County of Los Angeles
Health and Mental Health Services

FESIA A. DAVENPORT
Chief Executive Officer

DATE: Wednesday, November 17, 2021
TIME: 10:00 a.m.

THIS MEETING WILL CONTINUE TO BE CONDUCTED VIRTUALLY TO ENSURE THE SAFETY OF MEMBERS OF THE PUBLIC AND EMPLOYEES AS PERMITTED UNDER STATE LAW.

TO PARTICIPATE IN THE MEETING, PLEASE CALL AS FOLLOWS:
DIAL-IN NUMBER: 1 (323) 776-6996
CONFERENCE ID: 479494149#
MS Teams link (Ctrl+Click to Follow Link)

AGENDA

Members of the Public may address the Health and Mental Health Services Meeting on any agenda item. Two (2) minutes are allowed for each item.

THIS TELECONFERENCE WILL BE MUTED FOR ALL CALLERS. PLEASE DIAL *6 TO UNMUTE YOUR PHONE WHEN IT IS YOUR TIME TO SPEAK.

I. Call to order

II. **Information Item(s)** (Any Information Item is subject to discussion and/or presentation at the request of two or more Board offices)**:**

a. **DHS:** Approval of Amendment No.9 to Sole Source Agreement No. H-704447 with Global Healthcare Exchange LLC for Supply Chain Procurement and Data Management Software and Services

III. **Presentation Item(s):**

a. **AHI:** Approval for New Medi-Cal Waiver Contracting and Implementation Authority

b. **DMH:** Approval to Extend the Sole Source Consultant Contract with Steinberg Institute to Continue to Support Los Angeles County with Initiatives Involving the Mental Health Services Act and Mental Health Civil Commitment Reform

IV. Items Continued from a Previous Meeting of the Board of Supervisors or from the Previous Agenda Review Meeting

V. Items not on the posted agenda for matters requiring immediate action because of an emergency situation, or where the need to take immediate action came to the attention of the Department subsequent to the posting of the agenda

VI. Public Comment

VII. Adjournment

BOARD LETTER FACT SHEET

Agenda Review Date: November 17, 2021
Board Meeting Date: December 7, 2021
Sup. Dist. / SPA No.: All

BOS Approval

DEPARTMENT: ***Department of Health Services (DHS)***

SUBJECT: Approval of Amendment No. 9 to sole source Agreement No. H-704447 (Agreement) with Global Healthcare Exchange LLC (GHX) for supply chain procurement and data management software and services at DHS facilities.

I. PUBLIC BENEFIT (precise description, mandated or non-mandated)

Approval of Amendment No. 9 will enable DHS to continue supply chain automation that is essential for the purchase of medical commodities at all DHS facilities.

II. RECOMMENDED ACTIONS (summarized)

Authorize the Director of DHS (Director), or her designee, to execute Amendment No. 9 to the sole source Agreement with GHX to extend the term through 12/31/22, with four additional one-year automatic renewal periods through 12/31/26, expand the Agreement to upgrade and enhance an existing software module, and increase the maximum agreement sum by $4,622,549, which includes $1,502,164 in Pool Dollars for Optional Work.

Also, DHS requests delegated authority to the Director, or her designee, to (1) execute future amendments to revise certain terms and conditions in the Agreement, modify the Statement of Work, and approve additional operational and administrative workflow changes, with all actions subject to review and approval by County Counsel, and (2) execute future amendments and/or Change Notices to use Pool Dollars to acquire hardware and/or Optional Work such as additional software, interfaces, and professional services, as requested by County, subject to review and approval by County Counsel.

III. COST AND FUNDING SOURCES

Cost: $4,622,549

Funding: Included in DHS FY 2021-22 Final Budget, and will be requested in future FYs.

IV. BACKGROUND (critical and/or insightful)

GHX is the only company in the United States that offers integrated supply chain modules focusing on healthcare supply chain procurement and data management software and services that meets the procurement automation needs of DHS from the requisitioning process to the invoice/payment process.

Also, GHX is currently integrated with a for-profit entity, Vizient, Inc.'s (Vizient) Group Purchasing Organization (GPO), and receives a daily feed from Vizient of the GPO-contracted pricing unique to each member and matches the price to the products purchased through the MyExchange module. This ensures that Vizient contract pricing is honored during the procurement process, and allows DHS to leverage its purchasing power and benefit from Vizient-established group discounts realized from economies of scale that are only provided to Vizient members.

V. POTENTIAL ISSUE(S)

Without the Agreement, DHS will not be able to continue managing the supply chain effectively and maintaining its existing cost savings on the purchase of medical commodities.

VI. DEPARTMENT & COUNTY COUNSEL CONTACTS

- Jason Ginsberg, Chief, Supply Chain Operations, (323) 914-7926, jginsberg@dhs.lacounty.gov
- Christopher Kinney, Contracts Section Manager, (213) 288-8862, CKinney@dhs.lacounty.gov
- Lillian Anjargolian, Deputy County Counsel, (213) 288-8124, LAnjargolian@counsel.lacounty.gov

December 7, 2021

DRAFT
DHS LETTERHEAD

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

Dear Supervisors:

APPROVAL OF AMENDMENT NO. 9 TO SOLE SOURCE AGREEMENT NO. H-704447 WITH GLOBAL HEALTHCARE EXCHANGE LLC FOR SUPPLY CHAIN PROCUREMENT AND DATA MANAGEMENT SOFTWARE AND SERVICES (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

CIO RECOMMENDATION: APPROVE (X)

SUBJECT

Request approval of Amendment No. 9 to the existing Sole Source Agreement No. H-704447 with Global Healthcare Exchange LLC for supply chain procurement and data management software and services at Department of Health Services facilities to extend the term, amend the Statement of Work, and increase the maximum agreement sum by $4,622,549.

IT IS RECOMMENDED THAT THE BOARD:

1. Authorize the Director of Health Services (Director), or designee, to execute Amendment No. 9 to Sole Source Agreement No. H-704447 (Agreement) with Global Healthcare Exchange LLC (GHX), to: (a) extend the Agreement's term through December 31, 2022, with four (4) additional one-year automatic renewal periods through December 31, 2026, for the continued use of supply chain procurement and data management software and services; (b) expand the Agreement to upgrade and enhance an existing software module; and (c) increase the maximum agreement sum by $4,622,549, which includes $1,502,164 in Pool Dollars ($113,880 of the Pool Dollars are roll over funds from the previous five-year term), for Optional Work during the extended term.

2. Delegate authority to the Director, or designee, to execute future amendments to: (a) add, delete and/or change certain terms and conditions in the Agreement, as mandated by federal or State law or regulation, County policy, the County Board of Supervisors (Board) and/or Chief Executive Office (CEO); (b) modify the Statement of Work (SOW) to reflect County standards and needs, reduce scope, and add/delete County facilities; and (c) approve additional operational and administrative workflow changes, including modifications to Department of Health Services' (DHS or Department) protocols and policies reflected in the Agreement and SOW, with all actions subject to review and approval by County Counsel.

3. Delegate authority to the Director, or designee, to execute future amendments and/or Change Notices, as applicable, to use Pool Dollars to acquire Optional Work, such as hardware, additional software, interfaces, and professional services, as requested by County, subject to review and approval by County Counsel.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Background

On November 18, 1997, the Board authorized DHS to join the University HealthSystem Consortium (UHC), a nonprofit member alliance of academic medical centers, and its Group Purchasing Organization (GPO), Novation. UHC merged with VHA, Inc. on April 1, 2015 to form a new for-profit entity named Vizient, Inc. (Vizient) which continued providing DHS with GPO contracting services to negotiate vendor contracts, on behalf of its members, primarily for medical commodities, including medical supplies, implants, and equipment. Through its ongoing Vizient membership, DHS has been able to access Vizient-negotiated GPO vendor contracts as an alternative to conducting County solicitations, and has leveraged economies of scale for purchasing medical commodities. Prior to the merger, GHX was selected by UHC as its vendor for supply chain procurement and data management software and services through UHC's competitive bid process.

GHX is a business exchange consisting of healthcare providers and healthcare product vendors. GHX's core members include members of Vizient, one of which is DHS. GHX provides health care supply chain automation solutions that maintain updated procurement data on medical supplies, assist members with developing and maintaining a standardized and efficient supply formulary for medical supplies, ensure controls for compliance with these formularies, reconcile and cleanse purchasing data for consistency and completeness, and host established vendor agreements and pricing to automate the reconciliation of purchases to the GPO contract catalog.

Current Agreement

Under the Agreement, which expires on December 31, 2021, GHX has implemented the following proprietary solutions to manage, streamline and maximize efficiency and automation of supply chain transactions throughout the DHS enterprise for the purchase of medical commodities critical to timely patient care: an electronic requisitioning module, a data cleansing and procurement item master management module, a purchasing contract management module, an electronic invoice processing module, a business exchange module to electronically send purchase orders (POs) and receive PO status and electronic invoices (MyExchange), a Key Performance Indicator (KPI) dashboard module (Provider Intelligence), a business associate management module, and a vendor credentialing module.

Recommendations

The first recommendation will allow the Director, or designee, to execute an amendment to Agreement No. H-704447, substantially similar to Exhibit I, to extend the term of the Agreement through December 31, 2022, with four (4) additional one-year automatic renewal periods through December 31, 2026, for the continued use of supply chain procurement and data management software and services. GHX is the only company that offers a comprehensive set of integrated supply chain modules focusing on healthcare supply chain procurement and data management software and services in the United States that meets the procurement automation needs of the DHS enterprise from the requisitioning process to the invoice/payment process. Extending the Agreement is essential for the Department to continue managing the supply chain effectively and maintaining its existing cost savings on the purchase of medical commodities. Additionally, GHX is currently integrated with Vizient's GPO and receives a daily feed from Vizient of the GPO-contracted pricing unique to each member and matches the price to the products purchased through the MyExchange module. This validation ensures that Vizient contract pricing is honored during the procurement process, and it allows DHS to leverage its purchasing power and benefit from Vizient-established group discounts realized from economies of scale that are only provided to Vizient members.

Moreover, approval of the first recommendation will expand the Agreement to allow DHS to implement a software upgrade to the Provider Intelligence module, which will provide access to additional application features that will allow DHS to compare Key Performance Indicators (KPIs) to industry benchmarks and monitor progress over time of those KPIs. These additional features include an "Item Management" KPIs Dashboard that will allow DHS to monitor metrics based on its Procurement Item Master; an "Off Contract Opportunity Analysis" feature and report that will allow DHS to analyze its purchases from non-GPO contracted vendors against its purchases from GPO contracted vendors; access to Vendor Master reports that will provide lists of County-approved vendors that can be added to its Procurement Item Master; access to Invoice History reports that will provide analysis on invoices processed through the OnDemand AP module; and access to Expiring Contracts reports that will provide lists of GPO contracted vendors that will be removed from its Procurement Item Master.

Approval of the second recommendation will delegate authority to the Director, or designee, to execute future amendments to (a) add, delete, and/or change certain terms and conditions in the Agreement, as required under federal or State law or regulation, County policy, Board and/or CEO; (b) modify the SOW to reflect County standards and needs, reduce scope, and add/delete County facilities; and (c) approve additional operational and administrative workflow changes, including modifications to DHS' protocols and policies reflected in the Agreement and SOW, with all actions subject to review and approval by County Counsel.

Approval of the third recommendation will allow the Director, or designee, to execute future amendments and/or Change Notices, as applicable, to use Pool Dollars to acquire Optional Work, such as hardware, additional software, interfaces, and professional services, as requested by County, and subject to review and approval by County Counsel.

Also, approval of the third recommendation will allow the Director, or designee, to expand the Agreement for the purchase of certain hardware from GHX. The Agreement currently does not include terms for the purchase of hardware. GHX offers a vendor registration "kiosk", which will allow vendor representatives visiting DHS facilities to seamlessly check-in for a badge. The kiosks include GHX's proprietary software. As a workaround, DHS currently uses Workstations on Wheels and desktop computers to check-in visitors at the facilities. DHS is currently exploring the potential purchase of the kiosks and, if deemed suitable, DHS would like to amend the Agreement to include hardware terms (e.g., hardware warranty) to purchase the kiosks as Optional Work.

Implementation of Strategic Plan Goals

The recommended actions support Goal III, Realize Tomorrow's Government Today, Strategy III.2, Embrace Digital Government for the Benefit of our Internal Customers and Communities, and Strategy III.3, Pursue Operational Effectiveness, Fiscal Responsibility, and Accountability.

FISCAL IMPACT/FINANCING

The total maximum agreement sum under the Agreement will be increased by $4,622,549 (including $1,502,164 in Pool Dollars), from $5,791,407 to $10,413,956, for the Agreement period ending on December 31, 2026.

Funding is included in the DHS Fiscal Year 2021-22 Final Budget, and will be requested in future fiscal years. There will be no Net County Cost impact.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

The Agreement, which includes GHX's standard user agreement, was approved by the Board on September 21, 2010. The Agreement includes all of the Board's required provisions and also includes modifications to the County's standard terms and conditions, including the removal of the County's right to Terminate for Convenience and the addition of Termination Transition Services and Continuous Product Support. Such modifications were negotiated with GHX and approved by the Board on December 1, 2015. In the course of negotiating the current amendment, DHS again attempted to better align the Agreement with the County's standards, including the addition of more robust information security terms. In light of GHX's position as the sole source of the system and their relative negotiating position, DHS was required to modify the County's standard terms, including GHX's use of subcontractors and the County's information security terms. DHS accepts the risk associated with these variances and DHS has sufficient mitigation measures to manage these risks.

County Counsel has approved Exhibit I as to form. In compliance with Board Policy 6.020 "Chief Information Office Board Letter Approval", the Office of the Chief Information Officer (OCIO) reviewed the information technology (IT) components of this request and recommends approval. The OCIO determined this recommended action does not include any major new IT items that would necessitate a formal OCIO Analysis.

CONTRACTING PROCESS

GHX was initially selected as UHC's vendor for supply chain management services through its competitive bid process. Consequently, GHX was the only such firm to be integrated with UHC's GPO, which made GHX uniquely qualified to provide supply chain procurement and data management software and services to DHS.

The Board approved a sole source Agreement with GHX on September 21, 2010 for an initial term through June 30, 2013, with a two-year extension and six (6) month-to-month extensions through December 31, 2015. DHS exercised its delegated authority and executed Amendment No. 2 on May 22, 2013 to extend the Agreement term through June 30, 2015, and executed Amendment No. 4 on June 24, 2015 to extend the Agreement term through December 31, 2015.

On December 1, 2015, the Board approved Amendment No. 5 to extend the Agreement term for five (5) additional one-year periods through December 31, 2020, and expand the SOW for additional software modules and services.

On May 12, 2020, the CEO delegated authority to the Director, or designee, to extend various contracts in support of the response to the COVID-19 pandemic under authority delegated by the Board on March 31, 2020. DHS exercised this delegated authority and executed Amendment No. 6 on December 21, 2020 to extend the Agreement term through June 30, 2021, executed Amendment No. 7 on June 23, 2021 to extend the Agreement term through September 30, 2021, and executed Amendment No. 8 on September 29, 2021 to extend the Agreement term through December 31, 2021.

On June 22, 2020, DHS notified the Board via Attachment A of our intent to commence negotiations for the sole source Agreement extension in accordance with the revised Board Policy No. 5.100, Sole Source Contracts.

The Sole Source checklist is attached as Attachment B in compliance with the revised Board Policy 5.100, Sole Source Contracts.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will enable DHS to continue supply chain automation that is essential for the purchase of medical commodities at all DHS facilities.

Respectfully submitted,

Christina R. Ghaly, M.D.
Director

Reviewed by:

Peter Loo
Acting Chief Information Officer

CRG:PL:az
Enclosures (3)

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

ATTACHMENT A

Health Services
LOS ANGELES COUNTY

June 22, 2020

TO: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Janice Hahn

FROM: Christina R. Ghaly, M.D.
Director

SUBJECT: **ADVANCE NOTIFICATION OF INTENT TO EXTEND SOLE SOURCE AGREEMENT NO. H-704447 WITH GLOBAL HEALTHCARE EXCHANGE LLC**

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

Tel: (213) 288-8050
Fax: (213) 481-0503

www.dhs.lacounty.gov

"To advance the health of our patients and our communities by providing extraordinary care"

This is to advise the Board of Supervisors (Board) that the Department of Health Services (DHS) intends to request approval of an extension to the existing Sole Source Agreement No. H-704447 (Agreement) with Global Healthcare Exchange LLC (GHX) for the ongoing provision of supply chain procurement and data management software and services to support supply chain automation efficiencies and DHS' Group Purchasing Organization (GPO) supply chain initiatives.

Board Policy No. 5.100 requires written notice of a department's intent to enter into sole source negotiations for extension of a Board-approved agreement at least six months prior to the agreement's expiration date. DHS will exhaust its delegation of authority to extend the Agreement on December 31, 2020.

Background

On November 18, 1997, the Board authorized DHS to join the University HealthSystem Consortium (UHC), a nonprofit member alliance of academic medical centers, and its GPO, Novation. UHC merged with VHA, Inc. on April 1, 2015 to form a new for-profit entity named Vizient, Inc. (Vizient), which continued providing DHS with GPO contracting services to negotiate vendor contracts, on behalf of its members, primarily for medical commodities, including medical supplies, implants, and equipment. Through its ongoing Vizient membership, DHS has been able to access Vizient-negotiated GPO vendor contracts as an alternative to conducting County solicitations; and has leveraged economies of scale for purchasing medical commodities. Prior to the merger, GHX was selected by UHC as its

vendor for supply chain procurement and data management software and services through UHC's competitive bid process.

GHX is a business exchange consisting of healthcare providers and healthcare product vendors. GHX's core members include members of Vizient, one of which is DHS. GHX provides health care supply chain automation solutions that maintain updated procurement data on medical supplies, assist members with developing and maintaining a standardized and efficient supply formulary for medical supplies, ensure controls for compliance with these formularies, reconcile and cleanse purchasing data for consistency and completeness, and host established vendor agreements and pricing to automate the reconciliation of purchases to the GPO contract catalog.

The Board approved the current Agreement with GHX on September 21, 2010 for the provision of supply chain procurement and data management software and services. On December 1, 2015, the Board approved Amendment No. 5 to extend the term of the Agreement through December 31, 2020, expand the Agreement's Statement of Work for additional services, and increase the maximum agreement sum to $5,356,205.

Under the current Agreement, GHX has implemented the following proprietary solutions to manage, streamline and maximize efficiency and automation of supply chain transactions throughout the DHS enterprise for the purchase of medical commodities critical to timely patient care: an electronic requisitioning module (Procurement Suite), a data cleansing and Item Master management module (NuVia), a purchasing contract management module (Contract Center), an electronic invoice processing module (OnDemand AP), a business exchange module to electronically send Purchase Orders (POs) and receive PO status and electronic invoices (MyExchange), a Key Performance Indicator dashboard (Provider Intelligence), a Business Associate management module (Compliance Document Manager), and a vendor credentialing module (Vendor Credentialing).

Justification

DHS is requesting an extension to the Agreement because GHX is the only company that offers a comprehensive set of supply chain modules focusing on healthcare supply chain procurement and data management software and services in the United States that meets the procurement automation needs of the DHS enterprise from the requisition process to the invoice/payment process. Additionally, GHX receives a daily feed from Vizient of the GPO contracted pricing unique to each member and matches the price to the products purchased through the GHX exchange (MyExchange). This validation ensures that Vizient contract pricing is honored during the procurement process. By extending the Agreement with GHX, DHS will maintain our existing cost savings, continue to leverage our purchasing power as a result of economies of scale and Vizient-established group discounts on medical commodities, and effectively manage the supply chain.

DHS has also devoted significant resources to interface eCAPS with GHX to ensure the Department's compliance with County purchasing standards, while enabling DHS to remain aligned with the healthcare industry's standard practices and requirements. DHS has made many ongoing software enhancements and interface modifications to integrate eCAPS and GHX, including the development of DHS's first Item Master System, the Inventory Replenishment System, the Low Unit of Measure Information Systems, and the Procurement Suite and eCAPS interface. The interface between the Procurement Suite and eCAPS' eProcurement and eInventory applications pre-populates 95% of the data fields required to process a PO, which significantly decreases PO processing times.

If this Agreement is not extended, DHS will lose access to supply chain procurement and data management software and services that are essential to purchasing medical commodities. The resulting loss of gained efficiencies will require massive manual intervention by DHS employees. It will hamper efforts to provide patient care, as DHS facilities will be forced to revert to paper-based requisitions which will create internal backlogs. DHS will also be required to release a new solicitation to select and engage a new contractor to develop customized interfaces between eCAPS and a new contractor's system.

Conclusion

DHS has determined that GHX is uniquely positioned to continue providing supply chain procurement and data management software and services that will permit DHS facilities to continue meeting their clinical supply needs without interruption. DHS will commence negotiations for the Agreement extension no earlier than two weeks from the date of this notification unless otherwise instructed by the Board.

If you have any questions or require additional information, please let me know, or you may contact Jason Ginsberg, Chief of Supply Chain Network, at (323) 914-7926 or at jginsberg@dhs.lacounty.gov.

