EFT) or direct deposit, unless an alternative method of payment is deemed appropriate by the Auditor-Controller (A-C).

5.9.2 The Contractor shall submit a direct deposit authorization request via the website https://directdeposit.lacounty.gov with banking and vendor information, and any other information that the A-C determines is reasonably necessary to process the payment and comply with all accounting, record keeping, and tax reporting requirements.

5.9.3 Any provision of law, grant, or funding agreement requiring a specific form or method of payment other than EFT or direct deposit shall supersede this requirement with respect to those payments.

5.9.4 At any time during the duration of the Agreement, a Contractor may submit a written request for an exemption to this requirement. Such request must be based on specific legal, business or operational needs and explain why the payment method designated by the A-C is not feasible and an alternative is necessary. The A-C, in consultation with the contracting department(s), shall decide whether to approve exemption requests."

11. Agreement Paragraph **7.0, ADMINISTRATION OF AGREEMENT - CONTRACTOR**, subparagraph **7.1, Contractor's Project Manager**, is hereby deleted in its entirety and replaced as follows:

"7.1 Contractor's Project Manager

7.1.1 Contractor's Project Manager is designated in Exhibit D – Contractor's Administration. Contractor shall notify County in writing of any change in the name or address of Contractor's Project Manager within five (5) business days of such change.

7.1.2 Contractor's Project Manager shall be responsible for Contractor's day-to-day activities as related to this Agreement and shall coordinate with County's Project Manager on a regular basis."

12. Agreement Paragraph **7.0, ADMINISTRATION OF AGREEMENT - CONTRACTOR**, subparagraph **7.2, Contractor's Authorized Official(s)**, is hereby deleted in its entirety and replaced as follows:

"7.2 Contractor's Authorized Official(s)

7.2.1 Contractor's Authorized Official(s) are designated in Exhibit D – Contractor's Administration. Contractor shall promptly notify County in writing of any change in the name(s) or address(es) of Contractor's Authorized Official(s) within five (5) business days of such change."

13. Agreement Paragraph **7.0, ADMINISTRATION OF AGREEMENT - CONTRACTOR**, subparagraph **7.5, Background and Security Investigations**, is hereby deleted in its entirety and replaced as follows:

"7.5 Background and Security Investigations

7.5.1 At the discretion of County, all Contractor Staff performing work under this Agreement may be required to undergo and pass, to the satisfaction of County, a background investigation as a condition of beginning and continuing to work under this Agreement. County shall use its discretion in determining the method of background clearance to be used, which may include fingerprinting. The County shall perform the background check.

7.5.2 County may request that Contractor's Staff be immediately removed from working on County Agreement at any time during the term of this Agreement. County will not provide to Contractor nor to Contractor's Staff any information obtained through County conducted background clearance.

7.5.3 INTENTIONALLY OMITTED

7.5.4 Disqualification, if any, of the Contractor's staff, pursuant to this Sub-paragraph 7.5 shall not relieve the Contractor of its obligation to complete all work in accordance with the terms and conditions of this Agreement."

14. Agreement Paragraph **8.0, STANDARD TERMS AND CONDITIONS**, subparagraph **8.2, ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS**, is hereby deleted in its entirety and replaced as follows:

"8.2 ASSIGNMENT AND DELEGATION/MERGERS OR ACQUISITIONS

8.2.1 The Contractor shall notify the County of any pending acquisitions/mergers of its company unless otherwise legally prohibited from doing so. If the Contractor is restricted from legally notifying the County of pending acquisitions/mergers, then it should notify the County of the actual acquisitions/mergers as soon as the law allows and provide to the County the legal framework that

restricted it from notifying the County prior to the actual acquisitions/mergers.

8.2.2 The Contractor shall not assign its rights or delegate its duties under this Agreement, or both, whether in whole or in part, without the prior written consent of the County, in its discretion, and any attempted assignment or delegation without such consent shall be null and void. For purposes of this Sub-paragraph, the County consent shall require a written Amendment to the Agreement, which is formally approved and executed by the parties. Any payments by the County to any approved delegate or assignee on any claim under this Agreement shall be deductible, at the County's sole discretion, against the claims, which the Contractor may have against the County.

8.2.3 Shareholders, partners, members, or other equity holders of the Contractor may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of the Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Agreement, such disposition is an assignment requiring the prior written consent of the County in accordance with applicable provisions of this Agreement.

8.2.4 Any assumption, assignment, delegation, or takeover of any of the Contractor's duties, responsibilities, obligations, or performance of same by any entity other than the Contractor, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without the County's express prior written approval, shall be a material breach of the Agreement which may result in the termination of this Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against the Contractor as it could pursue in the event of default by the Contractor."

15. Agreement Paragraph **8.0, STANDARD TERMS AND CONDITIONS**, subparagraph **8.11, CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS**, is hereby deleted in its entirety and replaced as follows:

"8.11 CONSIDERATION OF HIRING GAIN/GROW PARTICIPANTS

8.11.1 Should the Contractor require additional or replacement personnel after the effective date of this Agreement, the Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services (DPSS) Greater Avenues for Independence

(GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet the Contractor's minimum qualifications for the open position. For this purpose, consideration shall mean that the Contractor will interview qualified candidates. The County will refer GAIN/GROW participants by job category to the Contractor. The Contractors shall report all job openings with job requirements to: **GAINGROW@dpss.lacounty.gov** and **bservices@wdacs.lacounty.gov** and DPSS will refer qualified GAIN/GROW job candidates.

8.11.2 In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees shall be given first priority."

16. Agreement Paragraph **8.0, STANDARD TERMS AND CONDITIONS**, subparagraph **8.13, CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW**, is hereby deleted in its entirety and replaced as follows:

"8.13 CONTRACTOR'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW

The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will also encourage its subcontractors, if any, to post this poster in a prominent position in the subcontractor's place of business. The Contractor, and its subcontractor(s), can access posters and other campaign material at www.babysafela.org"

17. Agreement Paragraph **8.0, STANDARD TERMS AND CONDITIONS**, subparagraph **8.17, COUNTY'S QUALITY ASSURANCE PLAN**, is hereby deleted in its entirety and replaced as follows:

"8.17 COUNTY'S QUALITY ASSURANCE PLAN

The County or its agent will monitor the Contractor's performance under this Agreement on not less than an annual basis. Such monitoring will include assessing the Contractor's compliance with all Agreement terms and conditions and performance standards. The Contractor deficiencies which the County determines are significant or continuing and that may place performance of the Agreement in jeopardy if not corrected will be reported to the Board and listed in the appropriate contractor performance database. The report to the Board will include improvement/corrective action measures taken by the County and the Contractor. If improvement does not occur consistent

with the corrective action measures, the County may terminate this Agreement or impose other penalties as specified in this Agreement"

18. Agreement Paragraph **8.0, STANDARD TERMS AND CONDITIONS**, subparagraph **8.28.1, Evidence of Coverage and Notice to County**, is hereby deleted in its entirety and replaced as follows:

"8.28.1 **Evidence of Coverage and Notice to County**

- Certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under Contractor's General Liability policy, shall be delivered to County at the e-mail address shown below and provided prior to commencing services under this Agreement.

- Renewal Certificates shall be provided to County not less than 10 days prior to Contractor's policy expiration dates. County reserves the right to obtain complete, certified copies of any required Contractor and/or Sub-Contractor insurance policies at any time.

- Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of Contractor identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand ($50,000.00) dollars, and list any County required endorsement forms.

- Neither County's failure to obtain, nor County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be e-mailed to:

cgcontractorinsurance@dhs.lacounty.gov

Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor Employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to

Contractor. Contractor also shall promptly notify County of any third party claim or suit filed against Contractor or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against Contractor and/or County."

19. Paragraph **8.60, COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLIC ON HUMAN TRAFFICKING**, shall be added to the Agreement as follows:

"8.60 COMPLIANCE WITH COUNTY'S ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING

8.60.1 The Contractor acknowledges that the County has established a Zero Tolerance Policy on Human Trafficking prohibiting Contractors from engaging in human trafficking.

8.60.2 If a Contractor or member of the Contractor's staff is convicted of a human trafficking offense, the County shall require that the Contractor or member of the Contractor's staff be removed immediately from performing services under this Agreement. The County will not be under any obligation to disclose confidential information regarding the offenses other than those required by law.

8.60.3 Disqualification of any member of the Contractor's staff pursuant to this Sub-paragraph shall not relieve the Contractor of its obligation to complete all work in accordance with the terms and conditions of this Agreement."

20. Paragraph **8.61, COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES**, shall be added to the Agreement as follows:

"8.61 COMPLIANCE WITH FAIR CHANCE EMPLOYMENT PRACTICES

Contractor shall comply with fair chance employment hiring practices set forth in California Government Code Section 12952, Employment Discrimination: Conviction History. Contractor's violation of this paragraph of the Agreement may constitute a material breach of the Agreement. In the event of such material breach, County may, in its sole discretion, terminate the Agreement."

21. Paragraph **8.62, COMPLIANCE WITH THE COUNTY'S POLICY OF EQUITY**, shall be added to the Agreement as follows:

"8.62 COMPLIANCE WITH THE COUNTY POLICY OF EQUITY

The Contractor acknowledges that the County takes its commitment to preserving the dignity and professionalism of the workplace very seriously,

as set forth in the County Policy of Equity (CPOE) (https://ceop.bos.lacounty.gov/pdf/PolicyOfEquity.pdf). The Contractor further acknowledges that the County strives to provide a workplace free from discrimination, harassment, retaliation and inappropriate conduct based on a protected characteristic, and which may violate the CPOE. The Contractor, its employees and subcontractors acknowledge and certify receipt and understanding of the CPOE. Failure of the Contractor, its employees or its subcontractors to uphold the County's expectations of a workplace free from harassment and discrimination, including inappropriate conduct based on a protected characteristic, may subject the Contractor to termination of contractual agreements as well as civil liability."

22. Agreement Paragraph **9.0, UNIQUE TERMS AND CONDITIONS**, subparagraph **9.4.10.3, Provider Roster**, is hereby deleted in its entirety and replaced as follows:

"9.4.10.3 Provider Roster: Prior to the commencement date of this Agreement, Contractor shall provide to Director a full listing of its then current medical Staff (including voluntary, part-time, full-time Staff, physicians-house Staff, osteopaths, pharmacists, mid-level practitioners, i.e., nurse practitioners, nurse midwives and physician assistants, dentists and dental hygienists, psychologists, and licensed clinical social workers if applicable). As applicable, data elements may include: name, National Provider Identifier; office address/telephone number; gender; current licenses/certificates (e.g., California Physicians and Surgeons License Number, DEA License Number, board status (board-eligible or board-certified)); whether provider is a County Employee or otherwise is providing services to County as a volunteer or under a separate contract with County; and any other information deemed necessary by the Director. Contractor shall provide Director with an updated provider roster, with a completed information sheet for each new provider (both voluntary and employed, physician and mid-level practitioner) and the deleted providers clearly indicated at least thirty (30) calendar days prior to any addition or deletion of a provider delivering services under this Agreement or as soon as Contractor becomes aware of the staffing change. Contractor shall promptly remove any primary care physician or non-physician medical provider scheduled to provide or providing services hereunder upon the written request of Director who shall state the reasons for this action in his/her request."

23. Agreement Exhibit A-1 – STATEMENT OF WORK, shall be replaced with Exhibit A-2 – STATEMENT OF WORK, attached hereto and incorporated herein by reference.

24. Agreement Exhibit B-2a – MY HEALTH LA PROGRAM PRICING SCHEDULE, shall be replace with Exhibit B-2b – MY HEALTH LA PROGRAM PRICING SCHEDULE, attached hereto and incorporated herein by reference.

25. Agreement Exhibit K (K-1 or K-2, as applicable)–MY HEALTH LA DENTAL CARE SERVICES, DESCRIPTION OF SERVICES, FUNDING, BILLING. AND PAYMENT, shall be replaced with Exhibit K-1 (K-2 or K-3, as applicable)–MY HEALTH LA DENTAL CARE SERVICES, DESCRIPTION OF SERVICES, FUNDING, BILLING. AND PAYMENT, attached hereto and incorporated herein by reference.

26. Except for the changes set forth hereinabove, Agreement shall not be changed in any other respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by its Director of Health Services, and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____
Christina R. Ghaly, M.D.
Director of Health Services

_____
Contractor

_____
Signature

_____
Printed Name

Title_____
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
MARY C. WICKHAM
County Counsel

EXHIBIT A-2
STATEMENT OF WORK

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EXHIBIT A-2
STATEMENT OF WORK

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EXHIBIT A-2
STATEMENT OF WORK
MY HEALTH LA PROGRAM
(Effective _____, 2018)

I. Background: Summary of program and purpose

The Department of Health Services (the Department or DHS) endeavors to meet the health care needs of certain low-income, uninsured Los Angeles residents who will remain uninsured after implementation of the federal Affordable Care Act's individual health insurance mandate. These individuals are known as the residually uninsured. The Department's mission is to ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at the Department's facilities and through collaboration with its community partners. In order to fulfill this mission, the Department seeks to enhance its partnership with community clinic providers which share a commitment to serve the health care needs of Los Angeles County's residually uninsured population in a way that encourages coordinated, whole-person care, similar to the services that have been provided to uninsured residents through the current Healthy Way LA (HWLA) Unmatched program. Consistent with this mission, the Department is re-designing the HWLA Unmatched program as the My Health LA (MHLA) program, and has identified long-term goals related to the delivery of services under the new access program. These goals include, but are not limited to:

- **Preserve Access to Care for Uninsured Patients:** Ensure preservation of a health care safety net delivery system comprised of the Department and its community partners for the estimated 400,000 Los Angeles County residents who will not be eligible for any health care coverage programs under the Affordable Care Act.

- **Encourage coordinated, whole-person care:** Encourage better health care coordination, continuity of care, and patient management within the primary care setting.

- **Payment Reform/Monthly Grant Funding:** Rationalize the payment system for community partners to encourage appropriate utilization and discourage unnecessary visits by providing Monthly Grant Funding as opposed to fee-for-service payment.

- **Improve Efficiency and Reduce Duplication:** Encourage collaboration among health clinics and providers, by among other things, improving data collection, developing performance measurements and tracking of health outcomes, to avoid unnecessary service duplication.

- **Simplify Administrative Systems:** Create a simplified administrative infrastructure that encourages efficiency, and an electronic eligibility determination and enrollment system (for enrollment, renewal and disenrollment) for individuals participating in the program.

The Department's intent is to work collaboratively with its partners to realize these goals. As such, the Department acknowledges that programmatic modifications, as described, require sufficient time to plan, test, and implement, and must be based on sound data.

The MHLA Agreements will provide the Department with an important opportunity to take these steps, in concert with its Contractors.

Terms used but not defined herein are defined in the Agreement for MHLA Program Services.

II. Program Services

1. **Health Care Services:** Contractor shall provide Primary Health Care Services and Care Coordination.

2. **Laboratory:** Contractor shall provide all Medically Necessary laboratory services related to Primary Health Care Services. As such, Contractor shall operate a full service laboratory or establish a formal subcontract agreement with a certified laboratory which will be reflected in the Site Profile. If Contractor performs any of the following nine laboratory tests on site, it must have a current Clinical Laboratory Improvement Act (CLIA) certification or exemption certificate: dip stick or tablet urinalysis; fecal occult blood; ovulation test using visual color comparison; urine pregnancy test using visual color comparison; Hemoglobin by copper sulfate non-automated; Spun micro hematocrit; Blood glucose using certain devices cleared by the U.S. Food and Drug Administration for home use; erythrocyte sedimentation rate non-automated; and automated hemoglobin. Lab testing beyond these services must meet any additional CLIA requirements and Contractor must have a CLIA certificate for them.

3. **Radiology:** Contractor shall provide basic radiology services that are within the scope of Ancillary Services. As such, Contractor shall operate a radiological unit or establish a formal subcontract agreement with a certified radiological entity which shall be reflected in the Site Profile. Radiological services that Contractor is not obligated to provide under the Program include ultrasound, invasive studies, CT or MRI scans, Doppler studies, and comparison views-extremity film. Contractor may refer Participants to Department for these non-obligated radiological services.

4. **Pharmacy:** Contractor shall provide or arrange for the provision of Pharmacy Services as follows:

   a. Pharmacy Phase One

      Pharmacy Phase One begins on the effective date of the Agreement and ends December 1, 2017 with the implementation of the MHLA pharmacy network through a contracted Pharmacy Services Administrator. Upon implementation of the MHLA pharmacy network, Pharmacy Phase Two, described in Subsection b. below, shall begin.

      During Pharmacy Phase One, Contractor shall be responsible for providing or assuring the provision of all medically necessary pharmaceuticals related to conditions for which the Participant is receiving Included Services, and for paying for such pharmaceuticals. Before prescribing a pharmaceutical not listed on the MHLA Formulary, Contractor shall submit a prior authorization request to MHLA and obtain prior authorization approval for the non-formulary pharmaceutical. To fulfill these obligations, Contractor may use its clinic dispensary, a licensed

pharmacy owned and operated by Contractor, or any licensed retail pharmacy with which it has a relationship.

b. 340B Program Requirements

With the exception of Clinic Sites in SPA 1, in order to participate in MHLA, Contractor is required to have access to 340B drug pricing and be registered with the Health Resource Services Administration (HRSA) Office of Pharmacy Affairs (OPA) on the effective date of this Agreement. Contractor is required to register at least one MHLA contracted 340B pharmacy with HRSA OPA to dispense 340B pharmaceuticals to Participants. If Contractor intends to utilize the County of Los Angeles-Auditor Controller (the DHS Central Pharmacy) to dispense 340B pharmaceuticals to Participants, Contractor shall submit its registration to HRSA OPA during a HRSA open enrollment period. A Contractor who intends to utilize the DHS Central Pharmacy shall execute a three-party 340B contract pharmacy services agreement with the DHS Central Pharmacy, NPI 1417364811, and RX E-Fill Solutions Pharmacy, NPI 1366889362, who will label, package and ship 340B pharmaceuticals to the Participant and/or Contractor on behalf of the DHS Central Pharmacy. This 340B pharmacy services agreement will allow the DHS Central Pharmacy to process 340B medications prescribed by Contractor's Primary Care Providers and the RX E-Fill Solutions Pharmacy to dispense and mail these pharmaceuticals during Pharmacy Phase Two.

Contractor shall have the right to audit and inspect the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy, including any relevant subcontractor, in order to comply with HRSA's 340B contract pharmacy guidelines. Contractor shall have the right to terminate its agreement with the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy so long as Contractor can demonstrate to the Department's satisfaction that Contractor has contracted with an alternate pharmacy in the MHLA pharmacy network to dispense 340B priced pharmaceuticals, and may terminate at any time upon a showing of demonstrable evidence to the Department's satisfaction that such agreement jeopardizes Contractor's compliance with Federal 340B requirements, such that the agreement poses an existing risk to Contractor's 340B status; and only if the Department is unable to remove such jeopardy after a reasonable cure period through a corrective action plan.

c. Pharmacy Phase Two

During Pharmacy Phase Two, the Department shall contract with a Pharmacy Services Administrator (PSA) to facilitate the use of a contract pharmacy network for Participants. The PSA shall establish, in coordination with the Department, a MHLA Pharmacy Network of licensed pharmacies from which Participants can obtain all MHLA Formulary pharmaceuticals to be established pursuant to Section II.4.d. below. If Contractor intends to use an on-site dispensary to dispense pharmaceuticals to Participants, the dispensary shall be an Eligible Dispensary as that term is defined in Paragraph 2.0, Definitions, subparagraph 2.21, Eligible Dispensary, of Agreement. If a Clinic operates an on-site licensed pharmacy, or contracts with a licensed pharmacy, that pharmacy must contract with the PSA in order to be included in the MHLA pharmacy network and to dispense pharmaceuticals to Participants.

Pharmacy Phase Two begins at the conclusion of Pharmacy Phase One and remains in effect for the remainder of the Agreement's term including any renewal period if extended by the County. The Department shall give Contractor at least thirty (30) days advance written notice of the date upon which the Department anticipates Pharmacy Phase Two will commence.

During Pharmacy Phase Two, Contractor shall be responsible for providing prescriptions to Participants for medically necessary pharmaceuticals associated with conditions for which Participant is receiving Included Services in accordance with the MHLA Formulary, including obtaining any prior authorizations. Pharmacy Services shall be provided to Participants at only the approved sites listed in Exhibit J, MHLA Site Profile (and any revisions thereto).

If Contractor operates an Eligible Dispensary, Contractor shall submit medication dispensing data to the PSA on a daily basis (within twenty-four [24] hours of dispensing) in a format determined by the Department. The required data fields and format for submission of daily medication dispensing data by onsite dispensaries shall be provided to Contractor with at least thirty (30) days advance written notice of the date upon which the Department anticipates Pharmacy Phase Two will commence. Contractor dispensing medications from an Eligible Dispensary shall be compensated for all MHLA Formulary and Prior Authorization approved pharmaceuticals provided to Participants, in accordance with the rates and terms established by the Department, contingent upon submission of the medication dispensing data to the PSA in the time frame described herein and in accordance with all data submission standards established by the Department.

For medications dispensed by an onsite State licensed pharmacy which is included in the MHLA pharmacy network, Contractor shall be paid either the current clinic wholesaler's 340B price and a dispensing fee, or an amount in accordance with the MHLA Formulary for a thirty (30)-day supply of designated drugs, in accordance with the terms and conditions established directly between the onsite licensed pharmacy and the PSA. For medications dispensed by an Eligible Dispensary, Eligible Dispensary shall be paid a total flat fee per thirty (30)-day supply of generic formulary agents in accordance with the MHLA Formulary and/or two dollars ($2.00) for over the-counter formulary agents as indicated in the MHLA Formulary. All other formulary agents or Prior Authorization approved non-formulary agents shall be paid the medication's 340B drug ingredient cost and an administrative fee of five dollars ($5.00). Drugs dispensed through a Patient Assistance Program (PAP) shall not be reimbursed. A Contractor dispensing pharmaceuticals from an Eligible Dispensary is required to submit all PAP applications for PAP drugs.

If Contractor intends to utilize the DHS Central Pharmacy to dispense 340B medications to Participants, Contractor shall enter into all necessary agreements with the PSA, the DHS Central Pharmacy, and the RX E-Fill Solutions Pharmacy, and take all other steps as are necessary to allow the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy to be included in Contractor's 340B pharmacy Network during Pharmacy Phase Two. During Pharmacy Phase Two, the Department will take reasonable steps to assure that the contracted PSA's processes and procedures will not jeopardize Contractor's participation in the Federal 340B drug program, and that such PSA and the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy shall make such records available and provide

such other assistance as is necessary to allow Contractor to comply with its obligations under the Federal 340B drug program, including ensuring Contractor's rights to audit and inspect the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy.