CRG:es

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Chief Information Office
Internal Services Department

ATTACHMENT B

SOLE SOURCE CHECKLIST

Department Name: Department of Health Services (DHS)

☐ New Sole Source Contract

☑ Sole Source Amendment to Existing Contract
Date Existing Contract First Approved: 9/21/2010

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS **Identify applicable justification and provide documentation for each checked item.**
☑	➢ Only one bona fide source (monopoly) for the service exists; performance and price competition are not available. A monopoly is an "*Exclusive control of the supply of any service in a given market. If more than one source in a given market exists, a monopoly does not exist* ."
☐	➢ Compliance with applicable statutory and/or regulatory provisions.
☐	➢ Compliance with State and/or federal programmatic requirements.
☐	➢ Services provided by other public or County-related entities.
☐	➢ Services are needed to address an emergent or related time-sensitive need.
☐	➢ The service provider(s) is required under the provisions of a grant or regulatory requirement.
☐	➢ Additional services are needed to complete an ongoing task and it would be prohibitively costly in time and money to seek a new service provider.
☐	➢ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
☐	➢ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/ system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
☐	➢ Maintenance service agreements exist on equipment which must be serviced by the original equipment manufacturer or an authorized service representative.
☐	➢ It is more cost-effective to obtain services by exercising an option under an existing contract.
☐	➢ It is in the best economic interest of the County (e.g., significant costs to replace an existing system or infrastructure, administrative cost savings and excessive learning curve for a new service provider, etc.) In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Mason Matthews
Chief Executive Office

10/13/2021
Date

BOARD LETTER FACT SHEET

Agenda Review Date: 11/17/2021
Board Meeting Date: 12/7/2021
Sup. Dist. / SPA No.:

DEPARTMENT: Alliance for Health Integration

SUBJECT:
APPROVAL FOR NEW MEDI-CAL WAIVER CONTRACTING AND IMPLEMENTATION AUTHORITY

I. PUBLIC BENEFIT (precise description, mandated or non-mandated)

Recommended actions will allow continued access of Medi-Cal beneficiaries to critical health, mental health, and substance use services

II. RECOMMENDED ACTIONS (summarized)

- Allow for each Health Department to operationalize CalAIM in a timely manner by granting authority to contract with health plans and other necessary providers in order to deliver CalAIM-related services as early as January 1, 2022.
- All agreements will be subject to prior review and approval by County Counsel
- Prior to any execution, CEO and BOS will receive then-current draft forms of contracts with feedback within 5 calendar days

III. COST AND FUNDING SOURCES

Cost: No New NCC

Funding: CalAIM will be financed through a mix of federal, State, and local funds

IV. BACKGROUND (critical and/or insightful)

CalAIM is a multi-year State Medi-Cal initiative, the goal of which is to reduce health disparities and promote health equity.
CalAIM also includes a significant focus on behavioral health system transformation and innovation through system modernization, payment reform, value-based initiatives, and reduced health disparities. CalAIM-related investments in both the specialty mental health and substance use systems support the broader aim to improve quality of life and health outcomes through enhanced and more integrated/coordinated care across health and social service systems.
The delegated authority rrequested is broad because the State of California Department of Health Care Services (DHCS) submission to CMS has not yet been approved, and DHCS continues to revise and clarify guidance on how CalAIM will be structured and implemented.

V. POTENTIAL ISSUE(S)

State has directed Whole Person Care and Health Homes Program participants to continue services to participants under transition into CalAIM ECM/ILOS starting January 2022 If applicable Department does not have executed contracts with MCPs for both ECM and ILOS, it may disrupt beneficiary access to critical services

VI. DEPARTMENT & COUNTY COUNSEL CONTACTS

County Counsel: Matthew Marlowe, mmarlowe@counsel.lacounty.gov, 213.971.1891
Alliance for Health Integration: Jaclyn Baucum, jbaucum@ahi.lacounty.gov, 213.760.3228

ALLIANCE FOR HEALTH INTEGRATION

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Holly J. Mitchell
Second District

Sheila Kuehl
Third District

Janice Hahn
Fourth District

Kathryn Barger
Fifth District

Jaclyn Baucum
Chief Operating Officer
Alliance for Health Integration

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

Jonathan E. Sherin, M.D, Ph.D.
Director, Department of Mental Health

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director, Department of Public Health

313 N. Figueroa Street, Suite 1014
Los Angeles, CA 90012

"To improve the health and well-being of Los Angeles County residents by aligning and efficiently implementing Board-approved prevention, treatment, and healing initiatives that require the collaborative contributions of the three health departments."

DRAFT

December 7, 2021

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 FOR NEW MEDI-CAL WAIVER CONTRACTING AND IMPLEMENTATION AUTHORITY
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

The Los Angeles County Departments of Health Services, Public Health, and Mental Health are seeking authority to negotiate, prepare, execute, and operationalize agreements associated with the State of California's pending Medicaid waiver proposal. The initiative, called California Advancing and Innovating Medi-Cal, aspires to improve the health and quality of life of the Medi-Cal managed care population through broad delivery system, program, and payment reforms.

IT IS RECOMMENDED THAT THE BOARD:

Delegate authority to each of the Directors of the Los Angeles County Departments of Health Services (DHS), Public Health (DPH), and Mental Health (DMH), (Directors) (or its respective designee(s)) to:

Negotiate, prepare, execute, and operationalize new agreements with health plans, provider groups, and pharmacy benefit networks necessary to establish or maintain California Advancing and Innovating Medi-Cal (CalAIM) initiatives. Such authority shall remain in effect until December 31, 2023, and the length of any agreement made pursuant to it may be up to five (5) years from the date of execution. The authority includes, without limitation, the authority to take any additional actions that are required by contract, law, regulation, rule, or guideline to enable DHS,DPH, and DMH (each a "Department" and together the "Departments") to effectuate the agreements. DHS, DPH, and DMH will each consider its overall financial impact to each respective department in negotiating these agreements.

Such agreements shall be subject to (a) prior review and approval by County Counsel, (b) not less than fifteen (15) days prior to the anticipated execution of any agreement under this request, submission to the Chief Executive Office (CEO) and Board of Supervisors (Board) in its then-current draft form with feedback provided to the relevant department within five (5) calendar days thereafter, and (c) subsequent notification to the CEO and the Board.

1. Negotiate, prepare, execute, amend, and operationalize existing agreements with health plans, provider groups and pharmacy benefit networks necessary to establish or maintain CalAIM. The authority includes, without limitation, the power to: (1) establish new rates of payment (which flow from the above entities to DHS, DPH, and DMH) whether capitated, fee-for-service (FFS) or otherwise; (2) adjust rates; (3) secure incentives and incentive payments from the foregoing parties or the State; (4) update or incorporate new State/federal law and regulations, County provisions and other regulatory/ contractual requirements; (5) make appropriate changes to contract language for clarity and efficiency (administrative, programmatic and operational); (6) extend such agreements; (7) add, remove, or migrate new lines of business or new service lines into or out of such agreements; (8) reallocate the division of financial responsibilities or allocation of financial risk among parties; (9) terminate agreements; and (10) take any additional actions that are required by contract, law, regulation, rule, or guideline to enable DHS, DPH, and DMH to effectuate the relevant amendments. Each Department will consider its overall financial impact to its respective department in negotiating these agreements. Such agreements shall be subject to (a) prior review and approval by County Counsel, (b) not less than fifteen (15) days prior to the anticipated execution of any agreement under this request, submission to the CEO and Board in its then-current draft form with feedback provided to the relevant department within five (5) calendar days thereafter, and (c) subsequent notice to the CEO and the Board. This amending authority shall remain in effect until the end of CalAIM plus the authority to make no more than two additional extensions of then-existing authorities for up to six (6) months at a time.

2. Negotiate, prepare, and accept CalAIM-related incentives, awards, and other payments whether deriving from federal or State governments or health plans. The delegation includes, without limitation, the authority to take any and all actions that are required by contract, law, regulation, rule, or guideline to enable DHS, DPH, and DMH to receive such payments (*e.g.,* without limitation execute a subsidiary contract, certification, attestation, pay an administrative fee, or make intergovernmental transfers, as required to obtain such funds). Such payments shall be subject to prior review and approval by County Counsel with subsequent notification to the CEO and the Board. This authority shall remain in effect until the end of CalAIM. Not less than fifteen (15) days prior to the anticipated execution of any agreement or amendment under this request, each department shall submit to CEO and the Board its own potential new CalAIM-related incentive, award and other payment-related draft agreements or amendments in their then-current draft form, with any feedback provided to the relevant department within five (5) calendar days.

3. For a period of six (6) months, negotiate, prepare, execute, amend, and operationalize contracts or subcontracts with third parties, including without limitation service providers, for the purpose of providing CalAIM-related services like Enhanced Care Management (ECM) and In Lieu of Services (ILOS) to populations (for a list of the latter, see, Attachment A) subject to applicable federal, State and County laws, regulations, ordinances, rules and policies. The term of such contracts or subcontracts may last no more than one (1) year, with a possible additional six (6) month renewal period. The delegation includes, without limitation, the authority to negotiate, prepare, execute and implement Master Agreements and work orders, and take any actions that are required by contract, law, regulation, rule, ordinance, or guideline to enable DHS, DPH, or DMH to effectuate the agreements. It will also allow amendments to allow revisions of statements of work, extensions, or new County and Board contracting requirements—provided that any such actions do not exceed total projected revenue for CalAIM over the course of the waiver. Such contracts shall be subject to review and prior approval by County Counsel with at least ten (10) days prior notification to the CEO and the Board.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

CalAIM is a multi-year State Medi-Cal initiative, the goal of which is to reduce health disparities and promote health equity. It is a renewal and redesign of the preexisting five (5) year Medi-Cal 2020 § 1115 waiver, with the addition of a managed care related waiver under Title XIX, § 1915(b) of the Social Security Act. Due to COVID-19, Medi-Cal 2020 was extended for an extra year by the United States Center for Medicare and Medicaid Services (CMS). Medi-Cal 2020 included programs like Whole Person Care, that are sunsetting December 2021. Many services from those programs are proposed to continue in CalAIM, but in different ways. (See the Facts and Provisions section below.)

Central to achieving the vision for CalAIM is greater alignment and integration of the Medi-Cal delivery system, which will be enabled by the consolidation of federal managed care authorities into a single waiver vehicle for:

- Medi-Cal Managed Care (MCMC);
- Dental Managed Care (Dental MC);
- The Specialty Mental Health Services (SMHS) Program; and
- The Drug Medi-Cal Organized Delivery System (DMC-ODS; includes components within a 1115 waiver [Institution for Mental Disease exclusion] and 1915b waiver [the remainder of DMC-ODS provisions]).

CalAIM also includes a significant focus on behavioral health system transformation and innovation through system modernization, payment reform, value-based initiatives, and reduced health disparities. CalAIM-related investments in both the specialty mental health and substance use systems support the broader aim to improve quality of life and health outcomes through enhanced and more integrated/coordinated care across health and social service systems.

Except as otherwise expressly stated, the Departments' recommendations relate effectuating the initiative as a whole--not only ILOS and ECM.

The delegated authority we have requested herein is broad because the State of California Department of Health Care Services (DHCS) submission to CMS has not yet been approved, and DHCS continues to revise and clarify guidance on how CalAIM will be structured and implemented. The purpose of each recommendation is as follows:

The Departments of Health Services, Mental Health and Public Health (Departments) make Recommendation Nos. 1 and 2 to allow each Department to emplace or amend the contracts fundamental to CalAIM—such as, and without limitation, fee-for-service and capitation agreements with managed care plans and ECM/ILOS agreements. Those agreements primarily serve as revenue generating for the County. For example, in DHS' case, DHS intends to be a network provider under CalAIM. Therefore, it will receive payments to provide related services to beneficiaries who are enrolled in Medi-Cal Managed Care health plans—like Health Net, Local Initiative Health Authority of Los Angeles County (L.A. Care) and their subcontractors. Historically those agreements have had components that are not part of CalAIM (for example, DHS contracts include commercial or Medicare lines of business). The requested delegations would include the powers to continue to engage in those arrangements and amend them from time-to-time. For convenience, we have included, as Attachment B a copy of: (a) DHCS' standard terms and conditions provider template for ECM and ILOS; (b) DHCS' two-plan Medi-Cal Managed Care health plan scope of work exhibit boilerplate. While the latter document relates to contract terms often found between the State and the health plans, it reflects many of the key responsibilities that are likely to be passed on to providers when they negotiate agreements with those plans. Neither of these documents represents a final version of the contracts under this Board Letter rather each serves to inform the Board about the kinds of terms—without limitation—that are being negotiated.

Recommendation No. 1, involving new agreements, is for two (2) years due to an anticipated transition period. On the heels of the two major plan agreements, we anticipate it will take time for provider groups and plan subcontractors to move into CalAIM. Without an authority that extends, for a limited time, into the future, the Departments may lose potential revenue.

While the Medi-Cal Managed Care health plans are integral to paying the Departments for providing services, the State also intends to emplace incentive programs, delivery reform programs, and other payments. Some will be provided through them, or negotiated with them, others may come directly from the State. Because it is not clear exactly how the various supplemental and directed payments associated with CalAIM will flow, request for delegated authority in Recommendation Number 3 allows each Department flexibility to negotiate for and accept such payments.

Board approval of Recommendation No. 4 will allow the Departments flexibility to expand their respective footprints, or specialize, in different service offerings by contracting with third parties for the provision of services like ECM and ILOS. The request is made for a short duration because, unlike Recommendations Nos. 1-3, it primarily involves money flowing out to vendors, service providers or other third parties.

The Departments will have the authority, in their discretion, to make agreements to provide new CalAIM's new Enhanced Care Management and In Lieu of Services (also called Community Support Services) through such agreements. In many instances, like Housing Navigation and Tenancy Support, Housing for Health (H4H) may continue to use or modify existing agreements in furtherance of this recommendation. Nothing in this Board Letter is intended to supersede or limit any of each Department's preexisting Board delegated authorities. If H4H has been permitted to enter longer-term contracts, for example, nothing in the time limitation related to ILOS is intended to interfere with or truncate them.

Similarly, the Departments of Mental Health and Public Health have independent authorities to extend their own networks because they actively maintain health plans. Nothing in this new requested delegation is intended to curtail their already granted powers.

CalAIM is intended to last for five (5) years. Therefore, setting aside Request No. 4, which is a short-term authority, we are requesting the contracting authority granted for a longer period of time. The Departments have recommended approximately two (2) years for new agreement authority, and amending authority throughout CalAIM. Finally, to permit a more thoughtful and deliberative negotiation for subsequent waivers, we also request authority for no more than two additional extensions of then-existing authorities for up to six (6) months at a time to permit negotiation and execution of new agreements or amendments at the end of CalAIM.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended actions are consistent with the principles of the Countywide Strategic Plan, Strategy I.2.2—Enhance Our Delivery of Comprehensive Interventions: Streamline Access to Integrated Health Services.

FISCAL IMPACT/FINANCING

CalAIM will be financed through a mix of federal, State, and local funds. The State has not yet determined the total value of CalAIM, the amount(s) the County will receive or the mechanisms of payment. For ECM, ILOS and incentive components, we expect that the State will provide the greater portion of non-federal share. Under a program called Providing Access and Transforming Health (PATH), we expect a portion to be locally financed. DHS, DPH, and DMH will receive payments for the provision of services or achievement of certain incentives through agreements with the health plans and/or the State.

The authority requested herein to negotiate or amend the division of financial responsibilities (DOFR) under agreements does potentially subject the County to greater financial liability for certain services. Each Department will consider the impact of such changes, including whether the State adopts mechanisms like risk corridors, to limit exposure.

Each Department will use its existing resources to support any new agreements entered into under this Board Letter and will not require additional NCC.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

In June, DHCS submitted its CalAIM proposal to CMS. Medi-Cal 2020, the current waiver, is set to expire on December 31, 2021. While CMS has not yet approved CalAIM, it is set to begin on January 1, 2022. The Departments believe that CMS will timely approve CalAIM.

CalAIM is a Statewide effort to streamline and standardize services for Medi-Cal beneficiaries through managed care plans. Many services that are included have previously been supported through Medi-Cal 2020 programs like Whole Person Care.

DHCS' submission is ambitious and includes § 1115 demonstration and 1915(b) managed care waivers. If approved, those waivers, along with related contractual and Medi-Cal State Plan changes, will enable California to fully execute the CalAIM initiative, providing benefits to certain high-need, hard-to-reach populations, with the goal of improving health outcomes for Medi-Cal beneficiaries and other low-income people in the State.

The CalAIM § 1115 demonstration amendment and renewal would continue successful elements of the current Medi-Cal 2020 demonstration, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS), while adding several new authorities to advance the State's goals. For example, the renewal request advances several key priorities by more fully addressing the complex challenges facing California's most vulnerable residents. These include justice-involved populations who have significant clinical and social needs, providing limited pre-release services to help them successfully transition back into the community. The renewal also proposes initiatives, such as PATH, that would strengthen the ability of health plans and community-based providers to ensure a seamless transition from the current pilots to a more ambitious statewide delivery system, and to support effective pre-release care for justice-involved populations.

Two core § 1915(b) programs will replace Whole Person Care and Health Homes Programs: ECM and ILOS. ECM will be a care coordination benefit for the highest need cases that launches for most eligible populations on January 1, 2022, with additional populations related to nursing home use that will be eligible January 2023. The State has created narrowly defined eligible populations, and will pay a modest increase to the health plans to cover ECM services, with plans being responsible for managing the amount of services available given a finite amount of funds. However, ECM is an entitlement; plans must cover services for all those who are eligible. To ensure that participants in Whole Person Care and Health Homes Programs continue to receive services upon the December 31, 20201 sunset date, the State has directed that these participants are temporarily "grandfathered" into ECM effective January 2022. If the applicable department does not have executed contracts with the Health Plans for both ECM and ILOS, it may disrupt access to critical services. To prevent institutionalization and/or incarceration and sustain participants in their community, the County should support seamless and uninterrupted participants' receipt of these services.

ILOS are a menu of 14 different services that provide social supports such as housing navigation, tenancy sustaining services, housing deposits, recuperative care, sobering

centers, and components of enhanced residential care for persons with disability who have support needs around their activities of daily living, to name a few. Most of these services are already offered through Housing for Health or ODR Housing, and in the DMH System of Care the three (3) housing related ILOS are currently provided in our WPC Programs and Outpatient Programs. Unlike ECM, ILOS services are voluntary for the managed care plans, and health plans will not receive any substantial ongoing payment to help cover the costs of these services because, in concept, these services are supposed to be "in lieu of" higher cost services that the plan is already paid to cover – namely emergency room visits and inpatient hospital stays.

The State plans to offer health plans incentive payments for starting January 2022, to help roll out ECM and ILOS programs. As currently proposed, the above payments are supported with State general fund and federal matching funds.

Because this managed care framework for providing care coordination and social supports is untested, it will likely take at least one to two years before we understand how the various State, plan, and provider stakeholders will respond to this new opportunity, and therefore, how sustainable these funding sources may be. Additional funding through the Medicaid 1115 waiver will likely be needed to sustain existing programs in the short term as this uncertainty plays out.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

The recommended actions will allow continued access of Medi-Cal beneficiaries to critical health, mental health, and substance use services

Respectfully submitted,

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

Jonathan E. Sherin, M.D., Ph.D., Director
Department of Mental Health

Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director
Department of Public Health

CRG:aw

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

Attachment A

In Lieu of Services (a.k.a. Community Supports)

1. **Housing Transition Navigation Services.**
   Assists members with finding and obtaining housing.
2. **Housing Deposits.**
   Assists with identifying, coordinating, securing, and/or funding one-time services and modifications necessary to enable a person to establish a basic household.
3. **Housing Tenancy and Sustaining Services.**
   Supports members in maintaining safe and stable tenancy once housing is secured.
4. **Short-term Post Hospitalization Services.**
   Provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an institutional setting.
5. **Recuperative Care (Medical Respite).**
   Provides short-term integrated and clinical care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions);
6. **Respite Services** *(for caregivers).*
   Respite services are provided to caregivers of participants who require intermittent
   temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.
7. **Day Habilitation Programs.**
   Day Habilitation Programs are provided in a participant's home or an out-of-home, non- facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers.
8. **Nursing Facility Transition/Diversion to Assisted-Living Facility, such as Residential Care Facilities for Elderly and Adult Residential Facilities.**
   Supports individuals who have a choice of residing in an assisted-living setting as an alternative to long-term placement in a nursing facility.
9. **Community Transition Services/Nursing Facility Transition to a Home.**
   Assists individuals who are transitioning from a licensed facility to a living arrangement in a private residence.
10. **Environmental Accessibility Adaptations (Home Modifications).**

Provides the physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function with greater independence in the home.

11. **Medically Tailored Meals/Medically Supportive Food.**
    Provides individuals with meals following discharge from a hospital or nursing home or medically tailored meals to meet the unique dietary needs of those with chronic diseases.
12. **Sobering Centers**.
    An alternative for individuals who are found to be publicly intoxicated or otherwise under the influence of drugs, to enable them to avoid an unnecessary ED visit while still providing a medically safe place for them as the effects of the substance(s) wear off.
13. **Personal Care and Homemaker Services.**
    Assists individuals with activities of daily living such as bathing or feeding, and instrumental activities of daily living such as meal preparation or money management.
14. **Asthma Remediation.**
    Provides physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or to enable the individual to function in the home, and without which acute asthma episodes could result in the need for emergency services and/or hospitalization. Examples include mold removal/remediation, ventilation improvements, and installation of dehumidifiers and air filters.
15. **Other DHCS Approved In Lieu of Services.**
    Additional DHCS approved in lieu of services, whether offered by a department or through a plan.