Consistent with Business and Professions Code section 4170(a)(7), the prescriber shall provide the Participant with written disclosure that the Participant has a choice between obtaining the prescription from the Contractor's onsite pharmacy or Eligible Dispensary, or obtaining the prescription at a MHLA network pharmacy of the Participant's choice.

d. My Health LA Formulary

During both Pharmacy Phase One and Pharmacy Phase Two, the Department shall maintain on-line, a MHLA Formulary, which are approved medications. Contractor shall prescribe medications whenever possible using the MHLA Formulary. Non-formulary and restricted pharmaceuticals shall require prior authorization with approval prior to dispensing. Contractor must submit a prior authorization in advance of prescribing any pharmaceutical that does not adhere to dispensing guidelines set forth in the MHLA Formulary, or in notices from the Department. The Department shall provide determination of the prior authorization request no later than one (1) business day after it was submitted. The Program requires the use of generic products whenever possible, in accordance with applicable law and regulations.

The MHLA Formulary also shall set forth the maximum supply of any medication that may be dispensed at one time.

e. Non-Prescription Therapies

Contractors shall counsel Participants on non-prescription therapeutic interventions, for example exercise, weight loss, and smoking cessation.

f. Patient Assistance Programs

The MHLA Formulary also shall identify the pharmaceuticals for which pharmaceutical manufacturer PAPs are available for MHLA patients. PAP information may also be provided for non-formulary prior authorization approvals. During Pharmacy Phase One, Contractor shall submit, on behalf of all of its Participants, applications for any applicable PAPs. During Pharmacy Phase Two, if Contractor operates an onsite licensed pharmacy that is part of the MHLA pharmacy network, Contractor shall obtain all applicable, necessary information and submit to the Department for pharmacy PAP submissions. Eligible Dispensaries shall be responsible for submitting their own PAP applications for applicable pharmaceuticals.

5. **Specialty Care:** When all treatment options by the Contractor's Primary Care Provider are exhausted, and/or the Participant's condition requires treatment by a Specialty Care Provider, Contractor shall refer the Participant to the Department in accordance with the Department's referral guidelines. Contractor shall assure that all appropriate examinations and Ancillary Services are completed prior to the referral,

and that the justification for the referral is noted in the Participant's medical record and included in the referral to the Department. If the Contractor uses non-physician providers, the referral shall be reviewed and approved by a physician prior to being submitted.

Contractor shall utilize eConsult to initiate specialty referrals, provided that it has been implemented for the particular specialty at the time of the referral. Contractor shall not be responsible for non-obligated radiological tests, as defined in Section II.3 above, recommended by the eConsult Specialty Care Provider. If eConsult is unavailable for any reason, Contractor shall submit referrals through the Department's Referral Processing System. Contractor shall coordinate any and all follow-up care with the Participant once the Participant is repatriated to his or her Medical Home.

6. **Emergency Services, Hospital and Urgent Care:** Participants shall be instructed to go to a Facility, if possible, in the event the Participant experiences an Emergency Medical Condition or urgent care situation requiring care that is beyond the scope of Contractor's capabilities. Participants requiring same or next day appointments for Included Services shall not be referred to the Department's emergency department or urgent care clinics. Contractor shall establish a mechanism to inform Participants how to access Emergency Services.

7. **After-Hour Services:** Contractor shall establish an after-hours plan consisting of, at a minimum, an outgoing after-hours phone message for Participants calling a Clinic or Clinic Site that is closed, which message shall include: (a) instructions to call 911 if the Participant is in need of Emergency Services, and (b) instructions on what the Participant should do if he or she is in need of prescription medications or medical advice. Such instructions may include contacting a specific nurse advice line, after-hours Clinic Health Professional or Pharmacist, or contracted pharmacy, if applicable. The after-hours plan may not include a referral to a DHS Facility for the purposes of obtaining pharmaceuticals or outpatient services after hours. Once the Pharmacy Services Administrator's system is implemented, the after-hours plan shall be modified to include referral to the MHLA pharmacy network as appropriate.

8. **Dental Care Services:** If Contractor has Dental Care Services available at its Clinic Site, those services may be provided as an option to Participants in accordance with Exhibit K-1 (K-2 or K-3, as applicable), Dental Care Services Description of Services, Funding, Billing and Payment. Dental Care Services shall be provided at only the approved sites listed in Exhibit J, MHLA Site Profile (and any revisions thereto).

III. Contractor Requirements

A. Licensing and Credentialing, and Health Professional and Clinic Site Requirements

1. Contractor shall abide by all applicable Federal and State laws, licensing requirements, and locally prevailing professional health care standards of practice, and shall represent and warrant that each Health Professional who provides Included Services shall maintain a current, unrestricted license certificate or registration to practice his or her profession in California. Contractor may use a Health Professional with a restricted license after receiving prior written approval from Department, which shall give such approval at its sole discretion. Such

approval may only be received after Contractor has submitted appropriate and complete information to the Department. Compliance with this provision includes annual reporting of clinic data to the Office of Statewide Health Planning and Development (OSHPD).

2. Contractor shall assure that Primary Health Care Services are provided by Health Professionals, including non-physician medical practitioners, and are predominantly in the areas of general medicine, family practice, internal medicine, pediatrics, obstetrics or gynecology. Non-physician medical practitioners may include nurse practitioners, nurse midwives, and/or physician assistants who are supervised in accordance with established clinical guidelines and applicable State and Federal law. If Contractor utilizes nurse practitioners, nurse midwives, and/or physician assistants in the delivery of Included Services, Contractor shall have in effect standardized protocols and agreements signed by a supervising physician, and shall comply with any applicable limits on the number of non-physician medical practitioners that may be supervised by a single physician, imposed on Contractor by state law. Contractor shall employ or contract with sufficient numbers of Health Professionals to provide all medically necessary Primary Health Care Services required by Participants who have selected Contractor as their Medical Home.

3. Contractor shall have a credentialing program for its Health Professionals which adheres to the established health care industry credentialing standards and guidelines and shall disclose to the Department information and documents relating to credentials, qualifications, and performance of its employed and contracted Health Professionals upon request. The Department shall request such information only where necessary to defend itself or to verify that credentialing is actually occurring. In addition, the Department shall assist Contractor in maintaining all applicable peer review protections to the greatest extent possible.

4. Contractor shall notify the Department within one (1) business day if it knows, or reasonably should know, based on credentialing or re-credentialing, peer review, and any other related quality assurance activities conducted by Contractor that:

    a. The license of any Health Professional is suspended, revoked or restricted, in any manner that renders him or her unable to provide Included Services;

    b. Any Health Professional is the subject of final adverse legal settlements or judgments against him or her concerning his or her qualifications or competence to perform medical services;

    c. A report regarding any Health Professional is filed with the California Medical Board or National Practitioner Data Bank;

    d. There is any material change in any of the credentialing information that has been provided to the Department regarding any Health Professional; or

    e. Any Health Professional is subject to sanctions under the Medicare or Medi-Cal Programs.

5. Contractor shall ensure that any Health Professional, whose professional license is revoked, suspended or restricted in a manner that renders him or her unable to

provide Program services shall not render service to Participants until the revocation, suspension or restriction has been removed or otherwise resolved.

6. Included Services delivered or pharmaceuticals prescribed to Participants shall follow evidence-based guidelines as appropriate to a Participant's medical condition as established by organizations including the Agency for Healthcare Quality and Research, National Quality Forum, U.S. Preventive Services Task Force, Centers for Disease Control.

7. In the event that Contractor provides pediatric Primary Health Care Services, Contractor must be Child Health and Disability Prevention Program (CHDPP) approved. Additionally, Internal Medicine and General Medicine practitioners who provide Primary Health Care and who see children twenty-one (21) years of age or younger shall be CHDPP-approved. Pediatricians and Family Practitioners who provide Primary Health Care and who see children twenty-one (21) years of age or younger should be CHDPP-approved but are not required to be so approved.

B. **Reporting Requirements and Protected Health Information**

1. **Health Professional Profile.** Contractor shall provide the Department with the information requested by the Department which is necessary for the Department to maintain a current detailed listing of Contractor's Health Professionals, at the time of contract execution and as requested by the Department. This information shall be included in the Clinic Health Professional Profile. To the extent possible, Contractor shall inform the Department of any changes in its Health Professionals no less than 48 hours, prior to the change.

2. **Clinic Site and Capacity Profile.** Contractor shall provide the Department with information requested by the Department which is necessary for the Department to maintain a current listing of Contractor's Clinic Sites and Mobile Clinics, and the anticipated capacity of each to serve Participants, at the time this Agreement is executed and as requested by the Department. This information shall be included in the Clinic Site and Capacity Profile. To the extent possible, Contractor shall inform the Department of any changes in its Clinic Site and Capacity Profile no less than fourteen (14) calendar days prior to the change. In the case of unforeseen circumstances that have the effect of changing the previously reported information, Contractor shall inform the Department as soon as Contractor becomes aware of the circumstances and the changed information. MHLA Services shall be provided at only the approved sites listed in Exhibit J, MHLA Site Profile (and any revisions thereto).

3. **Open/Closed Status.** Contractor shall report its open/closed status to the Department in accordance with Section III.H of this Statement of Work.

4. **Medical Encounter Data.** Contractor shall submit to the Department, on a monthly basis and beginning no later than April 1, 2015, utilization or medical encounter data provided in an File Transfer Protocol secure, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant format (such as the 837 Claim/Encounter file format), regarding the provision of Program Services to Participants. Medical encounter data shall be provided by Contractor to the Department for all Participants receiving Included Services, unless limited by the

Department through written notice. Contractor shall report data from all service locations, including satellite, mobile, and school based clinics, and shall accurately indicate the site where services were provided.

The Department will provide Contractor with all necessary template(s) for the electronic submission of HIPAA compliant medical encounter data to the Department. Medical encounter data shall be maintained and submitted in such detail, at such time, and in such form as is reasonable and consistent with the Department's requirements, which shall be provided by written notice. If the Department's requirements should change, the Department will provide Contractor at least thirty (30) days to comply therewith.

The provision of timely medical encounter data by Contractor is a Service Deliverable such that the failure to provide such medical encounter data due in a particular month will result in the suspension of payment to be made during that month.

The Department intends to use medical encounter data to track utilization of services by Participants, make informed decisions about potential program changes, establish normative standards, establish/maintain quality of care standards, and improve linkages among Program providers and the Department. These activities will be coordinated with broader Department wide performance/quality improvement activities. As provided in Section III.K.1.e. below, the Department shall review encounter data for completeness, accuracy, and compliance with formatting and submission requirements. Contractors which are not submitting accurate and complete medical encounter data in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve data submission issues in a prompt manner, may, at the sole discretion of the Department, be subject to suspension in monthly payments until such time as all medical encounter data has been received and accepted by the Department.

5. **Improvement Programs.** Contractor shall participate in Program quality improvement programs and provider education programs based on these reporting requirements. The Department may, at its discretion and at some point in the future, develop a quality and/or clinical outcomes improvement program, which may or may not be tied to encounter data. The Department will provide notice to Contractors via Provider Information Notice (PIN) within sixty (60) days of implementing any quality and/or clinical outcomes improvement program.

6. **Secured Email Transmission.** Contractor and its Staff are required securely to send Confidential Information via encrypted email, in accordance with all applicable State and Federal laws and County policies and guidelines as it pertains to the electronic transmission of Protected Health Information.

7. **Program Enrollment Targets.** Simultaneously with contract execution, Contractor shall provide to the Department its Program enrollment targets for the first term of this Agreement which shall be based on Contractor's anticipated capacity for the Program. By June 30 of each subsequent year, Contractor shall provide its program enrollment targets for the next fiscal year. Contractor's progress toward meeting its annual enrollment targets will be monitored by the Department.

8. **Visit Information.** Beginning in November, 2014, and continuing through and including March, 2015, Contractor shall provide to the Department, in the form and manner defined by the Department, an accurate count of the number of visits provided in the preceding month to Participants. Such count shall include only visits provided to persons who were actually enrolled in MHLA by the close of business on the date of service. Such information shall be provided no later than the 15th of each month (or the next business day following the 15th of the month if the 15th is a weekend day or holiday). Further, in the event that Contractor discovers any errors in the count of visits so reported, it shall immediately inform the Department and shall provide a corrected count as soon as it is known.

   The parties agree that time is of the essence in receiving the visit count information, which shall be used to assure that expenditures for MHLA do not exceed the available appropriation for Fiscal Year 2014-2015. The parties further agree that it will be impracticable or extremely difficult to fix the extent of actual damages resulting from the failure of Contractor to submit its data on time. The parties hereby agree that under the current circumstances, a reasonable estimate of such assessment is one hundred dollars ($100) per day until the data is submitted and that the Contractor shall be liable to the County for the assessment in said amount. Said assessment amount shall be deducted from any payments owed by County to the Contractor. The payment of assessment shall not, in any manner, restrict or limit the County's right to damages for any other breach of this Contract provided by law or as specified in this Agreement.

C. **Payment Requirements**

1. Included Services.

   For the period October 1, 2014 through March 31, 2015, Contractor shall be paid for Included Services provided to Participants on a fee-for-service basis in accordance with Paragraph 5.1 of the Agreement and Exhibit B.1, Fee-For-Service Payment and Billing, of the Agreement. Beginning April 1, 2015, Contractor shall be paid Monthly Grant Funding (MGF) by the Department in accordance with Paragraph 5.2 of the Agreement and Exhibit B.3, My Health LA Program Monthly Grant Funding, Billing, and Encounter Data Submission. The MGF is based upon data collection and analysis undertaken by the Department. The fee-for-service rate and MGF are specified in Exhibit B.2, Pricing Schedule. The fee-for-service rate and the MGF cover only Included Services.

2. Pharmacy Services.

   During the period in which Contractor is reimbursed for Included Services on a fee-for-service basis, Contractor shall not be compensated separately for the provision of Pharmacy Services.

   During Pharmacy Phase One, Contractor shall be paid Pharmacy MGF pursuant to the same terms and conditions, and using the same processes as the MGF, in accordance with subparagraph 5.3.2 of the Agreement.

   During Pharmacy Phase Two, payment for Pharmacy Services shall be managed by the Department's contract PSA, in accordance with subparagraph 5.3.3 of the

Agreement and Section II.4 of this Statement of Work.

3. Dental Care Services.

   Contractor shall be paid for the provision of Dental Care Services on a fee-for-service basis for dental services provided at only the approved sites listed in Exhibit J, MHLA Site Profile (and any revisions thereto), in accordance with Exhibit K-1 (K-2 or K-3, as applicable), Dental Care Services Description of Services, Funding, Billing, and Payment, of the Agreement.

4. Additional Conditions of Payment.

   As a condition of payment, Contractor shall meet all enrollment and re-enrollment requirements as defined in Subsections D. and E. below, and shall perform all Service Deliverables under the Agreement.

5. Contractor shall participate in the Medi-Cal Program and remain in good standing under that program for the entire term of the Agreement and shall maintain its status as a Federally Qualified Health Center (FQHC) or Federally Qualified Health Center Look-Alike (FQHC Look Alike), if applicable. Further, Contractor shall maintain all legally required licenses and/or certifications. Contractor shall have and maintain a Medi-Cal managed care contract with at least one of the Health Plans in the County of Los Angeles and shall maintain a Medi-Cal Managed Care or Department Facility Site Review score of 80 or better for each Clinic Site.

D. **Eligibility and Enrollment Requirements**

Contractor shall only enroll Eligible Persons as described herein.

Contractor shall enroll and re-enroll Participants into the Program through the Enrollment System. The Department will determine the Program eligibility rules to be used by the Enrollment System for the eligibility determination and application process. The Department shall provide Contractor a Program Eligibility Reference Manual, which contains detailed information regarding eligibility screening and enrollment. The Department shall provide on-going update and refresher training on eligibility and enrollment.

Applications for enrollment may only be taken and processed at Medical Homes, and at Administrative Enrollment Sites approved pursuant to Agreement Paragraph 2.0, Definitions, subparagraph 2.2, Administrative Enrollment Site, where the clinic processes enrollments for health insurance (e.g., Medicaid, Covered California).

Contractor shall utilize only Certified Application Assistors (CAAs), Certified Enrollment Counselors (CECs) and/or Certified Application Counselors (CACs), persons who have successfully completed the We've Got You Covered training, and/or any person who has met the training requirements specified by the Department in a PIN ("Qualified Enrollers") to take and submit Program applications according to Program rules. CAAs/CECs/CACs shall screen applicants for eligibility in Federal, State and other local health insurance programs. Contractor shall provide documentation demonstrating that persons performing enrollment have the required qualifications to be Qualified Enrollers. Program enrollment shall not occur when an applicant is found

to have eligibility for, or be enrolled in, another health care insurance program, unless the program is one which the Department, at its sole discretion, has excluded from this provision.

Prior to April 1, 2015, only persons who have successfully completed the MHLA eligibility and enrollment system training from the Department or from a Department designated trainer, or who is a CAA, and who are or intend to become a CEC and/or CAC, or complete training from We've Got You Covered, may receive access to the MHLA eligibility and enrollment system and act as a Qualified Enroller.

Contractor shall comply with the technical requirements specified in Attachment I, Minimum System Requirements for the MHLA eligibility and enrollment system, to this Exhibit, and provide adequately trained staff to perform enrollment functions. Enrollment functions include, but are not limited to:

1. Screen and assist Eligible Persons with submitting applications for a variety of local, State and Federal health insurance programs, if preliminarily determined eligible;

2. Enroll Eligible Persons in the Program who are not qualified for other health care insurance programs;

3. Access data regarding Program enrollment status for Eligible and/or Enrolled Persons;

4. Modify existing applications;

5. Renew Participants as set forth in Subsection E. below;

6. Support enrollment/application system users.

Contractor shall (i) participate in all required Program trainings, (ii) designate an individual(s) who will serve in a lead role with respect to the Department's Enrollment System within Contractor's organization, and (iii) ensure that all Qualified Enrollers enrolling participants into the Program via the Enrollment System have either paper or electronic access to the System's Program Eligibility Reference Manual.

Qualified Enrollers handling enrollment shall use the Enrollment System to screen and assist Los Angeles County residents with referrals to other public health programs as applicable.

E. Redetermination/Re-Enrollment

Contractor shall make every effort to obtain a Program renewal application from the Participants who have selected Contractor. Failure to complete the renewal process prior to the end of the one-year enrollment period will result in the disenrollment of that Participant from the program. Contractor may renew Participant enrollment as early as ninety (90) days prior to the end of a Participant's enrollment period.

Contractor's Qualified Enrollers who are handling redetermination or re-enrollment shall conduct an in-person interview with at least one adult household member that is

on the application for renewal or re-enrollment. If a Participant who was previously part of a household is no longer eligible to remain in that household upon renewal, that Participant must be present for their renewal. Contractor shall rescreen each Participant on the application for eligibility for other public programs and process the renewal application for the Program, if still eligible, via the Enrollment System. Qualified Enrollers shall update the Participant's information, including re-submittal of all required documentation for each individual on the application who is renewing, in the Enrollment System to reflect new demographic information (e.g. change of address, income or assets), and/or any other change that may link the applicant to a different program (e.g. change in pregnancy status, citizenship or family size). The Enrollment System will retain all documents collected during the initial enrollment and re-enrollment. Permanent documents (e.g., documentation of identification) do not require re-submission at re-enrollment while temporary documents (e.g., documentation of income or residence) will require submission of updated and recent information. Detailed Program requirements shall be set forth in the Program Eligibility Reference Manual.

F. **Dis-enrollment**

Participants who no longer meet program eligibility requirements shall be dis-enrolled from the Program. Participants can voluntarily dis-enroll at any time. A former Participant can re-enroll into the Program after disenrollment if the individual meets the Program eligibility requirements.

If Contractor obtains information that indicates that a Participant no longer meets program eligibility requirements during his or her enrollment period, a dis-enrollment request shall immediately be initiated by Contractor. Contractor shall submit documentation (e.g., proof of enrollment in full-scope [share-of-cost and no-share-of-cost] health insurance, proof of non-Los Angeles County residence) to County which demonstrates that the participant no longer meets program eligibility requirements in a manner to be determined by the County.

Participants with full-scope active Medi-Cal Hospital Presumptive Eligibility shall not be dis-enrolled from the Program.

G. **Medical Home Selection**

Participants must select a Medical Home for Primary Health Care Services and will receive a printed enrollment approval notice displaying their selected Medical Home. Participants will be sent an identification card and welcome packet by the Department.

Except as specified below, Participants may change their Medical Home no more than once per year. Participants may change their Medical Home at the time of their annual renewal and may not change their Medical Home at any other time unless: (1) the Participant has moved or changed jobs, and is seeking a new Medical Home closer to his/her new place of residence or employment, (2) the Participant has a change in his/her clinical condition and is seeking a new Medical Home that he/she believes can better manage this medical condition, (3) the Participant has a deterioration in the relationship with the health care provider(s) at his/her Medical Home, or (4) the location of the Medical Home is closed temporarily or permanently. The Participant may change his or her Medical Home for any reason within the first thirty (30) days of

enrollment in the Program. All Medical Home changes are effective the first day of the month following the request for change.

H. **Clinic Capacity, Open/Closed Status for New Enrollment, Access Standards**

Contractors will be surveyed a maximum of twice monthly by the Department to determine whether there are any changes to the Clinic's open/closed status based on their capacity. Response to this inquiry by the Department shall be considered a Service Deliverable. Capacity is defined by the number of days that a new Participant must wait before he or she can obtain a non-urgent Primary Health Care Services appointment at the Clinic Site.

A Clinic Site is considered to have capacity if the Clinic Site could schedule a non-urgent Primary Health Care Services appointment within twenty-one (21) calendar days. A non-urgent Primary Health Care Service is one that does not require an appointment within ninety-six (96) hours. A Clinic Site does not have capacity if the Clinic Site could not schedule a non-urgent Primary Health Care Services appointment within twenty-one (21) calendar days. A Clinic Site with capacity shall be considered "open" to new Participants. A Clinic Site without capacity shall be considered "closed" to new Participants.

Contractor shall make available to Participants appointments for Included Services within twenty-one (21) calendar days for non-urgent Primary Care Health Services, or within ninety-six (96) hours for urgent Primary Health Care Services. Participants requiring same or next day appointments for Included Services shall not be referred to the Department's Emergency Department or Urgent Care clinics during the Clinic Site's hours of operation.

The open or closed status of a Clinic Site shall be entered by the Department into the Enrollment System and is information that shall be available to all Clinics.

Contractor shall inform the Department within twenty-four (24) hours if a Clinic Site no longer has the capacity to accept new Participants. Contractor shall notify the Department of its intent to reopen its Clinic to new Participants.