Attachment B

Enhanced Care Management and In Lieu of Services Provider Standard Terms and Conditions

&

Exhibit A (Scope of Work) of the Two-Plan CCI Boilerplate

Enhanced Care Management (ECM)

1. ECM Definitions

Key terms are defined as follows:

a. **Enhanced Care Management (ECM)**: a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

b. **ECM Provider**: a Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

2. **Lead Care Manager**: a Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with MCP, as described in the DHCS-MCP ECM and ILOS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any In Lieu of Services (ILOS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

2. ECM Provider Requirements

Provider Experience and Qualifications

a. ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve;

b. ECM Provider shall have experience and expertise with the services it will provide;

c. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM program requirements in the DHCS-MCP ECM and ILOS Contract and associated guidance;

d. ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary;

e. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways;

f. ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral

health Providers, Specialists, and other entities, including ILOS Providers, to coordinate care as appropriate to each Member;

g. ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

Medicaid Enrollment/Vetting for ECM Providers

h. If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    i. If APL 19-004 does not apply to an ECM Provider, the ECM Provider must comply with the MCP's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

3. Identifying Members for ECM

a. ECM Provider is encouraged to identify Members who would benefit from ECM and send a request to the MCP, to determine if the Member is eligible for ECM, consistent with the MCP's process for such request.

4. Member Assignment to an ECM Provider

a. MCP shall communicate new Member assignments to ECM Provider as soon as possible, but in any event no later than ten business days after ECM authorization.
b. ECM Provider shall immediately accept all Members assigned by MCP for ECM, with the exception that an ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.
    i. ECM Provider shall immediately alert MCP if it does not have the capacity to accept a Member assignment.
c. Upon initiation of ECM, ECM Provider shall ensure each Member assigned has a Lead Care Manager who interacts directly with the Member and/or their

family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any In Lieu of Services (ILOS), and other services that address social determinants of health (SDOH) needs, regardless of setting.

d. ECM Provider shall advise the Member on the process for changing ECM Providers, which is permitted at any time.
    i. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.
    ii. ECM Provider shall notify MCP if the Member wishes to change ECM Providers.
    iii. MCP must implement any requested ECM Provider change within thirty days.

5. ECM Provider Staffing

a. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned Member consistent with this Provider Standard Terms and Conditions, the DHCS-MCP ECM ILOS Contract and any other related DHCS guidance.

6. ECM Provider Outreach and Member Engagement

a. ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with MCP's Policies and Procedures .

b. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

c. ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.
    i. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences:
        a. Mail
        b. Email
        c. Texts
        d. Telephone calls
        e. Telehealth

d. ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and the Contract with MCP.

7. Initiating Delivery of ECM

a. ECM Provider shall obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between MCP and ECM, ILOS, and other Providers involved in the provision of Member care to the extent required by federal law.
b. Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.
c. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to the MCP.
d. ECM Provider shall notify the MCP to discontinue ECM under the following circumstances:
    i. The Member has met their care plan goals for ECM;
    ii. The Member is ready to transition to a lower level of care;
    iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
    iv. ECM Provider has not had any contact with the Member despite multiple attempts.
e. When ECM is discontinued, or will be discontinued for the Member, MCP is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

8. ECM Requirements and Core Service Components of ECM

a. ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.
    i. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-MCP ECM ILOS Contract.
b. ECM Provider shall:
    i. Ensure each Member receiving ECM has a Lead Care Manager;

ii. Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;
iii. Alert MCP to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources; and
iv. Follow MCP instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

c. ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as ILOS Providers, as appropriate, to coordinate Member care.

d. ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with MCP's Policies and Procedures, as follows:
    i. Outreach and Engagement of MCP Members into ECM.
    ii. Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in-person contact;
            i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
        b. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.
        c. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
        d. Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

e. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and
f. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight

iii. Enhanced Coordination of Care, which shall include, but is not limited to:
   a. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;
   b. Maintaining regular contact with all Providers, that are identified as being a part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;
   c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
   d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
   e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
   f. Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

iv. Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:
   a. Working with Members to identify and build on successes and potential family and/or support networks;
   b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of

supporting Members' ability to successfully monitor and manage their health; and

c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

v. Comprehensive Transitional Care, which shall include, but is not limited to:

a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;

b. For Members who are experiencing, or who are likely to experience a care transition:

i. Developing and regularly updating a transition of care plan for the Member;

ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

iv. Coordinating medication review/reconciliation; and

v. Providing adherence support and referral to appropriate services.

vi. Member and Family Supports, which shall include, but are not limited to:

a. Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and MCP, as applicable;

b. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;

c. Ensuring the Member's ECM Provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);
d. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;
e. Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and
f. Ensuring that the Member has a copy of their Care Plan and information about how to request updates.

vii. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
a. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by MCP as ILOS; and
b. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

9. Training

a. ECM Providers shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by MCP, including in-person sessions, webinars, and/or calls, as necessary.

10. Data Sharing to Support ECM

a. MCP will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:
i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
ii. Encounter and/or claims data;
iii. Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members; and
iv. Reports of performance on quality measures and/or metrics, as requested.

11. Claims Submission and Reporting

a. ECM Provider shall submit claims for the provision of ECM-related services to MCP using the national standard specifications and code sets to be defined by DHCS.

b. In the event ECM Provider is unable to submit claims to MCP for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to the MCP with a minimum set of data elements (to be defined by DHCS) necessary for the MCP to convert the invoice to an encounter for submission to DHCS.

12. Quality and Oversight

a. ECM Provider acknowledges MCP will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions.
b. ECM Provider shall respond to all MCP requests for information and documentation to permit ongoing monitoring of ECM.

13. Payment for ECM

a. MCP shall pay contracted ECM Providers for the provision of ECM in accordance with contract established between MCP and ECM Provider.
b. ECM Provider is eligible to receive payment when ECM is initiated for any given MCP Member.
c. MCP shall pay 90 percent of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99 percent of all clean claims within 90 days. The date of receipt shall be the date MCP receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

In Lieu of Services (ILOS)

1. ILOS Definitions

Key terms are defined as follows:

a. I**n Lieu of Services (ILOS):** Pursuant to 42 CFR 438.3(e)(2), ILOS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. ILOS are optional for both the MCP and the Member and must be approved by DHCS. DHCS already has pre-approved the list of ILOS included in Section 2: DHCS-Approved ILOS ("pre-approved ILOS"). services *[See ILOS Section 2: DHCS Pre-Approved ILOS].*

b. **ILOS Provider:** a contracted Provider of DHCS-approved ILOS. ILOS Providers are entities with experience and/or training providing one or more of the ILOS approved by DHCS.

2. Overview

a. The ILOS Provider may elect to offer the following DHCS-authorized ILOS to Members (check as applicable):

i. ☐ Housing Transition Navigation Services
ii. ☐ Housing Deposits
iii. ☐ Housing Tenancy and Sustaining Services
iv. ☐ Short-Term Post-Hospitalization Housing
v. ☐ Recuperative Care (Medical Respite)
vi. ☐ Respite Services
vii. ☐ Day Habilitation Programs
viii. ☐ Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
ix. ☐ Community Transition Services/Nursing Facility Transition to a Home
x. ☐ Personal Care and Homemaker Services
xi. ☐ Environmental Accessibility Adaptations (Home Modifications)
xii. ☐ Meals/Medically Tailored Meals
xiii. ☐ Sobering Centers
xiv. ☐ Asthma Remediation

3. ILOS Provider Requirements

a. ILOS Providers for whom a State-level enrollment pathway exists, shall enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    i. If APL 19-004 does not apply to an ILOS Provider, the ILOS Provider will comply with the MCP's process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.
b. Experience and training in the elected ILOS.
    i. The ILOS Provider shall have experience and/or training in the provision of the ILOS being offered.
    ii. The ILOS Provider shall have the capacity to provide the ILOS in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by the MCP.
c. If the ILOS Provider subcontracts with other entities to administer its functions of ILOS, the ILOS Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.

4. Delivery of ILOS

a. ILOS Provider shall deliver contracted ILOS services in accordance with DHCS service definitions and requirements.
b. ILOS Provider shall maintain staffing that allows for timely, high-quality service delivery of the ILOS that it is contracted to provide.
c. ILOS Provider shall:
    i. Accept and act upon Member referrals from MCP for authorized ILOS, unless the ILOS Provider is at pre-determined capacity;
    ii. Conduct outreach to the referred Member for authorized ILOS as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;
    iii. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;
    iv. Coordinate with other Providers in the Member's care team, including ECM Providers, other ILOS Providers and the MCP;
    v. Comply with cultural competency and linguistic requirements required by federal, State and local laws, and in contract(s) with the MCP; and
    vi. Comply with non-discrimination requirements set forth in State and Federal law and the Contract with MCP.
d. When federal law requires authorization for data sharing, ILOS Provider shall obtain and/or document such authorization from each assigned Member,

including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to the MCP.

i. Member authorization for ILOS-related data sharing is not required for the ILOS Provider to initiate delivery of ILOS unless such authorization is required by federal law. ILOS Provider will be reimbursed only for services that are authorized by MCP. In the event of a Member requesting services not yet authorized by MCP, ILOS Provider shall send prior authorization request(s) to MCP, unless a different agreement is in place (e.g., if the MCP has given the ILOS Provider authority to authorize ILOS directly).

e. If an ILOS is discontinued for any reason, ILOS Provider shall support transition planning for the Member into other programs or services that meet their needs.

f. ILOS Provider is encouraged to identify additional ILOS the Member may benefit from and send any additional request(s) for ILOS to MCP for authorization.

5. Payment for ILOS

a. ILOS Provider shall record, generate, and send a claim or invoice to MCP for ILOS rendered.

i. If ILOS Provider submits claims, ILOS Provider shall submit claims to MCP using specifications based on national standards and code sets to be defined by DHCS.

ii. In the event ILOS Provider is unable to submit claims to MCP for ILOS-related services using specifications based on national standards or DHCS-defined standard specifications and code sets, ILOS Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the ILOS services rendered, and ILOS Providers' information to support appropriate reimbursement by MCPs, that will allow MCPs to convert ILOS invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

b. ILOS Provider shall not receive payment from MCP for the provision of any ILOS services not authorized by MCP.

c. ILOS Provider must have a system in place to accept payment from MCP for ILOS rendered.

i. MCP shall pay 90 percent of all clean claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt.

ii. MCP will provide expedited payments for urgent ILOS (e.g., recuperative care services for an individual who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be

exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

6. Data Sharing to Support ILOS

a. As part of the referral process, MCP will ensure ILOS Provider has access to:
   i. Demographic and administrative information confirming the referred Member's eligibility for the requested service;
   ii. Appropriate administrative, clinical, and social service information the ILOS Provider might need in order to effectively provide the requested service; and
   iii. Billing information necessary to support the ILOS Provider's ability to submit invoices to MCP.

7. Quality and Oversight

a. ILOS Provider acknowledges MCP will conduct oversight of its delivery of ILOS to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both the MCP and the ILOS Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

Exhibit A
SCOPE OF WORK

1. Service Overview

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

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

2. Service Location

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

3. Service Hours

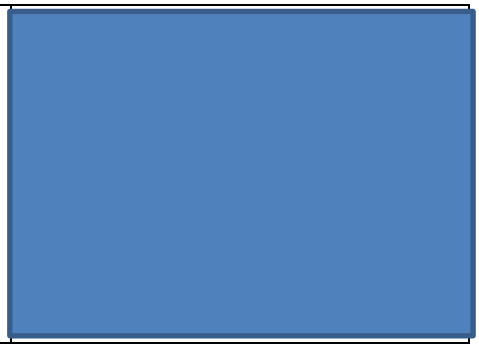
The services shall be provided on a 24-hour, seven (7) days a week basis.

4. Project Representatives

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

Department of Health Care Services Managed Care Operations Division Attention: Chief, Managed Care Systems and Support Branch Telephone: (916) 449-5100 Fax: (916) 449-5090	

B. Direct all inquiries to:

Department of Health Care Services Managed Care Operations Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 MS 4407 P.O. Box Number 997413 Sacramento, CA 95899-7413 Telephone: (916) 449-5000 Fax: (916) 449-5005	

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

Exhibit A, Attachment 1
ORGANIZATION AND ADMINSTRAT

1. Legal Capacity

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

2. Key Personnel (Disclosure Form)

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

1) Any person or corporation having 5% or more ownership or controlling interest in the Contractor.

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

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

B. Comply with Title 42 Code of Federal Regulations (CFR) 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106 and 42 CFR 438.610 (Prohibited Affiliations with Individuals Debarred by Federal Agencies).

3. Conflict of Interest – Current And Former State Employees

A. This Contract shall be governed by the Conflict of Interest provisions of Title 22 CCR Sections 53874 and 53600, and 42 CFR 438. 3(f)(2).

B. Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. For purposes of this subsection (B) only, employee in the State civil service is defined to be any person legally holding a permanent or intermittent position in the State civil service.

4. Contract Performance

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

A. The organization has an accountable governing body.

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

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

D. Staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

E. Written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

5. Medical Decisions

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

6. Medical Director

Contractor shall maintain a full time physician as medical director pursuant to Title 22 CCR Section 53857 whose responsibilities shall include, but not be limited to, the following:

A. Ensuring that medical decisions are:

1) Rendered by qualified medical personnel.
2) Are not influenced by fiscal or administrative management considerations.

B. Ensuring that the medical care provided meets the standards for acceptable medical care.

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

D. Developing and implementing medical policy.

E. Resolving Grievances related to medical quality of care.

F. Direct involvement in the implementation of Quality Improvement activities.

G. Actively participating in the functioning of Grievance and Appeal procedures.

7. Medical Director Changes

Contractor shall report to DHCS any changes in the status of the medical director within ten (10) calendar days.

8. Administrative Duties/Responsibilities

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

A. Member and enrollment reporting systems as specified in Exhibit A, Attachment 3, Management Information System, and, Exhibit A, Attachment 13, Member Services, and Exhibit A, Attachment 14, Member Grievance and Appeal System.

B. A Member Grievance and Appeal procedure, as specified in Exhibit A, Attachment 14, Member Grievance and Appeal System.

C. Data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment 3, Management Information System.

D. Financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment 2, Financial Information.

E. Claims processing capabilities as described in Exhibit A, Attachment 8, Provider Compensation Arrangements.

9. Member Representation

Contractor shall ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), and Members who use Managed Long Term Services and Supports (MLTSS) or their representatives are included and participate in establishing public policy within the Contractor's advisory committee or other similar committee or group.

10. Sensitivity Training

Exhibit A, Attachment 1
ORGANIZATION AND ADMINSTRAT

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

Exhibit A, Attachment 2
FINANCIAL INFORMATION

1. Financial Viability/Standards Compliance

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

A. Tangible Net Equity (TNE).

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

B. Administrative Costs.

Contractor's Administrative Costs shall not exceed the standards as established under Title 22 CCR Section 53864(b).

C. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Title 22 CCR Sections 53851, 53863, and 53864.

D. Working capital and current ratio of one of the following:

1) Contractor shall maintain a working capital ratio of at least 1:1; or

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

3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code, Section 14459. Certified Public Accountant’s audited Financial Statements shall be submitted to DHCS no later than 120 calendar days after the close of Contractor’s fiscal year. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon

Exhibit A, Attachment 2
FINANCIAL INFORMATION

Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

A. The independent accountant shall state in writing the reasons for not preparing combined Financial Statements.

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

1) In addition to annual certified Financial Statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The Certified Public Accountant's audited Financial Statements and DMHC required financial reporting forms shall be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

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

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

a) Jurat.

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

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

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

e) Report 4: Enrollment and Utilization Table.

f) Schedule F: Unpaid Claims Analysis.

g) Appropriate footnote disclosures in accordance with GAAP.

h) Schedule H: Aging Of All Claims.

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

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

E. Contractor shall submit to DHCS copies of any financial reports submitted to other public or private organizations as specified in Title 22 CCR Section 53862(c)(5).

3. All Financial Statements

A. Contractor shall submit Medi-Cal financial reports, including financial information for Adult Expansion Members. Contractor shall submit financial reports to DHCS no later than 120 calendar days after the close of the following periods:

1) January 1, 2014 to June 30, 2015 (18 months); and

2) July 1, 2015 to June 30, 2016 (12 months)

B. Contractor shall prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles. Contractor's financial reports shall be prepared in the DMHC required financial reporting format. All financial reports shall include the following reports/schedules:

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

2) Report 4: Enrollment and Utilization Table.

C. Where appropriate, this Contract refers to the Knox-Keene Health Care Service Plan Act of 1975 rules in Title 28, CCR Section 1300.51 et. seq. Contractor shall submit information based on current operations. Contractor, as well as Subcontractors, shall submit financial information consistent with DMHC filing requirements unless otherwise specified by DHCS.

Exhibit A, Attachment 2
FINANCIAL INFORMATION

4. Monthly Financial Statements

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

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

A. Jurat.

B. Report 1A and 1B: Balance Sheet

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

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

E. Report 4: Enrollment and Utilization Table.

F. Schedule F: Unpaid Claims Analysis.

G. Appropriate footnote disclosures in accordance with GAAP.

H. Schedule H: Aging of All Claims.

5. Quarterly Financial Statements

Contractor shall submit to DHCS no later than 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports. Contractor's quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat.

B. Report 1A and 1B: Balance Sheet

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

D. Statement of Cash Flow, prepared in accordance with Financial

Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

E. Report 4: Enrollment and Utilization Table.

F. Schedule F: Unpaid Claims Analysis.

G. Appropriate footnote disclosures in accordance with GAAP.

H. Schedule H: Aging of All Claims.

6. Annual Financial Statements

Contractor shall submit to DHCS no later than 120 calendar days after the close of Contractor's fiscal year, annual financial reports. Contractor's annual financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

A. Jurat.

B. Report 1A and 1B: Balance Sheet

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

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

E. Report 4: Enrollment and Utilization Table.

F. Schedule F: Unpaid Claims Analysis.

G. Appropriate footnote disclosures in accordance with GAAP.

H. Schedule H: Aging of All Claims.

7. Medi-Cal Line of Business Financial Statements

Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement and enrollment table on each financial reporting period required. Contractor shall prepare this income statement and enrollment table in the DMHC required financial reporting format for each specific county of operation and shall include, at a minimum, the following reports/schedules:

A. Report 2: Statement of Revenue, Expenses, and Net Worth by County.

B. Report 4: Enrollment and Utilization Table by County.

Medi-Cal line of business Financial Statements are to include expenses, revenues and enrollment only for Medi-Cal beneficiaries enrolled through direct contract with DHCS.

Contactor shall submit the Medi-Cal line of business financial statements within the same time frame as indicated for each required financial statement with the exception of the annual financial statement. The annual Medi-Cal line of business Financial Statements shall be submitted to DHCS no later than 120 calendar days after the close of the State fiscal year.

8. Annual Forecasts

Contractor shall submit to DHCS at least 60 days prior to the beginning of Contractor's fiscal year, an annual forecast for Contractor's next fiscal year. Contractor's annual forecast shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

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

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

C. TNE. (All lines of business)

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

9. Compliance with Audit Requirements

Contractor shall cooperate with DHCS' audits. Such audits may be waived upon submission of the financial audit for the same period conducted by DMHC pursuant to Health and Safety Code, Section 1382.

10. Submittal of Financial Information

A. Contractor shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections/forecasts are requested, these statements and projections/forecasts should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based

on current operations. Contractor and/or Subcontractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

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

11. Fiscal Viability of Subcontracting Entities

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

12. Contractor's Obligations

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

Exhibit A, Attachment 3
MANAGEMENT INFORMATION SYSTEM

1. Management Information System Capability

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

1) All Medi-Cal eligibility data,

2) Information of Members enrolled in Contractor's plan,

3) Provider claims status and payment data,

4) Health care services delivery Encounter Data,

5) Provider Network information, and

6) Financial information as specified in Exhibit A, Attachment 1, Provision 8. Administrative Duties/Responsibilities.

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

2. Encounter Data Reporting

A. Contractor shall maintain a MIS that collects and reports Encounter Data to DHCS in compliance with 42 CFR 438.242, and pursuant to applicable DHCS All Plan Letters (APL).

B. Contractor shall implement policies and procedures for ensuring ~~the~~ complete, accurate, reasonable, and timely submission of Encounter Data to DHCS for all items and services furnished to a Member under this Contract, whether directly or through Subcontracts or other arrangements, including capitated Providers. Encounter Data shall be submitted on at least a monthly basis in a form and manner specified by DHCS.

C. Contractor shall require Subcontractors and non-contracting Providers to submit claims and Encounter Data to Contractor to meet its administrative functions and the requirements set forth in this Section. Contractor shall have in place mechanisms, including edit and reporting systems sufficient

to assure Encounter Data is complete, accurate, reasonable, and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, reasonability, and timeliness of all Subcontractor Encounter Data regardless of whether Subcontractor is reimbursed on a Fee-For-Service (FFS) or capitated basis.

D. Contractor shall submit complete, accurate, reasonable, and timely Encounter Data within six (6) business days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

E. DHCS shall review and validate the Encounter Data for completeness, accuracy, reasonability, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonability, and timeliness of the Encounter Data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Encounter Data.

G. Contractor shall ensure all Encounter Data is submitted to DHCS within two (2) months of adjudication of a FFS claim or receipt of a capitated Encounter. Subcontractors and Providers must comply with this Provision for submission of Encounter Data to Contractor. All Encounter Data shall be submitted to Contractor no later than 12 months from the date of service.

H. DHCS or its agent will periodically, but not less frequently than once every three (3) years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, In accordance with 42 CFR 438.602(e).

3. MIS/Data Correspondence

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

4. Health Insurance Portability and Accountability Act (HIPAA)

Contractor shall comply with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements and all Federal and State regulations promulgated from this Act, as they become effective.

5. Participation in the State Drug Rebate Program

A. Contractor shall participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements in Section 1927(k)(2) of the Social Security Act.

1) Encounter Data for outpatient drugs shall comply with Section 1927(b)(1)(A) of the Social Security Act.