A Clinic Site's open or closed status will determine whether a Clinic Site is open to accept a referral of an Eligible Person from the Department. Any Clinic Site that is "open" to new Participants must be uniformly open to Eligible Persons regardless of whether the Eligible Person presents as a walk-in or is referred from the Department. Acceptance of Department-referred Eligible Persons to an "open" Clinic Site is a Service Deliverable. The Contractor shall not refuse to accept a Department-referred Eligible Person unless (1) the Clinic Site is "closed" to new Participants, or (2) the Clinic does not have the clinical capability to care for the Eligible Person, as determined by Contractor's physician who shall attest that the Contractor does not have the clinical capability to render appropriate care to the Eligible Person. Such attestation shall be in writing, signed by the physician, include a detailed explanation as to why care cannot be rendered and submitted to the Department within twenty-four (24) hours of the referral by the Department. The Contractor must respond within 30 days to the Department's request to return the Primary Care Linkage Form to the Department, indicating that Contactor has attempted to contact the Eligible Person for enrolled into the MHLA Program. The Department shall provide to Contractor the

complete protocol for Patient Referral through a future Provider Information Notice (PIN) process.

If Contractor is open to new Participants, Contractor must attempt to enroll the MHLA Eligible Persons referred to Contractor by the Department. Failure of Contractor to comply with the requirements of this paragraph may result in the assessment of liquidated damages as set forth in this Exhibit, Section III. N, and Attachment II-B, Table of Liquidated Damages.

A closure to new Eligible Persons must apply uniformly to all Eligible Persons. This means that a Clinic Site or Mobile Clinic may not be open to providing Primary Care Services to some new Eligible Persons, but not others. Clinic Sites and Mobile Clinics shall provide services to their existing Participants even if they are closed to new Eligible Persons. Contractor shall not close its practice to its existing Participants.

At no time shall Contractor be permitted to design or deploy programs in such a manner as to exclude or disadvantage Participants or to advantage patients with third-party payors or financial means.

I. **Deletion of Existing Approved Clinic, Mobile Clinic, or Administrative Enrollment Sites**

1. Contractor shall notify the Department consistent with Paragraph 8.38, Notices, of the Agreement at least ninety (90) days prior to the temporary or permanent closure of a Clinic Site, Mobile Clinic, and/or Administrative Enrollment Site.

2. Contractor shall provide at least sixty (60) days advance written notice of the pending closure to all Participants who have selected the closing Clinic Site as their Medical Home and shall obtain the Department's approval of this correspondence prior to sending it to the Participants. The Department will respond within five (5) business days with an approval or denial of the correspondence; otherwise Contractor may proceed.

3. In such notice, Participants shall be informed of the new Medical Home, which may be part of the same Contractor or may be under a different Contractor.

4. In the case of a closure due to an emergency or unforeseen circumstance (e.g., fire, flood), Contractor shall notify the Department and Participants of the closure as soon as feasibly possible, and shall make every effort to assist Participants with identifying a new Medical Home.

J. **Adding a New and/or Transferring a Clinic, Mobile Clinic, or Administrative Enrollment Site**

1. If a Contractor wishes to open a new or transfer a Clinic Site or Mobile Clinic during the duration of the Agreement, the new or transferred Clinic Site or Mobile Clinic shall meet the following criteria:

a. Shall be operational.

b. Shall demonstrate valid enrollment as a current, active provider in the State of California Medi-Cal Program.

c. Shall demonstrate enrollment as a current, active provider in a Medi-Cal Managed Care program by producing verification from Medi-Cal Managed Care Health Care Option or contracted health plan (i.e., approval letter or paid claim for a Medi-Cal managed care patient from a Health Plan).

d. Shall possess at least one (1) NPI Number of the Clinic Site or Satellite Site.

e. Shall have completed and passed either the Department or the Health Plan's Facility Site Review (FSR) process.

f. Shall have an appropriate, current license issued by California Department of Public Health, or meets the requirements to be exempt from licensure under California Health & Safety Code Section 1206(h). Not applicable for the Satellite Sites operating under the license of a Clinic Site.

g. Shall be registered with, or must be able to demonstrate proof of submission to, the Office of Statewide Health Planning and Development (OSHPD) as an appropriately licensed clinic. Not applicable for the Satellite Sites operating under the license of a Clinic Site.

h. Shall be designated by the Centers for Medicare and Medicaid Services as a FQHC or a FQHC Look-Alike, and registered with HRSA Office of Pharmacy Affairs to access the 340B program, and register at least one MHLA contracted 340B pharmacy to dispense 340B pharmaceuticals to Participants. An exception to this requirement is any Clinic Site that is operating in SPA 1 (including **the communities of Acton, Agua Dulce, Gorman, Lake Hughes, Lake Los Angeles, Lancaster, Littlerock, Palmdale, Quartz Hill, and others)** which is not subject to the FQHC or FQHC Look-Alike requirement. All other qualification requirements apply to Clinic Sites in SPA 1. For a full map of the County's SPAs, refer to:

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm)

i. Shall certify that all of its physicians and/or mid-level nurse practitioners working at the new Clinic Site or Mobile Clinic meet the requirements in Section III.A above.

2. If a Contractor wishes to open a new Administrative Enrollment Site during the duration of the Agreement, the new Administrative Enrollment Site shall meet the following criteria:

a. Shall be operational.

b. Shall demonstrate compliance with all requirements of an Administrative Enrollment Site pursuant to Agreement Paragraph 2.0, Definitions, subparagraph 2.2, Administrative Enrollment Site.

c. Shall have a business license or rental agreement. If more than one entity is occupying shared space/co-location, the Administrative Enrollment Site entity must submit a Memorandum of Understanding.

K. **Medi-Cal Requirements and Departmental Record Reviews and Audits**

Contractor must have a Medi-Cal Managed Care contract with at least one of the Health Plans in the County of Los Angeles and must receive full-scope facility site and medical record reviews through their Health Plan contract(s) and/or the Department. The Department shall review and may accept the Health Plan site and medical record review findings.

The Department has the right to audit or review any and all aspects of Contractor's performance related to this Agreement. In addition, the Department will conduct its own annual program monitoring, administrative and financial monitoring visits which include the following reviews.

1. **Program Monitoring and Administrative Reviews.** Program Monitoring and Administrative Reviews relate to Contractor compliance with the Agreement and Include the following:

   a. **Medical Record Review (MRR).** Applying file sampling standards used by the National Committee for Quality Assurance (NCQA), the Department shall review annually a random selection of medical records based on the number of Primary Care providers, which includes pharmacists, social workers and psychologists at the Clinic Site. The Department shall sample no fewer than eight (8) and no more than forty (40) medical records. In the event the Department's review of the eight (8) medical records finds that each such record meets or exceeds each of the review standards and elements identified in the Audit Tool ("Criteria"), then the Department's MRR shall end. In the event the Department finds that one (1) or more of the eight (8) medical records does not meet each of the Criteria, the Department shall randomly select an additional number of medical records, within the upper limit of forty (40) total medical records, and assess the additional medical records for compliance with the Criteria. During the term of this Agreement, Contractor shall maintain an MRR score of eighty percent (80%) or more.

   b. **Facility Site Review (FSR).** The Department shall evaluate the physical plant and operations at each Clinic Site to ensure quality standards are met in clinic facility operations Including patient access, safety, personnel and infection control. Contractors shall be expected to maintain a Health Plan and Department FSR scores of eighty (80) or better for the duration of the Agreement.

   c. **Eligibility and Enrollment Review.** The Department shall conduct monthly audits of a random sample of all new Program applications submitted through the Enrollment System to ensure data integrity, accuracy of Participant contact information, and adherence to Program rules as described in the Program Eligibility Reference Manual. The audit shall be conducted to validate, among other things, that the Contractor is compliant with Program rules, that

Contractor submitted legible and appropriate verification documents to accompany the Participant's application in the Enrollment System (e.g., income, identification, assets, signed acknowledgement form, etc.) and that income information in the Enrollment System is consistent with the supporting income documentation provided by the Participant.

If an audit/compliance review is conducted by County staff, Contractor shall have a reasonable opportunity to review County's findings prior to recoupment. If Contractor provides documentation to the County that demonstrates that any particular finding is erroneous, recoupment will not occur. The Department shall not pay, and may recoup, the MGF or the Dental fee-for-service, or both and, if applicable, Pharmacy MGF paid on behalf of a Participant who is found on audit or review to be ineligible for the Program and/or for whom legible and/or appropriate verification documents were not submitted.

d. (i) **Credentialing Review.**

The Department shall review Contractor's credentialing policies to ensure that the Contractor has a well-defined credentialing and re-credentialing process for evaluating and selecting licensed independent practitioners to provide care to its patients which is compliant with State and Federal laws and regulations. This process must meet the NCQA, Credentialing and Re-credentialing Standards, CR-1 through CR-8.

In the event Contractor credentials and/or re-credentials 40 or more individuals during the period under audit, the Department will select a random sample of up to 40 records (or all records if less than 40 credentialing or re-credentialing actions were taken). Eight randomly selected files will be reviewed for compliance. If each such file meets or exceeds each of the review standards and elements identified in the Audit Tool ("Criteria"), then the Department's audit shall end. If one or more of the initial eight files do not meet the Criteria then the additional selected records will be reviewed to assess the compliance status.

Contractor's failure to meet NCQA credentialing requirements shall be deemed a Critical Element/deficiency and may result in the assessment of liquidated damages per deficient site pursuant to Section III-N and Attachment II-B.

(ii) **Licensing Review.**

The Department shall review Contractor's compliance with all applicable Federal and State licensing requirements and supervision of non-physician medical practitioners.

Contractor's failure to meet licensing requirements at any site shall be deemed a Critical Element/deficiency and may result in the assessment of liquidated damages pursuant to Section III.N and Attachment II-B.

e. **Medical Encounter Data.** The Department shall review all submitted medical encounter data for completeness, accuracy and compliance with formatting and

submission requirements, as specified in Section III.B.4 of this Statement of Work. To the extent that the Department determines that the encounter data provided by Contractor is deficient in any of these areas, the Department shall notify Contractor in writing, (which may include notice by e-mail) of such deficiencies. Contractor shall have fourteen (14) calendar days to submit a credible plan of correction, which explains both how the deficiency will be rectified and how Contractor's processes or procedures will be modified to assure that the deficiency will not reoccur, and to resubmit corrected medical encounter data. For good cause shown, the Department may extend Contractor's time for submitting the plan of correction or resubmitting the medical encounter data. The Department may suspend payment if Contractor fails to meet the obligations of this subsection until such time as Contractor meets such obligation.

2. **Compliance Standards/Audit Response.** The specific compliance issues found during the audit shall be outlined in a letter from the Department to the Contractor. This letter shall address the identified deficiencies, summarize the audit activities, specify the areas in which mitigation is to be taken and identify required timelines and potential mitigation dates. Contractors with deficiencies identified during the audit process may be required to submit an Acceptable Corrective Action Plan (CAP) to address such deficiencies. An Acceptable CAP is a corrective action plan that sets forth the actions reasonably designed to fix the deficiency, a time line for the execution of each action in the CAP, a designation of the staff responsible for performing or overseeing the performance of each action in the CAP, and a system for monitoring to assure that the deficiency does not reoccur. Generally, the CAP should provide for the correction of the deficiency before the date the CAP is due.

   If Contractor fails timely to submit an Acceptable CAP, as determined by the Department, when required to do so under this Agreement, liquidated damages may be assessed pursuant to Section III. N, Liquidated Damages, and Attachment II-B.

   Categories for audit compliance scores are as follows:

   Full Compliance: Means a score of ninety-five percent (95%) or above without "Critical Elements, Pharmaceutical Services or Infection Control deficiencies" (as defined by the California Department of Health Care Services Medi-Cal Managed Care Division or as specified in this Agreement). A Contractor found to be in Full Compliance shall not be required to submit a Corrective Action Plan (CAP) to the Department.

   Substantial Compliance: Means (i) a score between eighty percent (80%) and ninety-four percent (94%), or (ii) ninety-five percent (95%) and above with deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. A Contractor found to be in Substantial Compliance shall be required to submit an Acceptable CAP to the Department.

   Non-Compliance: Means a score less than eighty percent (80%). A Contractor who is found to be in Non-Compliance shall be required to submit an Acceptable CAP. Any Contractor that achieves a Non-Compliance score shall receive a follow-up focused review as an extension of the audit process to determine the

depth of the identified deficiencies. Liquidated damages in accordance with Section III.N, Liquidated Damages, and Attachment II-B may be assessed if (1) a Clinic Site receives a score on either a Medial Record Review (MRR) or, a Facility Site Review (FSR) that is less than 80%; and (2) a focused review of the deficiencies conducted after an Acceptable CAP is submitted reveals (a) a failure by Contactor to implement the CAP, or (b) that the deficiencies continue.

MRR and FSR with Repeat Deficiencies: A Repeat Deficiency means a finding of less than Satisfactory Compliance, of same MRR or FSR audit element in the same audit tool from the prior fiscal year audit. Satisfactory Compliance is the minimum level of compliance for meeting a standard or element as specified in the audit tool. Contractor shall submit an Acceptable CAP for each Repeat Deficiency. If Contractor (a) has five or more of the same Repeat Deficiencies during each of three consecutive fiscal years, and (b) does not reduce its total number of Repeat Deficiencies between the first and third fiscal years of the three year period being assessed, liquidated damages may be assessed pursuant to Section III. N and Attachment II-B. The first year of the first period to which this provision applies is fiscal year 2018-19.

All deficiencies Including Critical Elements, Pharmaceutical Services or Infection Control deficiencies, and the Contractor's CAP, shall be tracked by the Department and analyzed for the purpose of identifying problems areas and barriers to the provision of quality health care. The Department will utilize this data to ensure that Contractor implements solutions to identified deficiencies. The Department will provide Contractor reasonable opportunity to respond to audit findings. The CAP itself is not considered complete until the Department provides final approval and the Contractor has implemented the provisions of the CAP.

Contractor shall meet the established minimum compliance threshold for all audits conducted by the Department. If Contractor fails to submit or implement an Acceptable CAP, is non-compliant with any reasonable request related to any audit, review or finding, and/or has not sufficiently remedied the issues or exceptions identified by the Department, the Department may, at its discretion, take the following actions: (1) prohibit Contractor from continuing to provide Included Services or Dental Care Services, as applicable, to Participants at the site or sites with the adverse audit findings; (2) transfer the Participants to a new medical home or refer the Participants to another approved dental site; (3) prohibit Contractor from adding new primary care or dental sites, or adding dental services to existing approved sites, or both; and/or (4) suspend MGF payments, fully or in part. Such actions shall be in effect until such time that the Department, at its sole discretion, determines that Contractor has implemented an Acceptable CAP, is compliant with any reasonable request related to any audit, review or finding, and/or has sufficiently remedied issues or exceptions identified by the Department. The Department shall provide timely notice to Contractor of any such actions, and of the termination or rescission thereof.

3. **Financial Review**

   a. **Financial and Employment Records.** Contractor shall maintain accurate and complete employment records and financial (including billing and eligibility) records of its operations as they relate to its services under this Agreement in

accordance with generally accepted accounting principles. Contractor shall retain such records for the period required by law but in any event no less than ten (10) years after date of service or five (5) years after contract termination, whichever is later. Contractor shall have their financial records audited by an independent auditor in a manner which shall satisfy the requirements of the Federal Office of Management and Budget Circular Number A-133 in accordance with Governmental Financial Auditing Standards developed by the Comptroller General of the United States, and any other applicable Federal, State, or County statutes, policies, or guidelines.

b. **Audit/Compliance Review.** Los Angeles County staff or Federal or State Government Officials may conduct an audit/compliance review of all payments made by the County including payments and/or services provided by a subcontractor on behalf of the Contractor. If the audit is conducted by County staff, any sampling shall be determined in accordance with generally accepted auditing standards, unless otherwise specified in the Agreement, and an exit conference shall be held following the performance of such audit/compliance review at which time the results shall be discussed with Contractor. Contractor shall be provided with a copy of any written evaluation reports prepared by County staff. If the audit/compliance review is conducted by County staff, Contractor shall have a reasonable opportunity to review County's preliminary findings for Contractor and to provide documentation to the County to demonstrate that the finding is erroneous, or that steps have been taken to correct the deficiency. If audit exceptions remain which have not been resolved to the satisfaction of the County, Contractor may be subject to a full or partial suspension in MGF payments, the Department may close the site to new Participants and/or the site(s) with the adverse audit findings may be prohibited from providing Included Services or Dental Care Services, or both, to the Participants until such time as all audit deficiencies are corrected and accepted by the County.

   The County shall recoup payment due from Contractor for overpayment or improper payment of MGF or Dental fee-for-service, or both, based on reconciliation or audit of enrolled Participants and eligibility, by requesting payment from Contractor, which repayment shall be remitted forthwith by Contractor to County by check made payable to the County of Los Angeles, or by withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set, unless any other recoupment plan is approved by County in writing.

L. **Performance Requirements Summary/Table of Liquidated Damages**

The Performance Requirements Summary (PRS) Chart, Attachment II.A to this Exhibit, and the Table of Liquidated Damages (TLD), Attachment II.B to this Exhibit lists required services that will be monitored by the County during the term of this Agreement.

1. All listings of services used in the PRS and TLD are intended to be consistent with the Agreement and the Statement of Work (SOW), and are not meant in any case to create, extend, revise, or expand any obligation of Contractor beyond that defined in the Agreement and the SOW. In any case of apparent inconsistency

between services as stated in the Agreement and the SOW and Attachment II.A, PRS Chart, or Attachment II.B, TLD, the language in the Agreement and then the SOW shall be given precedence. If any service seems to be created in this PRS or TLD which is not set forth in the Agreement and the SOW, that service will be null and void and place no requirement on Contractor.

2. The Contractor is expected to perform all services described herein. The PRS Chart and TLD describes certain required services which will be monitored by the County during the term of the Agreement, and for which Contractor may be assessed a suspension of payment or liquidated damage if the service has not been satisfactorily provided. The PRS Chart indicates the SOW and/or Agreement section of the performance referenced (column 1); a description of the service to be provided (column 2); the monitoring method that will be used (column 3); and the assessment for services that are not satisfactory (column 4). Once performance requirements are satisfied, the Department will pay all suspended payments in the next payment cycle. The TLD indicates the SOW section of the performance referenced (column 1); amount of liquidated damage (column 2); and the date on which liquidated damages may begin and end (column 3).

M. Performance Requirements

1. If, in the judgment of the Director, or his/her designee, the Contractor is deemed to be non-compliant with the terms and obligations assumed hereby, the Director, or his/her designee, at his/her option, in addition to, or in lieu of, other remedies provided herein, may suspend the entire MGF until such time that the performance requirements are met. A description of the work not performed, obligations not met, and whether MGF will be suspended by Department will be forwarded to the Contractor by the Director or his/her designee, in a written notice describing the reasons for said action, at least five (5) business days prior to the suspension of the MGF. If Contractor can demonstrate that its non-compliance has been remedied prior to the effective date of the suspension, such suspension shall not go into effect. When performance requirements have been satisfied, the Department will pay all suspended payments in the next payment cycle.

   If the Director, or his/her designee, determines that there are deficiencies in the performance of this Agreement that the Director, or his/her designee, deems are correctable by the Contractor within a reasonable period of time, as determined by the Department, the Director, or his/her designee, shall provide a written notice to the Contractor to correct the deficiency within specified time frames. Should the Contractor fail to correct deficiencies within said time frame, the Director may:

   a. Suspend MGF as specified in the PRS Chart, Attachment II.A, and/or:

   b. Upon giving five (5) business days written notice to the Contractor for failure to correct the deficiencies, the County may correct any and all deficiencies and the total costs incurred by the County for completion of the work by an alternate source, whether it be County forces or separate private contractor, will be deducted and forfeited from the payment to the Contractor from the County, as determined by the County.

2. The action noted in Subsection 1.(b) above shall not be construed as a penalty, but as adjustment of payment to the Contractor to recover the County cost due to the failure of the Contractor to complete or comply with the provisions of this Agreement.

3. This Subsection shall not, in any manner, restrict or limit the County's right to damages for any breach of this Agreement provided by law or as specified in the PRS, and/or the Table of Liquidated Damages, and shall not, in any manner, restrict or limit the County's right to terminate this Agreement as agreed to herein.

N. **Liquidated Damages**

1 If, in the judgment of the Director, or his/her designee, the Contractor is deemed to be non-compliant with the terms and obligations assumed hereby, the Director, or his/her designee, at his/her option, in addition to, or in lieu of, other remedies provided herein, may deduct from any amounts due to the Contractor the amount of any liquidated damages assessed pursuant to Attachment II-B. A description of the work not performed or obligations not met and the amount to be deducted from payments to the Contractor from the County, will be forwarded to the Contractor by the Director or his/her designee, in a written notice describing the reasons for said action.

2 If the Director, or his/her designee, determines that there are deficiencies in the performance of this Agreement that the Director, or his/her designee, deems are correctable by the Contractor within a reasonable period of time, as determined by the Department, the Director, or his/her designee, will provide a written notice to the Contractor to correct the deficiency within the timeframe specified by the Department. Should the Contractor fail to correct deficiencies within said time frame, the Director may deduct from any amounts due to the Contractor the amount of any liquidated damages assessed pursuant to Attachment II-B.

The parties agree that it will be impracticable or extremely difficult to fix the extent of actual damages resulting from the failure of the Contractor to correct a deficiency within the specified time frame. The parties hereby agree that liquidated damages shall be determined in accordance with Attachment II-B, Table of Liquidated Damages and that the Contractor shall be liable to the County for liquidated damages assessed in the specified amount listed on Attachment II-B. Said amount shall be removed from the MGF or deducted from the County's payment to the Contractor.

In addition to, or instead of any liquidated damages, upon giving five (5) days' notice to the Contractor for failure to correct the deficiencies, the County may correct any and all deficiencies and the total costs incurred by the County for completion of the work by an alternate source, whether it be County forces or separate private contractor, will be deducted and forfeited from the payment to the Contractor from the County, as determined by the County.

3. The actions noted in Sub-section N.2 shall not be construed as a penalty, but as adjustment of payment to the Contractor to recover the County's cost due to the failure of the Contractor to complete or comply with the provisions of this Agreement.

4. This Sub-section N shall not, in any manner, restrict or limit the County's right to damages for any breach of this Agreement provided by law or as specified in the Table of Liquidated Damages or Sub-section N.2, and shall not, in any manner, restrict or limit the County's right to terminate this Agreement as agreed to herein.

5. **Table of LIQUIDATED DAMAGES**

   Attachment II-B, Table of Liquidated Damages is attached to this Agreement and incorporated herein by reference. Pursuant to Sub-section N.2, County shall be entitled to deduct the amounts set forth therein as liquidated damages for each specified deficiency.

ATTACHMENT I

MINIMUM SYSTEM REQUIREMENTS
for One-e-App

Attachment I sets forth the minimum System Requirements for end user hardware/software configurations and network configurations to ensure System Compatibility with personal computers, tablets and mobile devices.

1.0 MINIMUM RECOMMENDED REQUIREMENTS FOR DESKTOP/LAPTOPS:

Hardware Requirements: Computers with 512 MB RAM or higher

Software Requirements:

- PDF Reader: Adobe Acrobat Reader software to view PDF images, version 7.0 or higher;
- Pop-up Blocker: Turned off for One-e-App;
- Operating System Firewall: Turn on the firewall in the operating system. For example, built-in for Microsoft Windows operating systems;
- Antivirus Software (including antispyware software): Symantec version 12.0 or higher, McAfee version 8.8 or higher, or equivalent. Virus and spyware definitions must be updated on a regular basis.