2) All outpatient drug Encounter Data shall include, at a minimum, the total number of units of each dosage form, strength, and package size, by National Drug Code, for each claim, including eligible Physician Administered Drug claims.

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

C. Contractor shall assist DHCS in resolving manufacturer rebate disputes due to Provider Network or Encounter Data submissions.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards set forth in Title 28, CCR, Section 1300.70 and 42 CFR 438.330. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all Providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the Provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a Subcontractor.

2. Accountability

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

3. Governing Body

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

A. Approves the overall QIS and the annual report of the QIS.

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

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

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

4. Quality Improvement Committee

A. Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Subcontractors, who are representative of the composition of the Provider Network including but

not limited to Subcontractors who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.

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

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

5. Provider Participation

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

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to Subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (Subcontractor) shall include in their Subcontract, at a minimum:

1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Subcontractor.

2) Contractor’s oversight, monitoring, and evaluation processes and Subcontractor’s agreement to such processes.

3) Contractor’s reporting requirements and approval processes. The agreement shall include Subcontractor’s responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

4) Contractor’s actions/remedies if Subcontractor’s obligations are not met.

B. Contractor shall maintain a system to ensure accountability for delegated

quality improvement activities, that at a minimum:

1) Evaluates Subcontractor's ability to perform the delegated activities including an initial review to assure that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

2) Ensures Subcontractor meets standards set forth by the Contractor and DHCS.

3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

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

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

B. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QIS committee(s) and staff within Contractor's organization.

C. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

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

E. The role, structure, and function of the quality improvement committee.

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

G. A description of the mechanisms used to continuously review, evaluate,

and improve access to and availability of services. The description shall include methods to ensure that Members are able to obtain appointments within established standards.

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

I. Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, and Members who use MLTSS in accordance with the standards set forth in 42 CFR 438.330(b)(5), designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services, and care management.

8. Quality Improvement Annual Report

Contractor shall develop an annual quality improvement report for submission to DHCS on an annual basis. Contractor's responsibilities shall include, but are not limited to:

A. Providing an annual report to DHCS that includes a comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the quality review of services rendered; the results of the External Accountability Set measures; and, outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys, and collaborative initiatives.

B. Providing copies of all final reports of independent private accrediting agencies (e.g. JCAHO, NCQA) relevant to Contractor's Medi-Cal line of business, including:

1) Accreditation status, survey type, and level, as applicable;

2) Accreditation agency results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

3) Expiration date of the accreditation.

C. Providing an annual report to DHCS that includes an assessment of all

Subcontractors performance of delegated quality improvement activities.

D. Upon request from DHCS to Contractor, authorizing any independent private accrediting agency to provide DHCS a copy of its most recent accreditation review.

9. External Quality Review Requirements

At least annually or as designated by DHCS, DHCS shall arrange for an External Quality Review of Contractor by an entity qualified to conduct such reviews in accordance with Title 22 CCR Section 53860(d), Title 42, USC, Section 1396u-2(c)(2), and 42 CFR 438.350, 438.358, and 438.364. Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) contracted with DHCS in the conduct of this review.

A. External Accountability Set (EAS) Performance Measures

The EAS performance measures consist of a set of Healthcare Effectiveness Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.

1) On an annual basis, Contractor shall submit to an on-site EAS Compliance Audit (previously referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the Contractor's information and reporting systems, as well as the Contractor's methodologies for calculating performance measure rates. Contractor shall use the DHCS-selected contractor for performance of the EAS/HEDIS Compliance Audit and calculation of DHCS-developed performance measures that constitute the EAS. Compliance Audits will be performed by an EQRO as contracted and paid for by the State.

2) Contractor shall calculate and report all EAS performance measures at the county level.

a) HEDIS rates are to be calculated by the Contractor and verified by the DHCS-selected EQRO. Rates for other standardized and/or DHCS-developed performance measures will be calculated by the Contractor, DHCS staff or the EQRO, as directed by DHCS.

b) Contractor shall report audited results on the EAS performance measures to DHCS no later than June 15 of

each year or such date as established by DHCS. Contractor shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.

3) Contractor shall meet or exceed the DHCS-established Minimum Performance Level (MPL) for each HEDIS measure, and any other EAS performance measures required pursuant to of this Provision.

a) For each measure that does not meet the MPL set for that year, or is reported as a "Not Report" (NR) due to an audit failure, Contractor must submit a plan outlining the steps that will be taken to improve the subsequent year's performance.

b) The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.

c) Improvement plans are due to DHCS within 60 calendar days of DHCS' notification that the Contractor has performed at or below the MPL for the period under review.

d) Additional reporting may be required of the Contractor until such time as improvement is demonstrated.

B. Under/Over-Utilization Monitoring

In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures selected by DHCS. These measures may be audited as part of the EAS/HEDIS Compliance Audit, and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify Contractors of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

C. Performance Improvement Projects (PIPs)

1) For this Contract, Contractor is required to conduct or participate in two (2) PIPs per year, approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required

to conduct or participate in two PIPs for each contract. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs.

a) One PIP must be either an internal performance improvement project (IPIP) or a small group collaborative (SGC) facilitated by a health plan or DHCS. The SGC must include a minimum of four (4) DHCS health plan contactors and must use standardized measures and clinical practice guidelines. Additionally, all contracting health plans participating in a SGC must agree to the same goal, timelines for development, implementation, and measurement. Contracting health plans participating in a SGC must also agree on the nature of contracting health plan commitment of staff and other resources to the collaborative project.

b) One PIP must be a DHCS facilitated Statewide Collaborative. If the Contract operation start date of this Contract is after the Statewide Collaborative has begun implementation, upon DHCS's approval, Contractor may substitute a SGC and/or IPIP in place of the Statewide Collaborative.

2) If this Contract covers multiple counties, Contractor must include all counties in a PIP unless otherwise approved by DHCS.

3) Contractor shall comply with APL 16-018, as well as any subsequent updates, and shall use the PIP reporting format as designated therein to request approval of proposed PIPs from DHCS and to report at least annually to DHCS on the status of each PIP. The required documentation for PIP proposals and for PIP status reports shall include but is not limited to:

a) In-depth qualitative and quantitative analysis of barriers and results.

b) Evidence-based interventions and best practices, when available, and system wide intervention, when appropriate.

c) Interventions that address health disparities.

d) Measurement of performance using objective quality indicators.

e) Strategies for sustaining and spreading improvement beyond

the duration of the PIP.

D. Consumer Satisfaction Survey

At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of members enrolled in Contractor's plan in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

10. Site Review

A. General Requirement

Contractor shall conduct Facility Site and Medical Record reviews on all Primary Care Provider sites in accordance with the Site Review Policy Letter, Policy Letter (PL) 14-004 and Title 22, CCR, Section 53856. Contractor shall also conduct Facility Site Physical Accessibility reviews on Primary Care Provider sites, and all Provider sites which serve a high volume of SPD beneficiaries, in accordance with the Site Review Policy Letter, PL 12-006 and W & I Code 14182(b)(9).

B. Pre-Operational Site Reviews

The number of site reviews to be completed prior to initiating plan operation in a Service Area shall be based upon the total number of new primary care sites in the Provider Network. For more than 30 sites in the Provider Network, a 5% sample size or a minimum of 30 sites, whichever is greater in number, shall be reviewed six (6) weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of Plan operation. For 30 or fewer sites, reviews shall be completed on all sites six (6) weeks prior to Plan operation.

C. Credentialing Site Review

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

D. Corrective Actions

Contractor shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified

within the established guidelines as specified in PL 14-004, the Site Review Policy Letter. Primary Care Provider sites that do not correct cited differences are to be terminated from Contractor's Network.

E. Data Submission

Contractor shall submit the Facility Site review data to DHCS by January 31 and July 31 of each year. All data elements defined by DHCS shall be included in the data submission report.

F. Continuing Oversight

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

11. Disease Surveillance

Contractor shall implement and maintain procedures for reporting any disease or condition to public health authorities as required by State law.

12. Credentialing and Recredentialing

Contractor shall implement and maintain written policies and procedures concerning the initial credentialing, recredentialing, recertification, and reappointment of Network Providers, developed by the Department in accordance with 42 CFR 438.214 and APL 16-012, and including but not limited to: Primary Care Physicians (PCP); Specialists; Providers for acute, behavioral health, and substance use disorders; and MLTSS Providers as appropriate per the requirements in Exhibit A, Attachment 21, Managed Long Term Services and Supports, Provision 4, Provider Network. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

A. Standards

All Network Providers who deliver Covered Services and have executed contracts or participation agreements with Contractor must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All Network Providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Provider Network.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

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

B. Delegated Credentialing

Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with Provision 6, Delegation of Quality Improvement Activities, above.

C. Credentialing Provider Organization Certification

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

D. Disciplinary Actions

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

E. Medi-Cal and Medicare Provider Status

Contractor will verify that their subcontracted Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed on the Suspended and Ineligible Provider List. Terminated providers in either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List, cannot participate in Contractor’s Provider Network.

F. Health Plan Accreditation

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

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

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

G. Credentialing of Other Non-Physician Medical Practitioners

Contractor shall develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists and Physician Assistants have been verified in accordance with State requirements applicable to the Provider category.

13. Medical Records

A. General Requirement

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

B. Medical Records

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

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

2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.

3) For the release of information and obtaining consent for treatment.

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

C. On-Site Medical Records

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

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22 CCR Section 53861, that reflects all aspects of patient care, including ancillary services, and at a

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

minimum includes:

1) Member identification on each page; personal/biographical data in the record.

2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

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

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

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

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

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

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

9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

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

Exhibit A, Attachment 5
UTILIZATION MANAGEMENT

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

A. Qualified staff responsible for the UM program.

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

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

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

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

F. An established specialty referral system to track and monitor referrals requiring prior authorization through Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting Providers.

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

G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of Appeals, denials, deferrals, and modifications to the appropriate QIS staff.

H. Contractor shall ensure its UM program timelines and processes do not impose Quantitative Treatment Limitations (QTL), or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on

medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq., to its timelines and processes.

I. Contractor shall make its UM or utilization review policies and procedures available to Members and Providers. These policies and procedures shall cover how Contractor, Subcontractors, or any contracted entity, authorize, modify, delay, or deny health care services via Prior Authorization, concurrent authorization, or retrospective authorization, under the benefits provided by Contractor.

1) Contractor shall ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested health care service, and are consistent with criteria or guidelines supported by sound clinical principles.

2) Contractor shall ensure the policies, processes, strategies, evidentiary standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

3) Contractor shall notify contracting health care Providers, as well as Members and Potential Enrollees upon request, of all services that require Prior Authorization, concurrent authorization, or retrospective authorization, and ensure that all contracting health care Providers are aware of the procedures and timeframes necessary to obtain authorization for these services

These activities shall be done in accordance with Health and Safety Code Sections 1363.5 and 1367.01 and Title 28, CCR, Section 1300.70(b)(2)(H) & (c).

2. Prior Authorizations and Review Procedures

Contractor shall ensure that its Prior Authorization, concurrent review, and retrospective review procedures meet the following minimum requirements:

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

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

C. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of Medical Necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny Prior Authorization for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by Contractor's medical director, in collaboration with Contractor's Pharmacy and Therapeutics Committee (PTC) or its equivalent.

D. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

E. Reasons for decisions are clearly documented.

F. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13, Member Services, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests. There shall be a well-publicized Appeals procedure for both Providers and patients.

G. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

H. Prior Authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

I. Records, including any Notice of Action (NOA), shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 19, Audit.

J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be orally or in writing.

K. All of Contractor's authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

3. Timeframes for Medical Authorization

A. Emergency Care: No Prior Authorization required, following the

reasonable person standard to determine that the presenting complaint might be an emergency.

B. Post-stabilization: Response to request within 30 minutes or the service is deemed approved in accordance with Title 22 CCR Section 53855 (a), or any future amendments thereto.

C. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.

D. Concurrent review of authorization for treatment regimen already in place: Within five (5) working days or less, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01(h)(3), or any future amendments thereto.

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

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

G. Routine authorizations: As expeditiously as the Member's condition requires but within five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-Network not otherwise exempt from Prior Authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's Provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

H. Expedited Authorizations: For requests in which a Provider indicates, or Contractor or a Subcontractor determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not

later than 72 hours after receipt of the request for services. The Contractor may extend the 72 hours' time period by up to 14 calendar days if the Member requests an extension, or if the Contractor justifies, to the satisfaction of DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

I. Hospice inpatient care: 24-hour response.

J. Therapeutic Enteral Formula for Medical Conditions in Infants and Children: Timeframes for medical authorization of Medically Necessary therapeutic enteral formulas for infants and children and the equipment/and supplies necessary for delivery of these special foods are set forth in PL 14-003, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.

4. Review of Utilization Data

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

5. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

Exhibit A, Attachment 6
PROVIDER NETWORK

1. Network Capacity

Contractor shall maintain a Provider Network adequate to serve sixty percent (60%) of all Eligible Beneficiaries, including SPD beneficiaries within Contractor's Service Area and provide the full scope of benefits. Contractor will increase the capacity of the Network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first 12 months of operation, if Enrollments do not achieve seventy-five percent (75%) of the required Network capacity, the Contractor's total Network capacity requirement may be renegotiated.

2. Network Composition

Within each Service Area, Contractor shall ensure and monitor an appropriate Provider Network, including adult and pediatric PCPs, OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, professional, Allied Health Personnel, supportive paramedical personnel, hospitals, pharmacies and an adequate number of accessible inpatient facilities and service sites. In addition, Contractor shall ensure and monitor MLTSS Providers, American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available.

3. Provider to Member Ratios

A. Contractor shall ensure that its Network continuously satisfies the following full-time equivalent Network Provider to Member ratios:

1)	Primary Care Physicians	1:2,000
2)	Total Physicians	1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's Provider Network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent Network Provider/patient caseload of one (1) Network Provider per 1,000 patients.

4. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with Title 22 CCR Section 51241, and that full-time equivalent Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

A.	Nurse Practitioners	1:4
B.	Physician Assistants	1:4

C. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) Certified Nurse Midwives or two (2) Physician Assistants.

5. Emergency Services

Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24 hours a day, 7 day a week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

6. Specialists

Contractor shall maintain adequate numbers and types of Specialists within their Network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code section 14182(c)(2).

7. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birth Center (FBC) Services

Contractor shall meet federal requirements for access to FQHC, RHC, and FBC services as a mandatory service and benefit, including those in 42 USC Section 1396 b(m). Contractor must include at least one (1) FQHC, one (1) RHC, and one (1) FBC in the Provider Network within Contractor's Service Area, to the extent that the FQHC, RHC and FBC Providers are licensed and recognized under State law and they are available within Contractor's Service Area. Contractor shall reimburse FQHCs, RHCs, and FBCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7. If FQHC, RHC, or FBC services are not available in the Provider Network, Contractor shall reimburse FQHCs, RHCs, and FBCs for services provided out-of-Network to Contractor's Members at a rate determined by DHCS. If FQHC, RHC, or FBC services are not available in Contractor's Provider Network, but are available within DHCS' time and distance standards for access to Primary Care for Contractor's Members in the Service Area, Contractor shall not be obligated to reimburse FQHCs, RHCs, or FBCs for services provided out-of-Network to Members, unless authorized by Contractor.

8. Time and Distance Standard

Contractor shall maintain a Network of PCPs which are located within 30 minutes or 10 miles of a Member's residence unless Contractor has a DHCS-approved alternative time and distance standard.

9. Plan Physician Availability

Contractor shall have a plan or contracting physician available 24 hours per day, seven (7) days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically Necessary post-stabilization services, and for general communication with emergency room personnel.

10. Network Provider Availability

Contractor shall ensure that Network Providers offer hours of operation to Members that are no less than the hours of operation offered to other patients, or to Medi-Cal FFS beneficiaries, if the Network Provider serves only Medi-Cal beneficiaries.

11. Provider Network Report

Contractor shall submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Provider Network.

A. The report shall be submitted at a minimum:

1) Quarterly

2) At the time of a significant change to the Network affecting Provider capacity and services, including:

a) Change in services or benefits;
b) Geographic service area or payments; or
c) Enrollment of a new population.

B. The report shall identify number of Primary Care Providers, Provider deletions and additions, and the resulting impact to:

1) Geographic access for the Members;

2) Cultural and linguistic services including Provider and Provider staff language capability;

3) The percentage of Traditional and Safety-Net Providers;

4) The number of Members assigned to each Primary Care Physician;

5) The percentage of Members assigned to Traditional and Safety-Net Providers; and

6) The Network Providers who are not accepting new patients.

C. Contractor shall submit the report 30 calendar days following the end of

the reporting quarter.

12. Plan Subcontractors

Contractor shall submit to DHCS, a quarterly report containing the names of all direct subcontracting provider groups including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their subcontracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. The report must be sorted by Subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect Subcontractors. The report shall be submitted within 30 calendar days following the end of the reporting quarter.

13. Ethnic and Cultural Composition

Contractor shall ensure that the composition of Contractor's Provider Network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis.

14. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall maintain policies and procedures, approved by DHCS, to ensure that Subcontractors fully comply with all terms and conditions of this Contract. Contractor shall evaluate the prospective Subcontractor’s ability to perform the subcontracted services, shall oversee and remain responsible and accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(1), (c)(1)(i)-(iii), (c)(2), (c)(3), Title 22 CCR Section 53867, APL 17-004, and this Contract.

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(c)(1)(i)-(iii), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, Section 1300 et seq.; Welfare and Institutions Code Section 14200 et seq.; Title 22 CCR Section 53800 et seq.; and other applicable federal and State laws and regulations.

B. Subcontract Requirements

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

Exhibit A, Attachment 6
PROVIDER NETWORK

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

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

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in Paragraph C. Departmental Approval – Non-Federally Qualified HMOs, or Paragraph D, Departmental Approval – Federally Qualified HMOs.

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

5) Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Subcontractors at risk for non-contracting emergency services.

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

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

8) Subcontractor's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Subcontract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State’s Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights:

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

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

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

    d) For a term of at least 10 years from the final date of the Contract period or from the date of completion of any audit,

whichever is later.

e) Including all Encounter Data for a period of at least 10 years.

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

g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Subcontract due to fraud.

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

10) Subcontractor's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Subcontractor:

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

b) Retain all records and documents for a minimum of 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

11) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 15. Phase out Requirements, Subparagraph B in the event of Contract termination.

12) Subcontractor’s agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

13) Subcontractor's agreement to notify DHCS in the event the agreement with Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the

United States Postal Service as first-class registered mail, postage attached.

14) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.

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

16) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the Subcontractor's possession, in accordance with Exhibit E, Attachment 2, Provision 25. Records Related to Recovery for Litigation.

17) Subcontractor's agreement to provide interpreter services for Members at all Provider sites.

18) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.

19) Subcontractor's agreement to participate and cooperate in Contractor's Quality Improvement System.

20) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.

21) Subcontractor's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program.

22) Subcontractor's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Subcontractor has not performed satisfactorily.

23) To the extent that the Subcontractor is responsible for the coordination of care for Members, Contractor's agreement to share with the Subcontractor any utilization data that DHCS has provided to Contractor, and the Subcontractor's agreement to receive the utilization data provided and use as they are able for the purpose of Member care coordination.

24) Contractor's agreement to inform the Subcontractor of prospective requirements added by DHCS to this Contract before the requirement would be effective, and Subcontractor's agreement to

comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

C. Departmental Approval - Non-Federally Qualified HMOs

1) Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, a Provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 calendar days of receipt. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval.

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

D. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontracts entered into by Contractor which is a federally qualified HMO shall be:

1) Exempt from prior approval by DHCS.

2) Submitted to DHCS upon request.

E. Public Records

Subcontracts entered into by the Contractor and all information received in accordance with the Subcontract will be public records on file with DHCS, except as specifically exempted in statute. DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS which are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and

owners of the Subcontractor, stockholders owning more than five (5) percent of the stock issued by the Subcontractor and major creditors holding more than five (5) percent of the debt of the Subcontractor will be attached to the Subcontract at the time the Subcontract is presented to DHCS.

15. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Subcontracts with FQHCs shall also meet Subcontract requirements of Provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, Provision 7. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

16. Traditional and Safety-Net Providers Participation

Contractor shall establish participation standards pursuant to Title 22 CCR Section 53800(b)(2)(C)(1) to ensure participation and broad representation of Traditional and Safety-Net Providers within a Service Area. Contractor shall maintain the percentage of Traditional and Safety-Net Provider within a Service Area submitted and approved by DHCS. Federally Qualified Health Centers meet the definitions of both Traditional and Safety-Net Providers.

17. Safety-Net Providers Subcontracts

Contractor shall offer a Subcontract to any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that the Contractor requires of other similar Providers.

18. Termination of Safety-Net Provider Subcontract

Contractor shall notify DHCS of intent to terminate a Subcontract with a Safety-Net Provider at least 30 calendar days prior to the effective date of termination unless such provider's license has been revoked or suspended or where the health and welfare of a Member is threatened, in which event termination shall be effective immediately, without DHCS prior approval, and Contractor shall notify DHCS concurrently with the termination.

19. Nondiscrimination in Provider Contracts

Contractor shall not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision. Contractor's Provider selection policies must not

discriminate against Providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of Contractor's Members; preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

Exhibit A, Attachment 7
PROVIDER RELATIONS

1. Exclusivity

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

2. Provider Grievance

Contractor shall have a formal procedure to accept, acknowledge, and resolve Provider grievances. A Provider of medical services may submit to Contractor a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by the Contractor. This process shall be communicated to contracting, subcontracting, and non-contracting Providers.

3. Non-Contracting, Non-Emergency Provider Communication

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

4. Contractor’s Provider Manual

Contractor shall issue a provider manual to the contracting and subcontracting Providers of health care services that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member Grievance, Appeal, and State Fair Hearing process. Contractor’s provider manual shall include the following Member rights information:

A. Member’s right to a State Fair Hearing, how to obtain a Hearing, and representation rules at a Hearing;

B. Member’s right to file Grievances and Appeals and their requirements and timeframes for filing;

C. Availability of assistance in filing;

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

E. Member’s right to request continuation of benefits during an Appeal or State Fair Hearing.

5. Network Provider Training

A. Contractor shall ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations. Contractor shall ensure that Network Provider training relates to Medi-Cal Managed Care services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, Network Provider, Member and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within ten (10) working days after Contractor places a newly contracted Network Provider on active status. Contractor shall ensure that Network Provider training includes information on all Member rights specified in Exhibit A, Attachment 13, Member Services, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Contractor shall ensure that ongoing training is conducted when deemed necessary by either Contractor or the State.

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

C. For Out-of-Network Providers who will not receive Network Provider training, Contractor shall develop and implement a process to provide them with Contractor's clinical protocols and evidence-based practice guidelines. Contractor shall arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an Out-of-Network Provider.

6. Submittal of Inpatient Days Information

Upon DHCS' written request, Contractor shall report hospital inpatient days to DHCS as required by Welfare and Institutions Code, Section 14105.985(b)(2) for the time period and in the form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor shall submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

7. Emergency Department Protocols

Contractor shall develop and maintain protocols for communicating and interacting with emergency departments. Protocols shall be distributed to all emergency departments in the contracted Service Area and shall include at a minimum the following:

A. Description of telephone access to triage and advice systems used by the Contractor.

B. Contractor's contact person responsible for coordinating services and who can be contacted 24 hours a day.

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Medi-Cal Members who present at the emergency department for non-emergency services.

D. Procedures for emergency departments to report system and/or protocol failures and process for ensuring corrective action.

8. Prohibited Punitive Action Against the Provider

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

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

1. Compensation

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

2. Capitation Payments

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

3. Physician Incentive Plan Requirements

Contractor may implement and maintain a Physician Incentive Plan only if:

A. No specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and

B. The stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR 417.479, 42 CFR 422.208 and 42 CFR 422.210 are met by Contractor.

4. Identification of Responsible Payor

Contractor shall provide the information that identifies the payor responsible for reimbursement of services provided to a Member enrolled in Contractor's Medi-Cal Managed Care health plan to DHCS' Fiscal Intermediary (FI) contractor. Contractor shall identify the Subcontractor (if applicable) or Independent Physician Association (IPA) responsible for payment, and the Primary Care Provider name and telephone number responsible for providing care. Contractor shall provide this information in a manner prescribed by DHCS once DHCS and the FI contractor have implemented the enhancement to the California Automated Eligibility Verification and Claims Management System (CA-AEV/CMS).

5. Claims Processing

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

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

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

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

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

E. Contractor shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision 2, Paragraph B.3).

6. Prohibited Claims

A. Except in specified circumstances, Contractor and any of its Affiliates and Subcontractors shall not submit a claim or demand, or otherwise collect reimbursement for any services provided under this Contract to a Medi-Cal Member. Collection of claim may be made under those circumstances described in Title 22 CCR Sections 53866, 53220, and 53222.

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

7. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

American Indian Health Service Programs.

A. FQHCs Availability and Reimbursement Requirement

If FQHC services are not available in the Provider Network of any Medi-Cal Managed Care Health Plan in the county, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor's Members at a level and amount of payment that is not less than the Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or RHC. If FQHC services are not available in Contractor's Provider Network, but are available within DHCS' time and distance standards for access to Primary Care for Contractor's Members within the Provider Network in the county, Contractor shall not be obligated to reimburse non-contracting FQHCs for services provided to Contractor's Members (unless authorized by Contractor).

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

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

To the extent that American Indian Health Service Programs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to Subcontracts with American Indian Health Service Programs. Contractor must also pay an amount equal to what Contractor would pay a subcontracted FQHC or RHC and DHCS must pay any supplemental payment, pursuant to 42 CFR 438.14(c), to an American Indian Health Service Program that qualifies as a FQHC or RCH but is not a subcontracted Provider.

C. American Indian Health Service Programs

1) Contractor shall attempt to contract with each American Indian Health Service Program as set forth in Title 22 CCR Sections 55120-55180. Contractor shall reimburse American Indian Health Service Programs at the applicable Fee-For-Service Medi-Cal rate for services provided prior to January 1, 2018 to Members who are qualified to receive services from an American Indian Health Service Program as set forth in 42 USC Section 1396u-2(h)(2), and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009. Contractor shall reimburse an American Indian Health Service Program that qualifies as a FQHC but is not a subcontracted Provider as set forth in 42 CFR 438.14(c)(1).

2) For services provided on or after January 1, 2018 to Members who are qualified to receive services from an American Indian Health Service Program as set forth under Supplement 6, Attachment 4.19-B, of the California Medicaid State Plan, regardless of whether the American Indian Health Service Program is a Network Provider:

   a) Contractor shall reimburse American Indian Health Service Programs at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service and in accordance with APL 17-020. Contractor shall adjust any payments to American Indian Health Service Programs if necessary to comply with any retroactive changes to the outpatient per-visit rates published in the Federal Register by the Indian Health Service.

   b) Contractor shall reimburse American Indian Health Service Programs at the Medi-Cal FFS rate for services that, in accordance Supplement 6, Attachment 4.19-B of the California Medicaid State Plan, are not eligible for the outpatient per-visit rate published in the Federal Register by the Indian Health Service.

8. Non-Contracting Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Reimbursement

If there are no CNMs or CNPs in Contractor's Provider Network, Contractor shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than the applicable Medi-Cal FFS rates. If an appropriately licensed non-contracting facility is used, Contractor shall pay the facility fee. For hospitals, the requirements of Provision 13, Paragraph C. below apply. For birthing centers, the Contractor shall reimburse no less than the applicable Medi-Cal FFS rate.

9. Non-Contracting Family Planning Providers' Reimbursement

Contractor shall reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse non-contracting family planning Providers for services listed in Exhibit A, Attachment 9, Provision 9, Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

10. Sexually Transmitted Disease (STD)

Contractor shall reimburse local health departments and non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS rate, for the diagnosis and treatment of a STD episode, as defined in PL 96-09. Contractor shall provide reimbursement only if STD treatment Providers provide treatment records or documentation of the Member's refusal to release medical records to Contractor along with billing information.

11. HIV Testing and Counseling

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

12. Immunizations

Contractor shall reimburse local health departments for the administration fee for immunizations given to Members. However, Contractor is not required to reimburse the local health department for an immunization provided to a Member who was already up to date. The local health department shall provide immunization records when immunization services are billed to the Contractor. Contractor shall not be obligated to reimburse Providers other than local health departments unless they enter into an agreement with the Contractor.

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

A. Emergency Services: Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. Further, Contractor may not deny payment for treatment obtained when a

representative of Contractor instructs the enrollee to seek Emergency Services.

B. Contractor may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Provider, the plan, or DHCS of the enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

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

E. For all non-contracting Providers, reimbursement by Contractor, or by a Subcontractor who is at risk for out-of-Network emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting Provider pursuant to this provision shall be made in accordance with Provision 5. Claims Processing above and 42 USC Section 1396u-2(b)(2)(D).

F. Contractor shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting Provider based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Contractor shall not limit what constitutes and Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.

G. In accordance with California Code of Regulations, Title 28, Section 1300.71.4, Contractor shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approved.

H. Post Stabilization Services: Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Contractor is financially responsible for post-stabilization services obtained within or outside Contractor's Network that are pre-approved by a plan Provider or other entity representative. Contractor is financially responsible for post-stabilization care services obtained within or outside Contractor's Network that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain the enrollee's stabilized condition within one (1) hour of a request to Contractor for pre-approval of further post-stabilization care services.

I. Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's Network that are not pre-approved by a Network Provider or other entity representative, but administered to maintain, improve or resolve the Member's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Contractor must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

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

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

1) For the purposes of this Paragraph K, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services

were rendered shall be the Medi-Cal FFS payment amounts that are:

a) Published in the annual All Plan Letter issued by the Department in accordance with California Welfare and Institutions Code Section 14091.3, which for the purposes of this Paragraph K shall apply to all acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (Welfare and Institutions Code Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable, which Item a) shall be applicable until it is replaced by the implementation of the payment methodology in Item b) below.

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

2) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph K shall constitute payment in full under this Paragraph K, and shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by Title 22 CCR 51536 shall not have any effect on payments made by Contractor pursuant to this Paragraph K.

L. Disputed emergency services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under provisions of Welfare and Institutions Code Section 14454 and, Title 22 CCR, Section 53620 et. seq., except Section 53698. Contractor agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting Provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and California Code of Regulations, Title 22 CCR, Section 53702.

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

14. Provider-Preventable Conditions

Contractor shall not pay any provider claims nor reimburse a provider for a Provider-Preventable Condition (PPC), in accordance with 42 CFR 438.3(g). Contractor shall report, and require any and all of its subcontracted providers to report, PPCs in the form and frequency required by APL 17-009.

15. Prohibition Against Payment of Excluded Providers

In accordance with Section 1903(i)(2) of the Act, Contractor shall not pay any amount for any Covered Service or item, other than Emergency Services, to an excluded provider as defined in Exhibit E, Attachment 2, Provision 26, Section B.8) of this Contract. This prohibition shall include services furnished by a Provider at the medical direction or by prescription of the excluded provider when the Provider knew or had a reason to know of the exclusion, or by an excluded provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of fraud.

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

1. General Requirement

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

Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through Subcontracts, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

2. Existing Patient-Physician Relationships

Contractor shall ensure that no Traditional or Safety-Net Provider, upon entry into Contractor's Network, suffers any disruption of existing patient-physician relationships, to the maximum extent possible.

3. Access Requirements

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

A. Appointments

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

B. First Prenatal Visit

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

C. Waiting Times

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

Paragraph A. Appointments, above.

D. Telephone Procedures

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

E. After Hours Calls

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

F. Unusual Specialty Services

Contractor shall arrange for the provision of seldom used or unusual specialty services from Specialists outside the Network if unavailable within Contractor's Network, when determined Medically Necessary.

4. Access Standards

Contractor shall ensure the provision of acceptable accessibility standards in accordance with Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these standards.

A. Appropriate Clinical Timeframes

Contractor shall ensure that Members are offered appointments for covered health care services within a time period appropriate for their condition.

B. Standards for Timely Appointments

Members must be offered appointments within the following timeframes:

1) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;
2) Urgent appointment for services that do require prior authorization – within 96 hours of a request;
3) Non-urgent primary care appointments – within ten (10) business days of request;
4) Appointment with a Specialist – within 15 business days of request;
5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

C. Shortening or Expanding Timeframes

Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Member's medical record that a longer timeframe will not have a detrimental impact on the Member's health.

D. Provider Shortage

Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time and distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible contracted Providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the Member's needs.

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

Contractor shall arrange for the timely referral and coordination of Covered Services to which the Contractor or Subcontractor has religious or ethical objections to perform or otherwise support. Contractor shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHCS. Contractor shall identify these services in the Member Services Guide.

6. Standing Referrals

Contractor shall provide for standing referrals to Specialists, in accordance with Health and Safety Code Section 1374.16, as follows:

A. Contractor shall have in place a procedure for a Member to receive a standing referral to a Specialist if the primary care physician determines, in consultation with the Specialist and Contractor's Medical Director or the Medical Director's designee, that a Member needs continuing care from a Specialist. If a treatment plan is necessary in the course of care and is approved by Contractor, in consultation with the primary care physician, Specialist, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves a current standing referral to a Specialist. The treatment plan may limit the number of visits to the Specialist, limit the period of time that the visits are authorized, or require that the Specialist provide the primary care physician with regular reports on the health care provided to the Member.

B. Contractor shall have in place a procedure for a Member with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling to receive a referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist coordinate the Member's health care. The referral shall be made if the primary care physician, in consultation with the Specialist or specialty care center and Contractor's Medical Director or the Medical Director's designee, determines that this specialized medical care is medically necessary for the Member. If a treatment plan is deemed necessary in the course of the care and is approved by Contractor, in consultation with the primary care physician, Specialist or specialty care center, and Member, a referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if Contractor approves the appropriate referral to a Specialist or specialty care center.

C. Determinations for standing referrals shall be made within three (3) business days from the date the request is made by the Member or the Member's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four (4) business days of the date the proposed treatment plan, if any, is submitted to Contractor's Medical Director or the Medical Director's designee.

D. Standing referrals do not require Contractor to refer to a Specialist who, or to a specialty care center that, is not employed by or under contract with Contractor to provide health care services to Members, unless there is no Specialist within the Provider Network that is appropriate to provide treatment to Members, as determined by a primary care physician in consultation with Contractor's Medical Director as documented in the treatment plan.

7. Emergency Care

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

A. Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216. Contractor shall coordinate access to emergency care services in accordance with the Contractor's DHCS-approved emergency department protocol (see Exhibit A, Attachment 7, Provider Relations).

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

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

8. Nurse Midwife and Nurse Practitioner Services

Contractor shall meet Federal requirements for access to Certified Nurse Midwife (CNM) services as defined in Title 22 CCR Section 51345 and Certified Nurse Practitioner (CNP) services as defined in Title 22 CCR Section 51345.1. Contractor shall inform Members that they have a right to obtain out-of-Network CNM services.

9. Access to Services with Special Arrangements

A. Family Planning

Members have the right to access family planning services through any family planning Provider without prior authorization. Contractor shall provide family planning services in a manner that protects and enables Member freedom to choose the method of family planning to be used consistent with 42 CFR 441.20. Contractor shall inform its Members in writing of their right to access any qualified family planning Provider without Prior Authorization in its Member Services Guide per Exhibit A, Attachment 13, Member Services.

1) Informed Consent

Contractor shall ensure that informed consent is obtained from Medi-Cal enrollees for all contraceptive methods, including sterilization, consistent with requirements of Title 22 CCR Sections 51305.1 and 51305.3.

2) Out-Of-Network Family Planning Services

Members of childbearing age may access the following services from out-of-Network family planning Providers to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods.

b) Limited history and physical examination.

c) Laboratory tests if medically indicated as part of decision-making process for choice of contraceptive methods. Contractor shall not be required to reimburse Out-of-Network Providers for pap smears, if Contractor has provided pap smears to meet the U.S. Preventive Services Task Force guidelines.

d) Diagnosis and treatment of a sexually transmitted disease episode, as defined by DHCS for each sexually transmitted disease, if medically indicated.

e) Screening, testing, and counseling of at risk individuals for HIV and referral for treatment.

f) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider.

g) Provision of contraceptive pills, devices, and supplies.

h) Tubal ligation.

i) Vasectomies.

j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without prior authorization to all Members both within and outside its Provider Network. Members may access out-of-Network STD services through local health department (LHD) clinics, family planning clinics, or through other community STD service Providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community Providers other than LHD and family planning Providers, out-of-Network services are limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care.

C. HIV Testing and Counseling

Members may access confidential HIV counseling and testing services through Contractor's Provider Network and through the out-of-Network local health department and family planning Providers.

D. Minor Consent Services

Contractor shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the Provider Network and Members shall be informed of the availability of these services. Minors do not need parental consent to access these services. Minor Consent Services are services related to:

1) Sexual assault, including rape.

2) Drug or alcohol abuse for children 12 years of age or older.

3) Pregnancy.

4) Family planning.

5) Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

6) Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

E. Immunizations

Members may access LHD clinics for immunizations. Contractor shall, upon request, provide updated information on the status of Members' immunizations to the LHD clinic. The LHD clinic shall provide immunization records when immunization services are billed to the Contractor.

F. American Indian Health Services Programs

Contractor shall ensure Members have access to American Indian Health Services Programs pursuant to, and in compliance with all requirements of 42 USC Section 1396o(a), and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009. American Indian Health Service Programs, whether a Network Provider or Out-of-Network Provider, can provide referrals directly to Network Providers without first requesting a referral from a Network Primary Care Provider. Contractor shall ensure timely access to American Indian Health Service Programs by including

American Indian Health Service Programs within Contractor's Network for American Indian Members, as well as permitting access to out-of-network American Indian Health Service Programs, in accordance with 42 CFR 438.14(b).

10. Changes in Availability or Location of Covered Services

Contractor shall provide notification to DHCS 60 calendar days prior to making any substantial change in the availability or location of services to be provided under this Contract. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

11. Access for Disabled Members

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

12. Civil Rights Act of 1964

Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 USC Section 2000d, 45 C.F.R. Part 80) that prohibits recipients of Federal financial assistance from discriminating against persons based on race, color, religion, or national origin. Contractor shall ensure equal access to health care services for limited English proficient Medi-Cal Members or Potential Enrollees through provision of high quality interpreter and linguistic services.

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update their cultural and linguistic services consistent with the group needs assessment (GNA) requirements stipulated below.

A. Written Description

Contractor shall implement and maintain a written description of its Cultural and Linguistic Services Program, which shall include at minimum the following:

1) An organizational commitment to deliver culturally and linguistically appropriate health care services.

2) Goals and objectives.

3) A timetable for implementation and accomplishment of the goals and objectives.

4) An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the Community Advisory Committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described.

5) Standards and Performance requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees

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

C. Group Needs Assessment (GNA)

Contractor shall conduct a GNA, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the GNA.

1) Contractor shall conduct an initial GNA within 12 months from the commencement of operations within a Service Area and at least every five (5) years from the commencement of operations thereafter. For Contracts existing at the time this provision becomes effective, the next GNA will be required at a time within the five (5) year period from the effective date of this provision, to be determined by DHCS.

2) Contractor shall submit a GNA Summary Report to the DHCS within six (6) months of the completion of each GNA. The summary report must include:

a) The objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references contained in the GNA.

b) The findings and conclusions must include the following information for Medi-Cal plan Members: 1) demographic profile; 2) related health risks, problems and conditions; 3) related knowledge, attitudes and practices including cultural beliefs and practices; 4) perceived health education needs including learning needs, preferred methods of learning and literacy level; and 5) culturally competent community resources.

3) Contractor shall annually update the GNA summary report, including a current update on the information required in item 2) b) above. Contractor shall maintain, and have available for DHCS review, the GNA summary report updates.

4) Contractor shall demonstrate that GNA and summary report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.

D. The results of the GNA shall be considered in the development of any Marketing or promotional materials prepared by Contractor.

E. Cultural Competency Training

Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers, and Subcontractors at key points of contact. The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider is trying to do to treat the patient; and, language and literacy needs.

F. Program Implementation and Evaluation

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

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

14. Linguistic Services

A. Contractor shall comply with Title 22 CCR Section 53853(c) and (d), and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Enrollees receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this provision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

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

1) Oral Interpreters, signers, or bilingual Providers and Provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal Members and Potential Enrollees and not limited to those that speak the threshold or concentration standards languages.

2) Fully translated Member information, including but not limited to the Member Services Guide, welcome packets, marketing information, and form letters including NOA letters and Grievance and Appeal acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within Contractor's Service Area, and by ~~the~~ Contractor in its GNA.

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

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

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

1) A population group of mandatory Eligible Beneficiaries residing in Contractor's Service Area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the Eligible Beneficiaries population, whichever is lower.

2) A population group of mandatory Eligible Beneficiaries residing in Contractor's Service Area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.

D. Key points of contact include:

1) Medical care settings: telephone, advice and urgent care transactions, and outpatient encounters with health care Providers including pharmacists.

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

15. Community Advisory Committee

Contractor shall form a Community Advisory Committee (CAC) pursuant to Title 22 CCR Section 53876 (c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net Providers. Contractor shall ensure that the CAC is included and involved in policy decisions related to Quality Improvement, educational, operational and cultural competency issues affecting groups who speak a primary language other than English.

16. Out-of-Network Providers

A. If Contractor's Network is unable to provide necessary services covered under the Contract to a particular Member, Contractor must adequately and timely cover these services out-of-Network for the Member, for as long as the entity is unable to provide them. Out-of-Network Providers must coordinate with the entity with respect to payment. Contractor must ensure that cost to the Member is not greater than it would be if the services were furnished within the Network.

B. Contractor shall provide for the completion of covered services by a terminated or Out-of-Network Provider at the request of a Member in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96.

C. For newly enrolled SPD beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an Out-of-Network Provider with whom they have an ongoing relationship if there are no quality of care issues with the Provider and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by the Contractor identifying a link between a newly enrolled

SPD beneficiary and an Out-of-Network Provider using FFS utilization data provided by DHCS.

D. In determining access to Out-of-Network Providers for mental health or substance use disorder benefits, Contractor must use processes, strategies, evidentiary standards, or other factors that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors for services identified within this Provision, in accordance with 42 CFR 438.910(d)(3).

Exhibit A, Attachment 10
SCOPE OF SERVICES

1. Covered Services

A. Contractor shall provide or arrange for all Medically Necessary Covered Services for Members. Covered Services are those services set forth in Title 22 CCR Chapter 3, Article 4, beginning with Section 51301, Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, and provided in accordance 42 CFR 438.210(a) and 42 CFR 440.230, unless otherwise specifically excluded under the terms of this Contract. Contractor shall ensure that the Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to beneficiaries under FFS. Contractor has the primary responsibility to provide all Medically Necessary Covered Services, including services which exceed the services provided by Local Education Agencies (LEA), Regional Centers, or local governmental health programs.