2.0 MINIMUM RECOMMENDED INTERNET CONNECTIVITY:

Internet Connectivity: Access to high-speed internet (DSL, Cable, T1 Line) through a hard-wired or wireless router OR a broadband "air card" for portable internet connectivity.

Internet Speed: The average bandwidth availability per computer is recommended to be 3.75 Kilobytes (KB) per second to run the One-e-App.

Internet Browser: Internet Explorer version 7.0 or higher.

3.0 OTHER REQUIRED EQUIPMENT:

Printer: Dedicated or network printer with at least 600×600 dpi (dots per inch)

Scan: Scanners must be set at a minimum of 300 dpi

Signature Pads (optional): For electronic signature capturing and viewing, Signature Pad and bundles SigPlusPro software from Topaz Systems, Inc.

PERFORMANCE REQUIREMENTS SUMMARY (PRS) CHART

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
LICENSING AND CREDENTIALING			
Contractor shall ensure that all Licensing and Credentialing and Health Professional and Clinic Site Requirements are met as stated in the Statement of Work Section III.A (1-7)	**Section III.A (1)** describes the Contractor's obligation to abide by all applicable Federal and State laws, licensing requirements and locally prevailing professional health care standards of practice. **Section III.A (2-3)** describes staff supervising requirements, staffing requirements, implementation of credentialing programs, standards and guidelines, disclosure of documents relating to credentials, qualifications, and performance of its employed and contracted Health Professionals, credentialing of Health Professionals. **Section III.A (4-6)** describes handling of a suspended, revoked or restricted license, the reporting of adverse legal settlements or judgments reporting to the California Medical Board or National Practitioner Data Bank, reporting material changes in credentialing information, sanctions by Medicare or Medi-Cal certification requirements and delivery of pharmaceuticals according to evidence-based guidelines. **Section III.A (7)** describes the Contractor's obligation when providing Primary Health Care to children 21 years of age or younger.	Inspection & Observation, Verification of documentation	Contractors who do not abide by the requirements of these sections **(Section III.A, 1-7)** may, after the Department has worked in good faith with the Contractor to resolve the issues in a prompt manner, as determined by the Department, have their Monthly Grant Funding payments suspended, at the discretion of the Department, until such time as all requirements are met. Any Health Professional whose professional license is revoked, suspended or restricted in a manner that renders him or her unable to provide Program services shall not render service to Participants until the revocation, suspension or restriction has been removed or otherwise resolved.

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
REPORTING REQUIREMENTS AND PROTECTED HEALTH INFORMATION			
Contractor shall ensure that all Reporting Requirements and Protected Health Information Requirements are met as stated in the Statement of Work Section III.B (1-4) **Contractor shall participate in the Department's quality improvement initiatives and established Participant complaint procedures.**	**Section III.B (1-3)** describes the Contractor's obligation to provide the Department with a Health Professional Profile, Clinic Site and Capacity Profile, update their Open/Closed Status. **Section III.B (4)** describes the Contractor's obligation to submit Medical Encounter Data to the Department in a HIPAA compliant format.	Receipt of documentation	Contractors who have not met Reporting Requirements (Section **III.B (1-3)** in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve issues in a prompt manner, as determined by the Department, may be subject to a suspension of Monthly Grant Funding until such time as all Reporting Requirements have been received and accepted by the Department. Contractors who do not submit Medical Encounter Data **(Section III.B, 4)** shall, after the Department has worked in good faith with the Contractor to resolve the issues in a prompt manner, as determined by the Department, have their Monthly Grant Funding payments suspended, at the discretion of the Department, until such time as all Encounter Data Reporting Requirements have been received and accepted by the

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
	Section III.B (8) describes the Contractor's obligation to provide to the Department in a timely manner an accurate count of the number of visits provided in the preceding month to Participants.		Department. Contractors who do not submit Visit Information (**Section III.B, 8)** in a timely manner shall be assessed $100 per day until the Visit Information data is submitted. Said assessment amount shall be deducted from any payments owed by County to the Contractor.
PAYMENTS REQUIREMENTS			
Contractor shall meet all Payments Requirements as stated in the Statement of Work Section III.C.	**Section III.C** describes the Contractor's obligation to participate in the Medi-Cal program and remain in good standing with all requirements related to Contractor's continued participation in the Program.	Inspection & Observation Verification of documentation	Contractors who do not participate in the Medi-Cal Program and/or who do not remain in good standing with all requirements related to Contractor's continued participation in the Program., shall have their Monthly Grant Funding suspended at the discretion of the Department, until such time as all requirements related to ongoing participation in the Program have been restored.

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
ELIGIBILITY, ENROLLMENT, RE-ENROLLMENT, DIS-ENROLLMENT, OPEN/CLOSED STATUS REPORTING, AND ADDING A NEW SITE REQUIREMENTS			
Contractor shall meet all Eligibility and Enrollment, Re-Enrollment, Dis-enrollment, Open/Closed Status Reporting and Deleting and Adding New Site Requirements as stated in the Statement of Work Sections III.D – III.J.	**Section III.D** describes the Contractor's obligation to only enroll into the Program Eligible Persons, enroll and re-enroll Participants using the County's approved Enrollment System using a Qualified Enroller and at an approved Medical Home or Administrative Enrollment Site. **Section III.E** describes the Contractor's obligation to make every effort to obtain a Program renewal application from Participants and rescreen Participants for continued eligibility via the Department's Enrollment System. **Section III.F** describes the Contractor's obligation to dis-enroll Participants who no longer meet Program requirements. **Section III.G** describes the process of Participates selecting a Medical Home for Primary Health Care Services. **Section III.H** describes the process by which clinics report to the Department any changes to the open/closed status of their clinic, based on their capacity to accept new Eligible Persons and Department-referred Eligible Persons, apply a closure uniformly to all Eligible Persons, not close its practice to existing Participants, or exclude or disadvantage Participants or advantage patients	Inspection & Observation Verification of documentation	Contractors who do not abide by the requirements of these sections in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve issues in a prompt manner, as determined by the Department, may have their Monthly Grant Funding payments temporarily suspended until such time that requirements are met.

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
	with third-party payors of financial means. **Section III.I** describes the process the Contractor must go through to delete an existing approved Clinic, Mobile Clinic or Administrative Enrollment Sites. **Section III.J** describes the process by which a clinic notifies the Department if they wish to add a new Clinic and/or transferring an approved Clinic, Mobile Clinic or Administrative Enrollment Site.		
MEDI-CAL REQUIREMENTS AND DEPARTMENTAL RECORD REVIEWS AND AUDITS			
Contractor shall meet all Medi-Cal Requirements and Departmental Record Review and Audit Requirements as stated in the Statement of Work Section III.K (1-3)	**Section III.K (1-3)** describes the Contractor's obligation to have a Medi-Cal Managed Care contract with at least one of the Health Plans in Los Angeles County, and to submit and implement all requested and required Corrective Action Plans (CAPs) that are identified by the County as part of its own annual program monitoring, administrative and financial monitoring reviews.	Inspection & Observation Verification of documentation	Contractors who do not abide by the requirements of this section in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve issues in a prompt manner, as determined by the Department, may have their Monthly Grant Funding suspended, at the Department's discretion, until such time that requirements are met.

TABLE OF LIQUIDATED DAMAGES

	CONDITIONS FOR IMPOSITION OF LIQUIDATED DAMAGES	SOW REFERENCE	AMOUNT	When Liquidated Damages Are Assessed**
1	Contractor which is open to new Participants (1) fails to attempt to enroll MHLA Eligible Persons referred by the Department to Contractor, or (2) fails to return the Primary Care Linkage Form to the Department	Exhibit A-2, Section III, H	$100 per day until the Primary Care Linkage Form is received	Assessed on a date to be determined by the MHLA Program Director and indicated on the formal notification letter sent by the Program Director to the Chief Executive Officer of the clinic, and ends when Contractor returns the completed Primary Care Linkage Form.
2	Contractor fails to comply with NCQA credentialing requirements	Exhibit A-2, Section III, K.1.d	$100 per day per site with deficiencies	Begin on date that audit findings specifying deficiencies is issued, and end when Contractor demonstrates to the Department that all credentialing deficiencies have been resolved.
3	Contractor fails to comply with Federal and State licensing requirements and/or requirements for the supervision of non-physician medical practitioners	Exhibit A-2, Section III, K.1.d	$100 perday per site with deficiencies	Begin on date that audit findings specifying deficiencies is issued, and end when Contractor demonstrates to the Department that all licensing and/or supervision deficiencies have been resolved.
4	Contractor fails timely to submit an Acceptable CAP as defined in the Statement of Work	Exhibit A-2, Section III, K.2	$100 per day per site which has not submitted an Acceptable CAP	Begin on the date that the notice of failure to file a timely and Acceptable CAP is issued, and end on the date the Department receives an Acceptable CAP.

TABLE OF LIQUIDATED DAMAGES

	CONDITIONS FOR IMPOSITION OF LIQUIDATED DAMAGES	SOW REFERENCE	AMOUNT	When Liquidated Damages Are Assessed**
5	Clinic Site (1) receives an overall score on either a Medical Record Review (MRR) or a Facility Site Review (FSR) that is less than 80% and (2) a focused review of the deficiencies conducted after an Acceptable CAP is submitted reveals (a) a failure by the Contractor to implement the CAP, or (b) that the deficiencies continue.	Exhibit A-2, Section III, K.2	$100 per day per site meeting requirements for Liquidated Damages	Begin on the date that Department issues a notice of the results of a focused review of the deficient areas and ends when Contractor demonstrates to the Department that the deficiencies have been corrected.
6	Clinic Site has (1) five or more of the same Repeat Deficiencies during each of three consecutive fiscal years starting with Fiscal Year 2018-19, and (2) does not reduce its total number of Repeat Deficiencies between the first and third year	Exhibit A-2Section III, K.2	$750 per deficiency, per clinic site	Assess in notice of audit findings for third year.

EXHIBIT B.2b
MY HEALTH LA PROGRAM
PRICING SCHEDULE

Effective October 1, 2014 Through no later than March 31, 2015 Fee-For-Service Rate	Included Services Effective April 1, 2015* Through June 30, 2016 Monthly Grant Funding (MGF)	Included Services Effective July 1, 2016 Through November 30, 2017 MGF	Included Services Effective December 1, 2017 through December 31, 2018 MGF	Included Services Effective January 1, 2019 MGF	Dental Care Services Effective October 1, 2014 Fee-For-Service Rate
$105 per clinic visit for: Included Services and Pharmacy Services	Monthly Grant Funding: $28.00*	Monthly Grant Funding: $28.56	Monthly Grant Funding: $28.56	Monthly Grant Funding: $32.00	Dental Care Services: Refer to Exhibit K***
	Pharmacy Monthly Grant Funding: $4**	Pharmacy Monthly Grant Funding: $4**			

* In accordance with Section III.C.1, of the Statement of Work, in the event that the Department determines that there will be insufficient appropriation to continue to fund MHLA through the end of Fiscal Year 2014-2015, assuming enrollment of 146,000 Participants, the Department may advance the start date of the MGF upon a 30-day notice to Contractor. Effective July 1, 2016, Cost of Living increase of 2% added.

** Pharmacy MGF will be added to Monthly Grant Funding during Pharmacy Phase One. Upon implementation of Pharmacy Phase Two, Pharmacy MGF will cease.

*** Paid at the State's Denti-Cal rates in effect on the date of service, but without any supplemental Denti-Cal payment amount."