B. Contractor shall ensure that services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the Covered Services are furnished, and may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a service on the basis of criteria such as Medical Necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and the services supporting Members with ongoing or chronic conditions, or who require MLTSS, are provided in a manner that reflects the Member's ongoing needs.

C. Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare and Institutions Code Section 14133.23, effective January 1, 2006, drug benefits for Full Benefit Dual Eligible Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq) are not a Covered Service under this Contract. Consequently, effective January 1, 2006, the capitation rates shall not include reimbursement for such drug benefits and existing capitation rates shall be adjusted accordingly, even if the adjustment results in a change of less than one percent of cost to Contractor. Additionally, Contractor shall comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, 42 USC Section 1395(x) et seq.

D. In addition to services covered under the California Medicaid State Plan, Contractor shall cover any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits and ensure that Members are given access to all mental health and substance use disorder benefits in accordance with 42 CFR 438.900 et seq. The types, amount, duration, and scope of these services must be

consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or substance use disorder services in any classification of benefits as described in 42 CFR 439.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or substance use disorder benefits.

2) Contractor shall provide referrals for all non-covered mental health and substance use disorder services.

2. Medically Necessary Services

For purposes of this Contract, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).

When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).

3. Initial Health Assessment (IHA)

An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.

A. Contractor shall cover and ensure the provision of an IHA (complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to each new Member within timelines stipulated in Provision 5 and Provision 6 below.

B. Contractor shall ensure that the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS-approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect

the findings or risk factors discovered during the IHA and IHEBA.

C. Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.

D. Contractor shall make reasonable attempts to contact a Member and schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement.

4. Health Risk Stratification and Assessment for SPD Beneficiaries

Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and APL 17-013.

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including services listed under 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v), unless otherwise excluded under this Contract.

Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

A. Provision of IHAs for Members under Age 21

1) For Members under the age of 18 months, Contractor shall ensure the provision of an IHA within 120 calendar days following the date of enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) for ages two and younger whichever is less.

2) For Members 18 months of age and older upon enrollment, Contractor is responsible to ensure an IHA is performed within 120 calendar days of enrollment.

3) Contractor shall ensure that performance of the California Child Health and Disability Prevention (CHDP) program's age appropriate assessment due for each child at the time of enrollment is accomplished at the IHA. The initial assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for age, and an age appropriate IHEBA. See PL 13-001 for specific IHEBA requirements.

B. Children's Preventive Services

1) Contractor shall provide preventive health visits for all Members under 21 years of age at times specified by the most recent AAP periodicity schedule (Bright Futures guidelines) and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. This schedule requires more frequent visits than does the periodicity schedule of the CHDP program. Contractor shall provide, as part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age-specific IHEBA as necessary.

2) Where the AAP periodicity exam schedule is more frequent than the CHDP periodicity examination schedule, Contractor shall ensure that the AAP scheduled assessment includes all assessment components required by the CHDP for the lower age nearest to the current age of the child.

3) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral from the local CHDP program, an appointment shall be made for the Member to be examined within two weeks of the request.

4) At each non-emergency primary care encounter with Members under the age of 21 years, the Member (if an emancipated minor) or the parent(s) or guardian of the Member shall be advised of the children's preventive services due and available from Contractor, if the Member has not received children's preventive services in accordance with CHDP preventive standards for children of the Members' age. Documentation shall be entered in the Member's Medical Record which shall indicate the receipt of children's preventive services in accordance with the CHDP standards or proof of voluntary refusal of these services in the form of a signed statement by the Member (if an emancipated minor) or the parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

5) The Confidential Screening/Billing Report form, PM 160-PHP, or

any other system or format implemented by DHCS, shall be used to report all children's preventive services Encounters, in addition to the Encounter Data submittal required in Exhibit A, Attachment 3, Management Information System Capability, Provision 2. Encounter Data Submittal. Contractor shall submit completed forms to DHCS and to the local children's preventive services program within the timeframe specified by DHCS.

C. Immunizations

Contractor shall ensure that all children receive necessary immunizations at the time of any health care visit. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement.

If immunizations cannot be given at the time of the visit, the Member must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made.

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

Upon Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within ~~thirty (30)~~ calendar days of the vaccine's approval date. Contractor shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with any Medi-Cal FFS guidelines issued prior to final ACIP recommendations.

Contractor shall provide information to all Network Providers regarding the VFC Program.

D. Blood Lead Screens

Contractor shall cover and ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000. Contractor shall document and appropriately follow up on blood lead screening test results.

Contractor shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide test. If the blood lead screen test is refused by the Member, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the blood lead screen test shall be considered evidence in meeting this requirement.

E. Screening for Chlamydia

Contractor shall screen all females less than 21 years of age, who have been determined to be sexually active, for chlamydia. Follow up of positive results must be documented in the medical record.

Contractor shall make reasonable attempts to contact the appropriately identified Members and provide screening for chlamydia. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and screen for chlamydia shall be considered evidence in meeting this requirement.

If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT services, unless otherwise excluded in this Contract. Covered Services include all Medically Necessary services, as defined in 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v). Covered Services shall include case management as well as Targeted Case Management services as defined in Attachment 11, Provision 3 of this Contract.

Contractor is required to provide appointment scheduling assistance and

necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary Covered Services that Contractor is responsible for providing pursuant to this Contract.

Contractor shall also ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 9, regarding CCS, or mental health services pursuant to Provision 8 below, regarding Mental Health Services. Contractor shall determine the Medical Necessity of EPSDT services using the criteria established in 42 USC Section 1396d(r), and Welfare and Institutions Code, Section 14132(v).

G. Behavioral Health Treatment (BHT) Services

For Members under 21 years of age diagnosed with Autism Spectrum Disorder (ASD), or for Members under 3 years of age with a rule out or provisional diagnosis, Contractor shall cover Medically Necessary BHT services as defined in the federally approved State Plan, and in accordance with Health and Safety Code sections 1374.72 and 1374.73, 28 California Code of Regulations 1300.74.72, APL 15-019, and APL 15-025 to the extent that they are consistent with the State Plan. APLs superseding APL 15-019 and APL 15-025 that clarify the delivery of BHT services shall be incorporated herein by this reference and become part of this Contract as of their effective date.

1) Contractor shall provide Medically Necessary BHT services as stated in the Member's treatment plan and/or continuation of BHT services under continuity of care with the Member's BHT Provider.

2) For Members 3 years or older, Contractor shall require a Comprehensive Diagnostic Evaluation before Members receive BHT services.

3) BHT services must be based upon a treatment plan that is reviewed no less than every six (6) months by a qualified autism service Provider as defined by Health and Safety Code Section 1374.73(c)(3) and by the federally approved State Plan.

4) Contractor shall provide continuity of care for Members diagnosed with ASD as stated below and in accordance with this Section G.

    a) For Members who had received BHT through a regional

center prior to September 15, 2014, Contractor shall not provide BHT services until such time as the Member may be safely transitioned into Contractor's Provider Network in accordance with the BHT services transition plan approved by DHCS and the Department of Developmental Services (DDS). If a Member, or a Member's parent or legal guardian, chooses to access BHT services from Contractor's Network Provider prior to the transition of regional center clients to the Contractor for BHT services, Contractor shall provide Medically Necessary BHT services from Contractor's Network Provider.

b) If Members received BHT services outside of Contractor's Network prior to September 15, 2014, and the Member or the Member's parent or legal guardian request continued access to their existing BHT Provider, Contractor shall ensure continuity of care in accordance with APL 15-019 and APL 15-025.Contractor must offer continuity of care with an out-of-Network BHT Provider if all of the following conditions are met:

i. The Member has an existing relationship with a qualified autism service Provider. An existing relationship means the Member has seen an out-of-Network BHT Provider at least one time during the six (6) months prior to Contractor assuming responsibility of BHT services from the regional center or the date of the Member's initial enrollment with Contractor if enrollment occurred on or after September 15, 2014;

ii. The Provider can agree to Contractor's rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;

iii. The Provider does not have any documented quality of care issues that would cause exclusion from Contractor's Network;

iv. The Provider is a qualified Provider under Health & Safety Code Section 1374.73 and the approved State Plan; and

v. The Provider supplies Contractor with all relevant treatment information, for purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

c) Contractor shall continue to authorize Medically Necessary BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period.

d) Contractor's Network Provider may update the BHT treatment plan upon completion of the assessment and discontinue BHT services if the evaluation determines that the authorization of BHT services is not Medically Necessary.

5) Contractor shall provide all necessary Member treatment information to the Member's regional center to enable care coordination, as permitted by federal and State law, APL 15-022, and this Contract.

6) Contractor shall enter into a Memorandum of Understanding (MOU) with each local regional center in accordance with Exhibit A, Attachment 12, Provision 2 of this Contract, to facilitate the coordination of services for Members with developmental disabilities, including ASD, as permitted by federal and State law, and specified by DHCS in APL 15-022. If Contractor is unable to enter into an MOU, Contractor shall inform DHCS why agreement with the regional center was not reached and demonstrate that a good faith effort was made by Contractor to enter into an MOU with the regional center.

6. Services for Adults

A. IHAs for Adults (Age 21 and older)

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

2) Contractor shall ensure that the performance of the initial complete history and physical exam for adults includes, but is not limited to:

a) blood pressure,
b) height and weight,
c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,
d) clinical breast examination for women over 40,
e) mammogram for women age 50 and over,
f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,
g) Chlamydia screen for all sexually active females aged 21

and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,

h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,

i) IHEBA.

B. Adult Preventive Services

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

1) Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. All preventive services identified as USPSTF “A” and “B” recommendations must be provided. For tobacco use prevention and cessation services, Contractor may use either the USPSTF recommendations or the latest edition of the US Public Health Service “Treating Tobacco Use and Dependence: A Clinical Practice Guideline.” As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by the USPSTF Guide to Clinical Preventive Services.

2) Contractor shall cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA or during visits for routine, urgent, or emergent health care situations. Contractor shall ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

C. Immunizations

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

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

Contractor shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered evidence in meeting this requirement.

7. Pregnant Women

A. Prenatal Care

Contractor shall cover and ensure the provision of all Medically Necessary services for pregnant women. Contractor shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized to provide, at a minimum, quality perinatal services.

B. Risk Assessment

Contractor shall implement a comprehensive risk assessment tool for all pregnant female Members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.

C. Referral to Specialists

Contractor shall ensure that pregnant women at high risk of a poor pregnancy outcome are referred to appropriate Specialists including perinatologists and have access to genetic screening with appropriate referrals. Contractor shall also ensure that appropriate hospitals are available within the Provider Network to provide necessary high-risk pregnancy services.

Exhibit A, Attachment 10
SCOPE OF SERVICES

8. Services for All Members

A. Health Education

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

2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator.

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

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

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

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

a) Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.

b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.

c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.

7) Contractor shall ensure that Members receive point of service education as part of preventive and primary health care visits.

Contractor shall provide education, training, and program resources to assist contracting medical Providers in the delivery of health education services for Members.

8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of Providers that are contracted to deliver health education services to ensure effectiveness.

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

10) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA; and that all existing Members complete the IHEBA at their next non-acute care visit. Contractor shall ensure: 1) that Primary Care Providers use the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the IHEBA; and 2) that the IHEBA tool is: a) administered and reviewed by the Primary Care Provider during an office visit, b) reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit, and c) re-administered by the Primary Care Provider at the appropriate age-intervals.

11) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 11.

B. The Health Information Form (HIF)/Member Evaluation Tool (MET)

Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR 438.208(b), Contractor shall, at a minimum, comply with the following:

1) Mail a DHCS-approved HIF/MET to all new Members as a part of Contractor's welcome packet and include a postage paid envelope for response.

2) Within 90 days of each new Member's effective date of enrollment:

   a) Make at least two (2) telephone call attempts to remind new Members to return the HIF/MET and/or collect the HIF/MET information from new Members. This outreach can be done

through head of household for Members under the care of parents, custodial parents, legal guardians, or other authorized representatives in accordance with applicable privacy laws.

b) Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and Coordination of Care.

3) Upon a Member's disenrollment, Contractor shall make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.

C. Hospice Care

1) Contractor shall cover and ensure the provision of hospice care services as defined in Sections 1905(o)(1) of the Social Security Act. Contractor shall ensure that Members and their families are fully informed of the availability of hospice care as a covered service and the methods by which they may elect to receive these services. Services shall be limited to individuals who have been certified as terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course, and who directly or through their representative voluntarily elect to receive such benefits in lieu of other care as specified. However, for a member under age 21, a voluntary election of hospice care shall not constitute a waiver of any rights of that member to be provided with, or to have payment made for covered services that are related to the treatment of that member's condition for which a diagnosis of terminal illness has been made.

For individuals who have elected hospice care, Contractor shall arrange for continuity of medical care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor shall cover the cost of all hospice care provided. Contractor is also responsible for all medical care not related to the terminal condition.

2) Admission to a nursing facility of a Member who has elected covered hospice services, as described in Title 22 CCR Section 51349, does not affect the Member's eligibility for enrollment under this Contract. Hospice services are Covered Services under this Contract and are not Long-Term Care (LTC) services regardless of

the Member's expected or actual length of stay in a nursing facility.

D. Vision Care - Lenses

Contractor shall cover and ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor shall arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories. Contractor shall cover the cost of the eye examination and dispensing of the lenses for Members. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA.

E. Mental Health and Substance Use Disorder Services

1) Contractor shall cover Outpatient Mental Health Services that are within the scope of practice of Primary Care Providers and mental health care Providers, in accordance with the Outpatient Mental Health Services requirements as defined in Exhibit E, Attachment 1, Definitions. Contractor's policies and procedures shall define and describe what services are to be provided by Primary Care Providers.

In addition, Contractor shall cover and ensure the provision of psychotherapeutic drugs prescribed by its Primary Care Providers or other mental health care professionals, except those specifically excluded in this Contract as stipulated below.

2) Contractor shall cover and pay for all Medically Necessary Covered Services for the Member, including the following services:

a) Emergency room professional services as described in Title 22 CCR Section 53855, except services provided by psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, or other specialty mental health Providers.

b) Facility charges for emergency room visits which do not result in a psychiatric admission.

c) All laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition.

d) Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services, including emergency mental health services, as described in Title 22

CCR Section 51323.

e) All NEMT services, as provided for in Title 22 CCR Section 51323, required by Members to access Medi-Cal covered mental health and substance use disorder services. These services include outpatient opioid detoxification, tobacco cessation, and Alcohol Misuse Screening and Counseling (AMSC) services, and are subject to a written prescription by Contractor's mental health or substance use disorder Provider within Contractor's mental health and substance use disorder Provider Network.

f) Medically Necessary Covered Services after Contractor has been notified by a Specialty Mental Health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by Title 9 CCR Section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

   i The initial health history and physical examination required upon admission and any consultations related to Medically Necessary Covered Services.

   ii. Notwithstanding this requirement, Contractor shall not be responsible for room and board charges for psychiatric inpatient hospital stays by Members.

   iii. When IMD services are provided to Members age 21 and under or age 65 and over, Contractor shall cover Skilled Nursing Facility (SNF) room and board. Contractor shall not cover other inpatient psychiatric facility/IMD room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/IMD per diem rate.

g) All Medically Necessary Medi-Cal covered psychotherapeutic drugs for Members not otherwise excluded under this Contract.

   i. This includes reimbursement for covered psychotherapeutic drugs prescribed by out-of-~~plan~~ Network psychiatrists for Members.

   ii. Contractor may require that covered prescriptions written by out-of-Network psychiatrists be filled by pharmacies in Contractor's Provider Network.

iii. Reimbursement to pharmacies for those psychotherapeutic drugs listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

h) Paragraphs c), e), and f) above shall not be construed to preclude Contractor from: (1) requiring that Covered Services be provided through Contractor's Provider Network, to the extent possible, or (2) applying utilization review controls for these services, including prior authorization, consistent with Contractor's obligation to provide Covered Services under this Contract.

3) Contractor shall develop and implement a written internal policy and procedure to ensure that Members who need Specialty Mental Health Services (services outside the scope of practice of Primary Care Providers) are referred to and are provided mental health services by an appropriate Medi-Cal FFS mental health Provider or to the county mental health plan for Specialty Mental Health Services in accordance with Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 6. Specialty Mental Health.

4) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service Provider(s). Contractor shall enter into a Memorandum of Understanding with the county mental health plan in accordance with Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination.

F. Tuberculosis (TB)

1) TB screening, diagnosis, treatment and follow-up are covered under this Contract. Contractor shall provide TB care and treatment in compliance with the guidelines recommended by

American Thoracic Society and the Centers for Disease Control and Prevention.

2) Contractor shall coordinate with Local Health Departments in the provision of direct observed therapy as required in Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB) and Attachment 12, Local Health Department Coordination.

G. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and Prescription Drugs in accordance with all federal and State laws and regulations including, but not limited to Title 22 CCR Sections 53214 and 53854, Title 16, Sections 1707.1, 1707.2, and 1707.3, 42 CFR 438.3(s), and Sections 1927(d)(5) and 1927(k)(2) of the Social Security Act. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and Contractor's provider manual.

2) At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours.

Contractor's drug utilization review (DUR) systems should be comparable to such programs administered by the State, and are subject to requirements outlined in 42 CFR 438.3(s), Section 1927(g) of the Social Security Act, and 42 CFR 456, subpart K.

3) Contractor shall ensure access to at least a 72-hour supply of a covered outpatient drug in an emergency situation. Contractor shall meet this requirement by doing all of the following:

a) Having written policies and procedures, including, if applicable, written policies and procedures of Contractor's Network hospitals' policies and procedures related to emergency medication dispensing, which describe the method(s) that are used to ensure that the emergency medication dispensing requirements are met, including, if applicable, specific language in Network hospital subcontracts. Written policies and procedures must describe how Contractor and/or Contractor's Network hospitals will monitor compliance with the requirements. Compliance monitoring does not require verification of

receipt of medications for each and every ER visit made by Members to an emergency room which does not result in hospitalization.

b) Providing the Member, in all cases, access to at least a 72-hour supply of Medically Necessary drugs. This requirement can be met by providing a 72-hour supply of the drug to the Member, or provision of an initial dose of medication and a prescription for additional medication, which together cover the Member for the 72-hour period. Contractor's policies and procedures can describe other methods for ensuring compliance with the 72-hour requirement.

c) Having a mechanism in place for informing Members of this requirement and of their right to submit a Grievance if they do not receive Medically Necessary medications in emergency situations.

d) Having a procedure for investigating and resolving Grievances related to the failure of Contractor to provide Medically Necessary medications in emergency situations.

e) Having policies and procedures and Grievance and Appeal logs available for inspection during any State audit or monitoring visit, upon request.

4) Continuity of Care

Contractor must maintain policies and procedures outlining continuity of care in compliance with the provisions of Welfare and Institutions Code 14185(b), and Health and Safety Code 1367.22. All newly enrolled Members shall be maintained on their current drug therapy, including non-formulary drugs without Prior Authorization until the Member is evaluated or re-evaluated by a Network Provider.

5) Formulary Requirements

Contractor shall post current formulary drug lists on Contractor’s website in a machine readable file and format, and make a printed version available to Members upon request pursuant to 42 CFR 438.10(i). Contractor’s drug formulary must meet the following requirements:

a) Contractor shall submit to DHCS a complete formulary for

review and approval, prior to use. Contractor shall also submit an annual formulary to DHCS for review and approval. Contractor may use the formulary as published until DHCS notifies ~~the~~ Contractor of approval or of required changes. In addition to the annual formulary submission, Contractor shall submit any changes to its formulary to DHCS as File and Use. DHCS may request an updated or current formulary at any time.

b) Contractor's formulary shall be comparable to the Medi-Cal FFS contract drugs list (CDL), except for drugs carved out through specific contract agreements. Comparable means that:

i. Every therapeutic category or class listed on the Medi-Cal FFS CDL shall be represented by at least one (1) drug on Contractor's formulary within six (6) months of its inclusion. Therapeutic category or class is defined by the American Hospital Formulary Service pharmacologic therapeutic classification system to include all tiers of United States Pharmacopeia.

ii. If Contractor places Prior Authorization requirements on all drugs within the same therapeutic category, and one (1) such drug is available on the Medi-Cal FFS CDL without treatment authorization request requirements, Contractor shall submit the following for all drugs of that same mechanism of action:

a. Clinical rationale for such an action.

b. Criteria used to decide on the Prior Authorization request and/or how the approval criteria for the formulary option(s) differs from the non-formulary options.

iii. A drug not listed on the formulary must be available by Prior Authorization if deemed Medically Necessary.

iv. All drugs listed on the Medi-Cal FFS list need not be included in Contractor's formulary.

6) Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated no less than quarterly by Contractor's PTC. The PTC must include the following:

a) A majority of members who are practicing Physicians and/or practicing pharmacists;

b) Contractor's Pharmacist as a voting member;

c) At least one (1) practicing Physician and at least one (1) practicing pharmacist who are independent and free of conflict of interest from pharmaceutical manufacturers; and

d) At least one (1) practicing Physician and one (1) practicing pharmacist who are experts regarding care of elderly or disabled Members.

This review and update of Contractor's formulary must consider all drugs approved by the FDA and/or added to the Medi-Cal FFS CDL. Deletions to the formulary must be documented and justified.

7) Drug Utilization Review (DUR)

Contractor shall develop and implement effective DURs and treatment outcome processes as directed in APL 17-008 to assure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DURs must meet or exceed the requirements described in Section 1927(g) of the Social Security Act and 42 CFR 456, Subpart K.

b) Contractor shall annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

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

8) Reimbursement to pharmacies for those drugs for the treatment of HIV/AIDS listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, shall be reimbursed through the Medi-Cal FFS program, whether these drugs are provided by a pharmacy contracting with Contractor or by an out-of-Network pharmacy Provider. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program.

9) Contractor shall not impose QTL or NQTL more stringently on mental health and substance use disorder drugs as compared to

medical/surgical drugs prescriptions in accordance with 42 CFR 438.900 et. seq.

H. Transportation

Contractor shall cover transportation services as required in this Contract and directed in APL 17-010 to ensure Members have access to all Medically Necessary services.

1) Contractor shall cover Emergency Medical Transportation services necessary to provide access to all Medi-Cal Covered Services as described in Title 22 CCR Section 51323

2) Contractor shall cover NEMT services required by Members to access Medi-Cal services, as provided for in Title 22 CCR Section 51323, subject to Contractor's Physician Certification Statement form being completed by the Member's Provider. Contractor shall refer and coordinate NEMT for Medi-Cal services not covered in this Contract.

3) As provided for in W & I Code Section 14132(ad), Contractor shall authorize all NMT for Members to obtain Medically Necessary Covered Services in accordance with the requirements and guidelines set forth in APL 17-010. Nothing in this Provision should be construed to prohibit the Contractor from developing policies and procedures which may include Prior Authorization requirements for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through Medi-Cal FFS.

9. Investigational Services

Contractor shall provide investigational services as defined in Title 22 CCR Section 51056.1(b) when a service is determined to be investigational pursuant to Section 51056.1(c), and that all requirements in Section 51303(h) are clearly documented.

Exhibit A, Attachment 11
CASE MANAGEMENT AND COORDINATION OF CARE

1. Comprehensive Case Management Including Coordination of Care Services

Contractor shall ensure the provision of Comprehensive Medical Case Management to each Member.

Contractor shall maintain procedures for monitoring the coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside ~~the~~ Contractor's Provider Network. These services are provided through either Basic or Complex Case Management activities based on the medical needs of the Member.

A. Basic Case Management Services are provided by the Primary Care Provider, in collaboration with Contractor, and shall include:
   1) Initial Health Assessment (IHA);
   2) Individual Health Education Behavioral Assessment (IHEBA);
   3) Identification of appropriate Providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs;
   4) Direct communication between the Provider and Member/family;
   5) Member and family education, including healthy lifestyle changes when warranted; and
   6) Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

B. Complex Case Management Services are provided by Contractor, in collaboration with the Primary Care Provider, and shall include, at a minimum:
   1) Basic Case Management Services
   2) Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
   3) Intense coordination of resources to ensure member regains optimal health or improved functionality
   4) With Member and PCP input, development of care plans specific to individual needs, and updating of these plans at least annually

C. Contractor shall develop methods to identify Members who may benefit from complex case management services, using utilization data, the HIF/MET, clinical data, and any other available data, as well as self and physician referrals. Complex case management services for SPD beneficiaries must include the concepts of Person-Centered Planning.

D. Person-Centered Planning for SPD Beneficiaries
   1) Upon the enrollment of a SPD beneficiary, Contractor shall provide, or ensure the provision of, Person-Centered Planning and treatment approaches that are collaborative and responsive to the SPD beneficiary’s continuing health care needs.
   2) Person-Centered Planning shall include identifying each SPD

beneficiary's preferences and choices regarding treatments and services, and abilities.

3) Contractor shall allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.
4) Contractor shall ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.

2. Discharge Planning and Care Coordination

Contractor shall ensure the provision of discharge planning when a SPD beneficiary is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that necessary care, services, and supports are in place in the community for the SPD beneficiary once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the patient and/or caregiver. Minimum criteria for a discharge planning checklist must include:

A. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

B. Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD beneficiary or a representative of the SPD beneficiary as applicable, physical and mental function, financial resources, and social supports.

C. Services needed after discharge, type of placement preferred by the SPD beneficiary/representative of the SPD beneficiary and hospital/institution, type of placement agreed to by the SPD beneficiary/representative of the SPD beneficiary, specific agency/home recommended by the hospital, specific agency/home agreed to by the SPD beneficiary/representative of the SPD beneficiary, and pre-discharge counseling recommended.

D. Summary of the nature and outcome SPD beneficiary/representative of the SPD beneficiary involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

3. Targeted Case Management Services

Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.

If a Member is receiving TCM services as specified in Title 22 CCR Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM Provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM Provider that are Covered Services under the Contract.

If Members under age 21 are not accepted for TCM services, Contractor shall ensure the Members' access to services are comparable to EPSDT TCM services per Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age.

4. Disease Management Program

Contractor is responsible for initiating and maintaining a disease management program. Contractor shall determine the program's targeted disease conditions and implement a system to identify and encourage Members to participate.

5. Out-of-Network Case Management and Coordination of Care

Contractor shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services presented in Provisions 6 through 18 below.

6. Specialty Mental Health

A. Specialty Mental Health Services

1) All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.

2) Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:

a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the county mental health plan, as defined in PL 00-001 Revised and APL 13-021, the Member shall be referred to the county mental health plan in accordance with the Memorandum of Understanding (MOU) between Contractor and the county mental health plan and APL 13-018.

b) For those Members whose mental health diagnosis is not covered by the county mental health plan because the adult Member's level of impairment is mild to moderate, or the recommended treatment for adult and child Members do not

meet the criteria for Specialty Mental Health Services, the Member shall be referred to an appropriate Medi-Cal mental health Provider within Contractor's Provider Network. Contractor shall consult with the county mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services.

3) Disputes between Contractor and the county mental health plan regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. If Contractor and the county mental health plan cannot agree, disputes shall be resolved pursuant to Title 9, CCR, Section 1850.505. Any decision rendered by DHCS regarding a dispute between Contractor and the county mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.

B. County Mental Health Plan Coordination

Contractor shall execute a Memorandum of Understanding (MOU) with the county mental health plan as stipulated in Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination for the coordination of Specialty Mental Health Services to Members.

7. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program.

Contractor shall identify individuals requiring alcohol and or substance use disorder treatment services and arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification Providers available through the Medi-Cal FFS program, for appropriate services. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within the Contractor's Service Area, the Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care

and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between the Primary Care Providers and the treatment programs.

Contractor shall execute a MOU with the county department for alcohol and substance use disorder treatment services.

8. Services for Children with Special Health Care Needs

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

Contractor shall implement and maintain a program for CSHCN which includes, but is not limited to, the following:

A. Standardized procedures for the identification of CSHCN, at enrollment and on a periodic basis thereafter;

B. Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, and specialized equipment and supplies; these may include assignment to a Specialist as PCP, standing referrals, or other methods as defined by Contractor;

C. Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all Medically Necessary follow-up services are documented in the medical record, including needed referrals;

D. A program for case management or care coordination for CSHCN, including coordination with other agencies which provide services for children with special health care needs (e.g. mental health, substance use disorder, Regional Center, CCS, local education agency, child welfare agency); and

E. Methods for monitoring and improving the quality and appropriateness of care for children with special health care needs.

9. California Children’s Services (CCS)

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

A. Contractor shall develop and implement written policies and procedures

for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which:

1) Ensure that Contractor's Providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;

2) Assure that contracting Providers understand that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network; and only from the date of referral;

3) Enable initial referrals of Member's with CCS-eligible conditions to be made to the local CCS program by telephone, same-day mail or fax, if available. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program.

4) Ensure that Contractor continues to provide all Medically Necessary Covered Services to the Member until CCS eligibility is confirmed.

5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by CCS and shall ensure the coordination of services and joint case management between its Primary Care Providers, the CCS specialty Providers, and the local CCS program.

6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for obtaining the service, if it is Medically Necessary, and paying for the service if it has been provided.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members.

C. The CCS program authorizes Medi-Cal payments to Contractor Network physicians who currently are members of the CCS panel and to other Providers who provided CCS-covered services to the Member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling. Contractor shall inform Providers, except as noted above, that CCS reimburses only CCS paneled Providers. Contractor

shall submit information to the CCS program on all Providers who have provided services to a Member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Contractor Network physician, via telephone, fax, or mail. In an emergency admission, Contractor or Contractor Network physician shall be allowed until the next Working day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

10. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

B. Contractor shall maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist Members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution as required by W & I Code Section 14182(c)(10).

C. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers, such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services and Medically Necessary Outpatient Mental Health Services, which need to be provided to the Member.

D. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS Waiver program administered by the State Department of Developmental Services (DDS).

If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with developmental disabilities.

11. Early Intervention Services

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

12. Local Education Agency Services

LEA assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22 CCR Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020 are not covered under this Contract. However, ~~the~~ Contractor is responsible for providing a PCP and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's PCP cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

13. School Linked CHDP Services

A. Coordination of Care

Contractor shall maintain a "medical home" and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

B. Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Cooperative arrangements (e.g. Subcontracts) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.

2) Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.

3) Referral protocols/guidelines between the Contractor and the school sites, which merely screen, for the need of CHDP services, including strategies for the Contractor to follow-up and document if services are being provided to the Member within the required State and Federal time frames.

4) Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. Subcontracts

Contractor shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, Provision 13, regarding Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and Grievance and Appeal procedures.

14. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS)

Services provided under the HIV/AIDS Home and Community Based Services Waiver Program are not covered under this Contract. Contractor shall maintain procedures for identifying Members who may be eligible for the HIV/AIDS Home

and Community Based Services Waiver Program and shall facilitate referrals of these Members to the HIV/AIDS Home and Community Based Services Waiver Program.

Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care Health Plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space. Persons already enrolled in the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program may voluntarily enroll in a Medi-Cal managed care health plan.

15. Dental

Contractor shall cover and ensure that dental screenings/oral health assessments for all Members are included as a part of the IHA. For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract.

Contractor shall ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered Prescription Drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of dental procedures.

If the Contractor requires Prior Authorization for these services, Contractor shall develop and publish the procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. Contractor shall submit such procedures to DHCS for review and approval.

16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

A. DOT is offered by LHDs and is not covered under this Contract.

Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); Members whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). Contractor shall refer Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of Contractor's Providers, a Member with one or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

B. Contractor shall execute a MOU with the LHD as stipulated in Exhibit A, Attachment 12, Provision 2, for the provision of DOT.

17. Women, Infants, and Children (WIC) Supplemental Nutrition Program

A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services. As part of the referral process, Contractor shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. Contractor shall also document the laboratory values and the referral in the Member's medical record.

Contractor, as part of its IHA of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c).

B. Contractor shall execute a MOU with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program.

18. Excluded Services Requiring Member Disenrollment

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll and receive major organ transplants through the Medi-Cal FFS program until the date of disenrollment is effective.

A. Major Organ Transplants

Except for kidney transplants, major organ transplant procedures that are Medi-Cal FFS benefits are not covered under the Contract. When a Member is identified as a potential major organ transplant candidate, Contractor shall refer the Member to a Medi-Cal approved transplant center. If the transplant center physician considers the Member to be a suitable candidate, the Contractor shall submit a Prior authorization Request to either the San Francisco Medi-Cal Field Office (for adults) or the CCS Program (for children) for approval. Contractor shall initiate disenrollment of the Member when all of the following has occurred: referral of the Member to the organ transplant facility; the facility's evaluation has concurred that the Member is a candidate for major organ transplant and, the major organ transplant is authorized by either DHCS' Medi-Cal Field Office (for adults) or the CCS Program (for children).

B. Contractor shall continue to provide all Medically Necessary Covered Services until the Member has been disenrolled.

Upon the disenrollment effective date, Contractor shall ensure continuity of care by transferring all of the Member's medical documentation to the transplant physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the Member was approved as a major organ transplant candidate. The request for reimbursement for services in the month during which the transplant is approved are to be sent by the Provider directly to the Medi-Cal FFS fiscal intermediary. The Capitation Payment for the Member will be recovered from ~~the~~ Contractor by DHCS.

C. If the Member is evaluated and determined not to be a candidate for a major organ transplant or DHCS denies authorization for a transplant, the Member will not be disenrolled. Contractor shall cover the cost of the evaluation performed by the Medi-Cal approved transplant center.

19. Immunization Registry Reporting

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

accordance with all applicable State and Federal laws.

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

Erectile dysfunction drugs and other ED therapies are excluded from this Contract. These excluded drugs include all drugs used for the treatment of ED that are listed in the Medi-Cal Pharmacy Provider Manual in the Erectile Dysfunction Treatment Drug listings. The drugs listed in the Medi-Cal Pharmacy Provider Manual are not reimbursed by the Medi-Cal Fee-For-Service program.

Contractor shall assist Members requiring ED drugs or therapies in locating available treatment service sites and arranging for referral for appropriate services. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the ED drugs or ED therapies and coordinate services between the Primary Care Providers and the treatment programs.

21. Waiver Programs

DHCS administers a number of Medi-Cal Home and Community Based Services (HCBS) Waiver programs authorized under Section 1915(c) of the Social Security Act. Contractor shall have procedures in place to identify Members who may benefit from the HCBS Waiver programs, and refer Members to the agency administrating the waiver program. These waiver programs include, but are not limited to, the nursing facility/acute hospital waiver and all HCBS waivers. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive HCBS waiver services while remaining enrolled with Contractor. Contractor shall continue comprehensive case management and shall continue to cover all Medically Necessary Covered Services to the Member. If the Member does not meet the criteria for the HCBS Waiver Program, or if placement is not available, Contractor shall continue to case manage and provide all Medically Necessary covered Services to the Member.

Exhibit A, Attachment 12
LOCAL HEALTH DEPARTMENT COORDINATION

1. Subcontracts

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

A. Family Planning Services: as specified in Exhibit A, Attachment 8, Provision 9.

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

C. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, Provision 11.

D. Immunizations as specified in Exhibit A, Attachment 8, Provision 12.

To the extent that Contractor does not meet this requirement on or before four (4) months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Subcontracts or Memoranda of Understanding

If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute a Subcontract with the LHD or agency as stipulated in Provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies.

A. California Children Services (CCS)

B. Maternal and Child Health (MCH)

C. Child Health and Disability Prevention (CHDP) Program

D. Tuberculosis Direct Observed Therapy

E. Women, Infants, and Children (WIC) Supplemental Nutrition Program

F. Regional Centers for services for persons with developmental disabilities.

G. Local Governmental Agencies for Targeted Case Management services.

H. County department for alcohol and substance use disorder treatment services.

I. The county In-Home Support Services (IHSS) office and IHSS Public Authority.

3. County Mental Health Plan Coordination

A. Contractor shall negotiate in good faith and execute a MOU with the county mental health plan (MHP) in accordance with Welfare and Institutions Code Section 14715. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

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

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

3) Protocols for the delivery of mental health services within the Primary Care Provider’s scope of practice;

4) Protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records;

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

a) Pharmaceutical services and Prescription Drugs;

b) Laboratory, radiological and radioisotope services;

c) Emergency room facility charges and professional services;

d) Emergency Medical Transportation and NEMT;

e) Home health services;

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

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

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

4. Any MOU that Contractor enters into with the county IHSS office and IHSS Public Authority shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the MOU. DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval within five (5) working days of receipt.

1) These MOUs shall not become effective until written approval is provided by DHCS and the California Department of Social Services (CDSS) or by operation of law where DHCS has acknowledged receipt of the proposed MOU, and has neither approved nor rejected the proposed MOU within 60 calendar days of receipt.

2) Any new or updated MOU that makes a material change to the MOU must be re-submitted to DHCS. Previous MOU approval shall be valid only until such time as the new or amended MOU is approved by DHCS and CDSS.

5. MOU Monthly Reports

To the extent Contractor does not execute an MOU within four (4) months after the effective date of this Contract, Contractor shall submit documentation substantiating its good faith efforts to enter into an MOU. Until such time as an MOU is executed, Contractor shall submit monthly reports to DHCS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU has not been executed.

Exhibit A, Attachment 13
MEMBER SERVICES

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, and, upon request, Potential Enrollees.

1) Contractor's written policies regarding Member rights shall include the following:

a) To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.
b) To be provided with information about the organization and its services.
c) To be able to choose a Primary Care Provider within the Contractor's Network.
d) To participate in decision making regarding their own health care, including the right to refuse treatment.
e) To voice Grievances, either verbally or in writing, about the organization or the care received.
f) To receive oral interpretation services for their language.
g) To formulate advance directives.
h) To have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services and emergency services outside the Contractor's Network pursuant to the federal law.
i) To request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
j) To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
k) To change Medi-Cal Managed Care Health Plans upon request, if applicable.
l) To access Minor Consent Services.
m) To receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request and in accordance with W & I Code Section 14182 (b)(12).
n) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
o) To receive information on available treatment options and alternatives, presented in a manner appropriate to the

Member's condition and ability to understand.

p) To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

q) Freedom to exercise these rights without adversely affecting how they are treated by Contractor, Providers, or the State.

r) To file a request for an Appeal of an action within 60 days of the date on a NOA.

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

B. Members' Right to Confidentiality

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

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the Network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22 CCR Section 51009.

C. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.3(j).

2. Member Services Staff

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

B. Contractor shall ensure Member services staff are trained on all contractually required Member or Potential Enrollee service functions including, policies, procedures, and scope of benefits of this Contract.

C. Contractor shall ensure that Member Services staff provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with Grievance and Appeal resolution, access barriers, and disability issues and referral to appropriate clinical services staff.

D. Contractor shall ensure that Member Services staff will refer Potential Enrollees to the DHCS enrollment broker, Health Care Options (HCO) when Potential Enrollees make a request for enrollment with Contractor.

3. Call Center Reports

Contractor shall report quarterly, in a format to be approved by DHCS, the number of calls received by call type (questions, Grievance and Appeals, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and the Member services telephone calls abandonment rate.

4. Written Member Information

A. Contractor shall provide all new Medi-Cal Members, and Potential Enrollees upon request only, with Member information as specified in Title 22 CCR Section 53895 and as stated in this Provision. Compliance with items required by Section 53895(b) may be met through distribution of the Member Services Guide.

The Member Services Guide shall meet the requirements of an enrollee handbook in 42 CFR 438.10(g), and an Evidence of Coverage and Disclosure Form (EOC/DF) as stipulated by Title 28, CCR, Sections 1300.51(d), Exhibit T (EOC) or U (Combined EOC/DF) and Title 22 CCR Section 53881. In addition, the Member Services Guide shall meet the requirements contained in 42 CFR 438.10(d), and Health and Safety Code, Section 1363, as to print size, readability, and understandability of text.

B. Contractor shall provide the Member information no later than seven (7) calendar days after the effective date of the Member's enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit. To provide Member information in any format other than as printed materials, including but not limited to in electronic format or upon request, Contractor must submit their process to DHCS for review and approval before implementing.

C. Contractor shall ensure that all Member information is provided to Members at a sixth grade reading level or as determined appropriate

through Contractor's GNA and approved by DHCS. Member information shall ensure Members' understanding of Contractor's processes and the Member's ability to make informed health decisions.

D. Member information shall include the Member Services Guide, provider directory, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point, pursuant to 42 CFR 438.10.

1) Member information shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, Provision 13, Linguistic Services.

2) Member information shall be provided in alternative formats (including Braille, large-size print font no smaller than 18-point, or audio format) and through Auxiliary Aids at no cost, upon request, and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or LEP.

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

4) Member information shall include taglines and information on how to request Auxiliary Aids and services, including materials in alternative formats, in large print font no smaller than 18-point, and in all State threshold languages as required in this Provision. The taglines shall explain the availability of written Member information translated in that language or oral interpretation to understand the information provided, and the toll-free and TTY/TDD telephone number for Contractor's Member services.

E. Provider Directory

1) Contractor shall furnish its Medi-Cal provider directory to all Members and make available to DHCS for distribution as needed.

2) Contractor's provider directory shall be made available in both a paper and electronic form. Provider directory information shall be included with Contractor's written Member information for new Members, and thereafter available upon request. Electronic provider directories shall be posted on Contractor's web site in a machine readable file and format.

3) Contractor shall submit a complete provider directory to DHCS for review and approval prior to initial operations.

4) Contractor shall update its paper and electronic provider directories in accordance with 42 CFR 438.10(h)(3) and submit updated complete directories to DHCS as File and Use. DHCS may ask for changes at any time.

5) Contractor's provider directory is reviewed every six (6) months by DHCS. Findings shall be addressed immediately by Contractor.

6) Provider directories shall be compliant with 42 CFR 438.10(h) and Health and Safety Code 1367.27, and shall include the following information for PCPs, Specialists, hospitals, pharmacies, behavioral health Providers, MLTSS Providers as appropriate, and any other Providers contracted for Medi-Cal Covered Services:

   a) The Provider or site's name and any group affiliation, NPI number, address, telephone number, and, if applicable, web site URL for each service location, and Provider specialty as appropriate;

   b) For a medical group/foundation or IPAs, the medical group/foundation or IPA name, NPI number, address, telephone number, and, if applicable, web site URL shall appear for each Physician Provider;

   c) The hours and days when each service location is open;

   d) The services and benefits available, including accessibility symbols approved by DHCS and whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities;

   e) The Provider's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility, and if the Provider has completed cultural competence training;

   f) The telephone number to call after normal business hours; and

   g) Identification of Providers or sites that are not available to all or new Members.

Exhibit A, Attachment 13
MEMBER SERVICES

F. Contractor shall provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of, and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide prior to distribution to Members. Contractor shall submit a complete Member Services Guide to DHCS for review and approval prior to implementing. Contractor shall ensure that the Member Services Guide includes the following information:

1) The plan name, address, toll-free telephone number(s) for Member services and any other Contractor staff providing services directly to Members, and service area covered by the health plan.