EXHIBIT K-1 (K-2 or K-3, as applicable)

MY HEALTH LA DENTAL CARE SERVICES
DESCRIPTION OF SERVICES
FUNDING, BILLING, AND PAYMENT
(Effective _____, 2018)

1.0 Dental Care Services

Contractor shall provide outpatient Dental Care Services to MHLA Participants for the prevention, detection, and treatment of dental problems, including dental support services, charting to dental records, and administrative management. Unless rates are frozen pursuant to Section 5.0, Contractor shall bill and be paid in accordance with the State's Denti-Cal Program approved codes and published Schedule of Maximum Allowances (SMA) rates, without regard to any supplemental payments in effect at the time of service, except those codes that require prior authorization or are restricted. Such codes requiring prior authorizations or which are restricted are not covered by the Program except for those listed on Attachment I – MHLA Dental Approved Pre-Authorization Codes.

2.0 Dental Care Pharmacy

Contractor shall be responsible for prescribing and providing medically indicated pharmaceutical services or supplies, prescription medications, and over-the-counter medications required in conjunction with Dental Care Services to MHLA Participants. Contractor shall use the Department's approved Drug Formulary for the MHLA Program, which shall be provided to Contractor pursuant to the MHLA Agreement. Contractor may prescribe drugs beyond what is listed in the Formulary upon prior authorization from DHS, pursuant to the MHLA Agreement. Contractor may also counsel patients on non-prescription therapeutic interventions whenever feasible, for example exercise, weight loss, and smoking cessation. Contractor shall participate in all Patient Assistance Programs ("PAPs"), or assist the Department in participating in all PAPs pursuant to the MHLA Agreement.

3.0 Dental Service Sites

Contractor shall provide Dental Care Services to MHLA Participants at only the approved sites listed in Exhibit J, MHLA Site Profile. Contractor shall inform Director in writing at least forty-five (45) calendar days prior to adding or relocating Dental Care Services at an approved Clinic Site. The addition or relocation of Dental Care Services at an approved Clinic Site may only be affected after obtaining Director's written approval. The deletion of Dental Care Services at an approved Clinic Site requires the Contractor to notify the Department consistent with Paragraph 8.38, Notices, of the Agreement at least ninety (90) days prior to the deletion of Dental Care Services at an approved Clinic Site.

4.0 Patient Eligibility and Documentation

Contractor shall provide Dental Care Services to patients who are enrolled in the MHLA program in accordance with Paragraph 2.20, Eligible Person, of the Agreement, and

Exhibit A, Statement of Work-Subsection III D - Eligibility and Enrollment Requirements, E - Redeterminations/Re-Enrollment, and F – Dis-Enrollment. Documentation must be maintained in accordance with Paragraph 8.42, Record Retention and Inspection/Audit Settlement, of the Agreement.

5.0 Records and Audits

Contractor shall keep clear records of the Dental Participants served hereunder, including the Dental Care Service(s) provided. Contractor shall record such information on a regular basis and retain same in accordance with Paragraph 8.42, Record Retention and Inspection/Audit Settlement, of the Agreement, so that if requested, Contractor will be able to provide such information for the duration of Agreement and for a period of ten (10) years after date of service or five (5) years after contract termination, whichever is later.

6.0 Personnel

Prior to the commencement date of this Agreement, Contractor shall provide to Director a full listing of its then current Staff providing Dental Care Services under this Agreement, in accordance with subparagraph 9.4.10.3, Provider Roster, of the Agreement. Contractor may not add any new dentists and dental hygienists without prior written notice to Director in accordance with the Agreement. Contractor must also provide written notice to Director of any dentist that is no longer available to provide services under this Agreement within thirty (30) calendar days of the change.

7.0 Performance Improvement

Contractor shall participate in County activities to improve performance across the Dental Care Services program. As reasonable, this may include performance meetings with individual Contractors, peer review meetings, the review and development of new policies and procedures as it relates to dental care, and the provision of information, as needed.

8.0 Clinic Capacity, Open/Closed Status for New Patients, Access Standards

Contractors will be surveyed a maximum of twice monthly by the Department to determine whether there are any changes to the Clinic's open/closed status based on their capacity. Capacity is defined by the number of days that a new Dental Participant must wait before he or she can obtain a non-urgent Dental Care Services appointment at the Clinic Site. A Clinic Site is considered to have capacity if the Clinic Site could schedule a non-urgent Dental Care Services appointment within ninety (90) calendar days. A Clinic Site does not have capacity if the Clinic Site could not schedule a non-urgent Dental Care Services appointment within ninety (90) calendar days. A Clinic Site with capacity shall be considered "open" to new Dental Participants. A Clinic Site without capacity shall be considered "closed" to new Dental Participants.

Contractor shall make available to Dental Participants same or next day appointments for Participants whose dental condition requires them to be seen outside of a scheduled appointment.

Contractor shall inform the Department within twenty-four (24) hours if a Clinic Site no longer has the capacity to accept new Dental Participants. Contractor shall notify the Department of its intent to reopen its Clinic to new Dental Participants.

A Clinic Site's open or closed status will determine whether a Clinic Site is open to accept a referral of an Eligible Person from the Department. Any Clinic Site that is "open" to new Dental Participants must be uniformly open to Eligible Persons regardless of whether the Eligible Person presents as a walk-in or is referred from the Department. The Contractor shall not refuse to accept a Department-referred Eligible Person unless (a) the Clinic Site is "closed" to new Dental Participants, or (b) the Clinic does not have the clinical capability to care for the Eligible Person, as determined by Contractor's physician who shall attest that the Contractor does not have the clinical capability to render appropriate care to the Eligible Person. Such attestation shall be in writing, signed by the physician, include a detailed explanation as to why care cannot be rendered, and submitted to the Department within twenty-four (24) hours of the referral by the Department. The Department shall provide to Contractor the complete protocol for Patient Referral through a future PIN process.

A closure to new Eligible Persons must apply uniformly to all Eligible Persons. This means that a Clinic Site or Mobile Clinic may not be open to providing Dental Care Services to some new Eligible Persons, but not others. Clinic Sites and Mobile Clinics shall provide services to their existing Dental Participants even if they are closed to new Eligible Persons. Contractor shall not close its practice to its existing Dental Participants.

At no time shall Contractor be permitted to design or deploy programs in such a manner as to exclude or disadvantage Dental Participants or to advantage patients with third-party payors or financial means.

9.0 Payment Rates

Dental Care payments shall be limited only to those dental visit codes, procedures and SMA rates established by the State of California's Denti-Cal Program on the date of service without regard to any supplemental payments. Such codes requiring prior authorization or which are restricted are not covered by the Program except for those listed on Attachment I – MHLA Dental Approved Pre-Authorization Codes.

10.0 Payments Process for Fee-For-Service Compensation

10.1 Contractor shall invoice the Department, in arrears, for each dental visit performed in the prior month. The invoices shall contain the information specified from time to time by Department, but shall, at a minimum, identify each Dental Participant receiving services, the service received, and the price of such service in accordance with those dental visit codes, procedures and SMA rates established by the State of California's Denti-Cal Program on the date of service without regard to any supplemental payments.

10.2 Contractor shall submit, as directed by the Department, monthly invoices to the Department by the 15th calendar day of the month following the month of service.

10.3 County Approval of Invoices. All invoices submitted by Contractor for payment must have the written approval of County's Project Manager prior to any payment thereof. In no event shall County be liable or responsible for any payment prior to such written approval. Approval for payment will not be unreasonably withheld.

10.4 Contractor's invoice shall only be approved for payment if Contractor (a) is not in default under the terms of this or any agreement with County; (b) has met all financial obligations under the terms of this and any prior agreements with County; and (c) the invoice has been received and accepted by County.

11.0 Patient Billings

Contractor shall not bill any Dental Participants who are receiving services hereunder, but may accept voluntary donations from those Participants or their families, provided that such donations are not linked to the receipt of services nor are a condition of receipt of service hereunder. In the event that Contractor determines that a Dental Participant is eligible for services hereunder, but that the Dental Participant requires services not provided by the Denti-Cal Program, and therefore, not reimbursable pursuant to this Agreement, Contractor shall be permitted to charge that Dental Participant for any and all services rendered in accordance with Contractor's customary policies, procedures and practices pertaining to the provision of its dental services.

12.0 Electronic or Manual Billing

12.1 Contractor shall submit to Department's Claims Adjudicator data elements substantially similar to those found on the dental Billing Form(s) heretofore approved by Director. Contractor shall use its best efforts to submit claims to Department's Claims Adjudicator electronically within thirty (30) days of the service date. In no event shall Contractor submit new, appealed, and corrected claims later than sixty (60) days after the service date. Claims submitted later than this timeframe will be rejected and will not be paid. Such data shall be submitted electronically for each visit provided to a Dental Participant monthly in arrears. Contractor shall not bill for Dental Care Services if the Dental Participant is eligible for Denti-Cal and/or Medi-Cal, or if the Participant has any other dental insurance of any kind.

12.2 If electronic billing between Contractor and Department's Claims Adjudicator is not operational, Contractor shall use its best efforts to submit claims to Department's Claims Adjudicator manually using the Billing Form(s) completed in duplicate within thirty (30) days of the service date. In no event shall Contractor submit new, appealed, and corrected claims later than sixty (60) days after the service date. Claims submitted later than this timeframe will be rejected and will not be paid. All manual information must be submitted on a Billing Form, as approved by Director. Contractor shall retain one billing copy for its own records and shall forward the original billing copy to the Department's Claims Adjudicator. Contractor shall not bill for Dental Care Services if the Dental Participant is eligible for Denti-Cal and/or Medi-Cal, or if the Participant has any other dental insurance of any kind.

13.0 County's Manual Reprocessing of Contractor's Denied and Canceled Claims

If claims were denied or canceled through no fault of County or Department's Claims Adjudicator, and solely through the fault of Contractor, Contractor shall, at the County's sole discretion, pay County the appropriate County contract, per-claim fee billed County by Department's Claims Adjudicator. County shall not charge the processing fee to the Contractor in those instances where County cannot conclusively determine which party is at fault for the denial or the cancellation. Contractor shall be advised by Director, by means of a PIN, of the current fee charged to County. The County may, at its sole discretion, recoup payment due from Contractor for denied or canceled claims by requesting payment from Contractor, which repayment shall be remitted forthwith by Contractor to County by check made payable to the County of Los Angeles, or by withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set.

14.0 **Billing Guidelines**

Contractor shall follow the billing guidelines contained in this Exhibit and as set forth in any PIN, which shall be provided to Contractor as necessary according to the process set forth in this Agreement. Addresses, both electronic and U.S. mailing, for billing of County shall be provided to Contractor prior to the commencement of services hereunder through a PIN.

ATTACHMENT I
MHLA Dental Approved Pre-Authorization Codes

CDT-4	DESCRIPTION
D2710	Crown-resin (indirect)
D2721	Crown-resin with predominantly base metal
D2740	Crown-porcelain/ceramic substrate
D2751	Crown-porcelain fused to predominantly base metal
D2781	Crown-3/4 cast predominantly base metal
D2791	Crown-full cast predominately base metal
D3310	Anterior (excluding final restoration)
D3320	Bicuspid (excluding final restoration)
D3330	Molar (excluding final restoration)
D4341	Periodontal scaling & root planing-4 or >contiguous teeth or bounded teeth spaces per quad
D4342	Periodontal scaling & root planing-1 to 3 teeth per quadrant
D4999	Unspecified periodontal procedure, by report
D5110	Complete denture-maxillary
D5120	Complete denture-mandibular
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandiblar partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)