2) A description of the full amount, duration, and scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by Contractor's personnel and at service sites, and an explanation of "carve out" services and any service limitations and exclusions from coverage or charges for services. Include information and identification of services to which the Contractor or Subcontractor has a moral objection to perform or support.

3) Procedures for accessing Covered Services, which explain that Covered Services shall be obtained through Contractor's Providers unless otherwise allowed under this Contract, and the process for Members selecting and changing their PCP. Include any applicable Subcontractor arrangements that may restrict access.

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

5) Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a Provider may request a change.

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

7) The appropriate use of health care services in a managed care system.

8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate Provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no

cost, to assist in receiving after hours services.

9) Definition of what constitutes an emergency medical condition, emergency health care and post-stabilization services, in accordance with 42 CFR 438.10(g)(2)(v), and that Prior Authorization is not required to receive emergency services. Include the use of 911 for obtaining emergency services.

10) The right to receive emergency health care in any hospital or other setting, including at least a 72-hour supply of Medically Necessary medication in an emergency situation. Also include procedures for obtaining emergency health care from specified Network Providers or from Out-of-Network Providers, including outside of Contractor's Service Area.

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

12) Procedures for obtaining any transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical transportation and NMT services and the conditions under which transportation is available.

13) The right, and procedures, to file a Grievance and request an Appeal with Contractor, either orally, in writing, or over the phone, including procedures to Appeal decisions that deny, delay or modify a Member's request for services. Include the toll-free telephone number a Member can use to file a Grievance or request an Appeal, and the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals and providing assistance completing the request. Information regarding the process shall include the requirements for timeframes to file a Grievance or request an Appeal, notification that an oral request for an Appeal of an action should be followed by a written request for an Appeal, and timelines for ~~the~~ Contractor to acknowledge receipt of Grievances and Appeals, to resolve Grievances and Appeals, and to notify the Member of the resolution of Grievances or Appeals. Contractor shall inform the Member that services previously authorized by Contractor will continue while the Appeal is being resolved.

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

15) Procedures for disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

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

17) Information on the availability of, and procedures for obtaining, services at FQHCs and American Indian Health Service Programs.

18) Information on the Member's right to seek family planning services from any qualified Provider of family planning services under the Medi-Cal program, including Providers outside Contractor's Provider Network, how to access these services, that a referral is not necessary, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get.

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

20) The Department of Social Services (DSS) Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

21) Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Exhibit A, Attachment 9, Provision 7. Nurse Midwife and Nurse Practitioner Services.

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

23) Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

24) Information concerning the provision and availability of services covered under the CCS program from Providers outside Contractor's Provider Network and how to access these services.

25) An explanation of the expedited disenrollment process for Members qualifying under conditions specified under Title 22 CCR Section 53889(j) which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

26) Information on how to obtain Minor Consent Services through Contractor's Provider Network, an explanation of those services, and information on how they can also be obtained out of the Contractor's Provider Network.

27) An explanation on how to use the FFS system when Medi-Cal

Covered Services are excluded or limited under this Contract and how to obtain additional information.

28) An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access American Indian Health Service Programs, to choose an American Indian Health Care Provider within Contractor's Network as a Primary Care Provider, and to disenroll from Contractor's plan at any time, without cause.

29) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

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

31) Contractor's drug formulary information notice. Pursuant to California Health and Safety Code, Section 1363.01, and 42 CFR 438.10(d)(6) and (i), the drug formulary information notice shall: (1) be in an easily understood language and format; (2) include an explanation of what a formulary is, which medications are covered, both generic and name brand, what tier each medication is on, how the plan decides which Prescription Drugs are included ~~in~~ or excluded from the formulary, and how often the formulary is updated; (3) indicate that the drug formulary is available on Contractor's website in a machine readable file, available in a hard copy, and provide the telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.

32) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of State law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect

changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

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

34) That oral interpreter services are available for any language spoken by the Member, and written translations of Member materials are available in the identified threshold languages, both free of charge, with instruction on how to access these services.

35) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services. Include taglines in large-size print font no smaller than 18-point, on how to request Auxiliary Aids and Member information in alternative formats.

36) Information on how to report suspected fraud or abuse.

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

G. Member Identification Card

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

5. Notification of Changes in Access to Covered Services

A. Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR Section 438.10(g), at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible. The notification must ~~also~~ be presented to and approved in writing by DHCS prior to its release.

B. Pursuant to 42 CFR 438.10(f)(1) Contractor shall make a good faith effort to give written notice of termination of a contracted Provider within 15 calendar days after receipt or issuance of the termination notice to each

Member who received his or her primary care from, or was seen on a regular basis by, the terminated Provider. This notification must also be presented to and approved in writing by DHCS prior to its release.

6. Primary Care Provider Selection

A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician.

1) Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first 30 calendar days of enrollment.

2) Contractor may allow Members to select a clinic that provides primary care.

3) If the Contractor's Provider Network includes Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, the Member may select a Nurse Practitioner, Certified Nurse Midwife, or Physician Assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with Title 22 CCR Section 53853(a)(4).

4) Contractor shall provide a mechanism for SPD beneficiaries to select a Specialist or clinic that meets DHCS subcontracting requirements as stated in Attachment 6 of this contract as a Primary Care Physician if the Specialist or clinic agrees to serve as a Primary Care Provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W & I Code Section 14182 (b)(11).

5) Contractor shall ensure that Members are allowed to change a Primary Care Physician, Nurse Practitioner, Certified Nurse Midwife or Physician Assistant, upon request, by selecting a different Primary Care Provider from Contractor's Network.

B. Contractor shall disclose to affected Members any reasons for which their selection or change in Primary Care Physician could not be made.

C. Contractor shall ensure that Members with an established relationship with a Provider in Contractor's Network, who have expressed a desire to continue their patient/Provider relationship, are assigned to that Provider without disruption in their care.

D. Contractor shall ensure that Members may choose Traditional and Safety-

Net Providers as their Primary Care Provider, and that American Indian Members may choose an American Indian Health Care Provider within Contractor's Network as their Primary Care Provider.

E. Contractor shall not be obligated to require Full Benefit Dual Eligible Members to select a Medi-Cal Primary Care Provider. Nothing in this section shall be construed to require Contractor to pay for services that would otherwise be paid for by Medicare.

7. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to Providers.

B. For Riverside/San Bernardino Counties Only
If an Adult Expansion Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, and resides in a public hospital system county, as defined in Welfare and Institutions Code Section 17612.2, Subdivision (u), Contractor shall assign the Adult Expansion Member to a Primary Care Provider as follows:

1) During a three (3) year period, ending on December 31, 2016, Contractor shall assign at least 75 percent of Adult Expansion Members who do not select a Primary Care Provider, to a Primary Care Provider within the county public hospital health system, until the county public hospital health system meets its enrollment target, as defined in Welfare and Institutions Code Section 14199.1(b)(3).

2) Following the expiration of the three (3) year period as stated above, Contractor shall assign at least 50 percent of Adult Expansion Members who do not select a Primary Care Provider to a Primary Care Provider within the county public hospital health system until the county public hospital health system meets its applicable enrollment target.

3) The above two paragraphs shall not apply with respect to a county public hospital health system during any time period in which the county public hospital health system meets or exceeds its applicable enrollment target. For these time periods, Adult Expansion Members shall be assigned to Primary Care Providers in the same manner as other Members who do not affirmatively select

a Primary Care Provider. A county public hospital health system can notify Contractor that it has reached its maximum capacity for the assignment of Adult Expansion Members.

4) If at any time the county public hospital health system notifies Contractor that it again has capacity to accept assignment of Adult Expansion Members, the requirements set forth in Paragraphs 1) and 2) shall apply, effective on the first day of the month following that notice.

5) In implementing the requirements contained in this Provision, Contractor shall first assign Adult Expansion Members to a Primary Care Provider within the county public hospital health system from whom the Adult Expansion Member has accessed care two or more times within the past 12 months, if the Contractor is appropriately notified by DHCS of the prior existing relationship.

   a) Contractor shall use utilization data or other data sources, including electronic data, as provided by DHCS to establish existing Provider relationships with county public hospital health system Providers for the purpose of Primary Care Provider assignment.

   b) DHCS shall work with the county public hospital health systems to gather and provide this data to Contractor.

6) Contractor shall not assign Adult Expansion Members to a Primary Care Provider within the county public hospital health system if that Primary Care Provider has notified Contractor that it does not have capacity to accept new Adult Expansion Members.

7) The assignment process described in this Provision shall not apply to LIHP Members subject to Welfare and Institutions Code Section 14005.60.

8) Nothing set forth in this Provision shall alter, reduce, or modify in any manner the way Contractor assigns other Members to the county public hospital health systems.

9) Nothing in this Provision shall modify the ability of Adult Expansion Members from selecting or changing their Primary Care Providers.

10) If the Contractor identifies a concern regarding patient quality or access (through mechanisms such as Grievances, Member satisfaction, secret shopper Provider surveys, etc.) within the county public hospital health system (PHHS), Contractor may

cease default enrollment into the PHHS upon approval from DHCS and until such time as the issue has been satisfactorily addressed.

C. If a Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall use utilization data or other data sources provided by DHCS, including electronic data, to establish existing Provider relationships for the purpose of Primary Care Provider assignment, including a Specialist or clinic for a SPD beneficiary if a preference for either has been indicated. Contractor shall comply with all federal and State privacy laws in the provision and use of this data.

D. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the Provider within ten (10) calendar days from when selection or assignment is completed by the Member or the Contractor, respectively.

E. Contractor shall maintain procedures that proportionately include contracting Traditional and Safety-Net Providers in the assignment process for Members who do not choose a Primary Care Provider.

F. Contractor shall not be required to assign Members who are eligible for services through Medicare to a Medi-Cal Primary Care Provider except as specified in APL 14-015. Nothing in this section shall be construed to require health plans to pay for services that would otherwise be paid for by Medicare.

G. Contractor shall provide any Member utilization data received from DHCS to the Primary Care Provider or Subcontractor to which a Member has been assigned for the coordination of the Members care. To the extent the Provider is not equipped to receive the data, Contractor shall make it available to the Primary Care Provider or Subcontractor.

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

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with 42 CFR 438.210(c) and Title 22 CCR Sections 51014.1 and 53894 by providing a NOA to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in 42 CFR 438.404, Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

B. Contractor shall ensure that at least ten (10) days of advanced notice is given to a Member when a NOA results in a termination, suspension, or reduction of previously authorized covered services. The Contractor shall

shorten the advanced notice to five (5) days if fraud probable recipient fraud has been verified.

Contractor shall not be required to provide advanced notice of a termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:

1) Death of a Member;

2) Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;

3) Member admission into an institution that makes the Member ineligible for further services;

4) Member's address is unknown and mail directed to the Member has no forwarding address;

5) Member has been accepted for Medi-Cal services by another local jurisdiction;

6) Member's Primary Care Physician prescribes a change in the level of medical care;

7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or

8) Safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

C. Contractor shall provide expedited advanced notice to a Member when Contractor or Primary Care Physician indicates that the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than 72 hours after receipt of the request for services. Upon approval from DHCS, Contractor may extend the 72 hour expedited period to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and that the extension is in the Member's interest.

D. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:

1) The Member’s right to, and method of obtaining, a State Fair Hearing to contest the denial, deferral, or modification action and the decision the Contractor has made.

2) The Member’s right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel, friend or other spokesperson.

3) The name and address of Contractor and the State of California Department of Social Services toll-free telephone number for obtaining information on legal service organizations for representation.

E. Contractor shall provide a required notification to Members and their authorized representatives in accordance with the time frames set forth in Title 22 CCR Sections 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, Provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide a written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, Provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM

1. Member Grievance and Appeal System

Contractor shall have in place a system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13), and 42 CFR 438. 402-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL 17-006. Contractor shall ensure that the following requirements are met through its Grievance and Appeal system:

A. Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may file a Grievance or request an Appeal with Contractor either orally or in writing.

B. Ensure timely acknowledgement for each Grievance and request for an Appeal, and provide a notice of resolution to the Member as quickly as the Member's health condition requires, within 30 calendar days from the date Contractor receives the Grievance or request for an Appeal. Contractor shall notify the Member of the resolution in a written Member notice.

C. For Members accessing the Grievance and Appeal system, ensure that reasonable assistance is given in completing forms and other procedural steps, which includes but is not limited to, providing Auxiliary Aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

D. Ensure that the person making the final decision for the proposed resolution of Grievances and Appeals has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in a prior decision, and has clinical expertise in treating a Member's condition or disease if deciding on any of the following:

   1) An Appeal of a denial based on lack of Medical Necessity;

   2) A Grievance regarding denial of an expedited resolution of an Appeal; and

   3) Any Grievance or Appeal involving clinical issues.

E. Take into account all comments, documents, records, and other information submitted by the Member or their representative, without regard to whether such information was submitted or considered in the initial action.

F. Ensure that Members are given a reasonable opportunity to present to Contractor evidence and testimony, and make legal or factual arguments, in person as well as in writing, in support of their Grievance or Appeal.

Contactor shall inform Members of the limited time available to present evidence sufficiently in advance of the resolution timeframes specified in this Contract, including for expedited Appeals.

G. Notice of resolutions for Grievances and Appeals shall be in a format and language that, at a minimum, meets the standards set forth in 42 CFR 438.10 and Exhibit A, Attachment 13, Provision 4 of this Contract.

H. Provide oral notice of the resolution of an expedited review within 72 hours.

I. Provide its Grievance and Appeal system requirements to Subcontractors at the time that they enter into a Subcontract.

J. Compile the systematic aggregation and analysis of Grievance and Appeal data and use for Quality Improvement.

2. Grievance Process

Contractor shall implement and maintain procedures as described below for Grievances and the expedited review of Grievances required under 42 CFR 438.402, 406, and 408, Title 28, CCR, Sections 1300.68 and 1300.68.01, and Title 22 CCR Section 53858.

A. Procedure to ensure a Member may file a Grievance with Contractor at any time to express dissatisfaction about any matter other than an action resulting in a NOA.

B. Procedure to allow Members to file a Grievance when they disagree with Contractor's decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. Procedure to ensure that every Grievance submitted is reported to an appropriate level, i.e., quality of care versus quality of service.

D. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to Contractor's medical director.

3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

A. Contractor shall accurately maintain and make accessible to DHCS, and have available for CMS upon request, Grievance and Appeal logs, including copies of Grievance and Appeal logs of any subcontracting entity delegated the responsibility to maintain and resolve Grievances. Grievance and Appeal logs shall include all the required information set forth in Title 22 CCR Section 53858(e). Contractor shall also apply the

information requirements for Grievance logs to the inclusion of Appeals.

B. Contractor shall submit a quarterly Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to the DMHC as set forth in Title 28 CCR Section 1300.68(f), with additional information required by DHCS per 42 CFR 438.416.

1) In addition to the types or nature of Grievances listed in Title 28 CCR Section 1300.68(f)(2)(D), the report shall also include, but not be limited to, timely assignments to a Provider, issues related to cultural and linguistic sensitivity, difficulty with accessing Specialists, and Grievances related to Contractor's denial of requests for out-of-Network requests.

2) For the Medi-Cal category of the report, Contractor shall provide the following additional information on both Grievances and Appeals:

a) The date Contractor received the Grievance or Appeal;

b) A general description of the reason for the Grievance or Appeal;

c) The date(s) of Contractor's review of the Grievance or Appeal, or if applicable, a review meeting;

d) The resolution and date of resolution, at each level of the Grievance or Appeal;

e) The name of the Member for whom review of a Grievance or Appeal was requested;

f) The timeliness of responding to the Member; and

g) The geographic region, ethnicity, gender, and primary language of the Member.

C. Contractor shall submit the quarterly Grievance and Appeal report for Medi-Cal Members the following quarters: April – June, July – September, October – December, January – March. The report is due 30 calendar days from the date of the end of the reporting quarter.

4. Notice of Action (NOA)

A. A NOA is a formal letter, in a format approved by DHCS, informing a

Exhibit A, Attachment 14
MEMBER GRIEVANCE AND APPEAL SYSTEM

Member of any of the following actions taken by Contractor and sent within the corresponding timeframes:

1) For the denial or limited authorization of a requested Covered Service, send within five (5) business days from receipt of the information reasonably necessary to render a decision, with a possible extension of up to 14 additional calendar days if the Member requests an extension, or if Contractor justifies to DHCS a need for additional information and how the extension is in the Member's interest.

2) For the reduction, suspension, or termination of a previously authorized Covered Service, send within the timeframes stated in Exhibit A, Attachment 13, Provision 8, Paragraph B.

3) For a denial, in whole or in part, of payment for a Covered Service, send at the time of any action affecting the claim.

4) For the failure to authorize Covered Services in a timely manner, send on the date that the timeframe expires.

5) For the decision to extend the time frame to authorize a Covered Service and provide information on filing a Grievance if the Member disagrees, send within 14 calendar days following receipt of the request.

6) For an expedited service authorization decision, send within 72 hours of receipt of the request.

B. A written NOA shall be in a format and language that, at a minimum, meets the standards set forth in Exhibit A, Attachment 13, Provision 4, and must include all of the following:

1) The action that Contractor or its Subcontractor has taken or intends to take;

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information relevant to the action, including the Medical Necessity criteria, and any processes, strategies, or evidentiary standards used;

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) The Member's right to request a State Fair Hearing after requesting an Appeal and receiving notice that Contractor is upholding its action, or after Contractor fails to send a resolution notice or extension in response to the Appeal within 30 calendar days;

5) Procedures for exercising the Member's rights to request an Appeal or a State Fair Hearing;

6) Circumstances under which an expedited Appeal is available and how to request it;

7) The Member's right to have Covered Services continue pending the resolution of the Appeal; and

8) How to request a continuation of Covered Services.

C. Once a NOA is sent:

1) Members have 60 calendar days from the date on the NOA to request an Appeal of Contractor's action.

2) Members may request a review of Contractor's action, called an Independent Medical Review (IMR), from the Department of Managed Health Care (DMHC).

D. Member must be notified that the State must reach its decision for a standard State Fair Hearing within 90 days of the date of the request. For an expedited State Fair Hearing, the State must reach its decision within three (3) working days of receipt of the expedited State Fair Hearing request. Contractor shall also comply with all other requirements as outlined in APL 03-009 and APL 17-006.

5. Appeal Process

Contractor shall have in place a process as described below to resolve Member requests for Appeals. Contractor may have only one level of Appeal for Members.

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, an oral request for an Appeal should be followed by a written and signed Appeal. However, Contractor shall still consider the date the Member made the oral request for an Appeal as the filing date without regard to whether the

Member submitted a written request for an Appeal.

B. If Contractor fails to send a Member resolution notice within 30 calendar days, the Member is deemed to have exhausted Contractor's internal Appeal process and can request a State Fair Hearing. A Member resolution notice, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Member's favor, Contractor, at a minimum, must include:

1) Member's right to request a State Fair Hearing;

2) How to request a State Fair Hearing;

3) Right to continue to receive benefits pending a State Fair Hearing;

4) How to request the continuation of benefits, and requirements to file a continuation within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed action; and

5) The right to request an IMR or a review of Contractor's decision by DMHC.

C. Contractor may extend the timeframe to resolve an Appeal by up to 14 calendar days if the Member requests an extension or Contractor shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe extension has not been requested by the Member, Contractor shall:

1) Make reasonable efforts to give the Member prompt oral notice of the delay.

2) Give the Member a written notice of the reason to extend the timeframe within two (2) calendar days, including information on the right to file an additional Grievance for the delay.

3) Resolve as expeditiously as the Member's health condition requires and no later than the date the extension expires.

D. Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it reverses the action, if the services are not furnished while the Appeal is pending and Contractor reverses a decision to deny, limit, or delay services.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor shall continue providing Covered Services while the Appeal is pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes,

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The Covered Services were ordered by an authorized Provider;

4) The period covered by the original authorization has not expired; and

5) The Member files for continuing Covered Services within 10 calendar days of when the NOA was sent, or before the intended effective date of the proposed action.

G. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Fair Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Fair Hearing;

2) The Member fails to request a State Fair Hearing and continuation of Covered Services within 10 calendar days of when the NOA was sent; or

3) The State Fair Hearing decision is adverse to the Member.

H. The Member must be given the opportunity before and during their Appeals process to examine their case file, including medical records and any other documents and records considered during the Appeals process. Contractor shall provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including medical records and any other documents and records considered during the Appeal process.

6. Responsibilities in Expedited Appeals

Contractor shall implement and maintain procedures as described below to resolve expedited Appeals. Contractor shall follow the expedited Appeal process when it determines or the Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

A. A Member, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may file an expedited Appeal either orally or in writing and no additional Member follow-up is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must provide a Member notice, as quickly as the Member's health condition requires, within 72 hours from the day Contractor receives the request for an Appeal.

D. Contractor may extend the timeframe to resolve an expedited Appeal by up to 14 days if the Member requests an extension or if Contractor shows that there is a need for additional information and how the delay is in the Member's interest. If the extension was not requested by the Member, Contractor shall make reasonable efforts to give the Member a prompt oral notice of the delay, and within two (2) calendar days give the Member a written notice of both the reason for the extension and the right to file a Grievance if the Member disagrees with the decision. Contractor shall resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

E. Contractor must make a reasonable effort to provide oral notice of expedited Appeal decision.

F. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Provision 5 of this Attachment.

7. State Fair Hearings and Independent Medical Reviews

A. State Fair Hearings

1) Members, or a Provider or authorized representative acting on behalf of a Member and with the Member's written consent, may request a State Fair Hearing:

a) After receiving a notice of resolution stating that Contractor's action has been upheld, and the request is made within 120 calendar days from the date on the notice of resolution; or

b) If they have exhausted the Appeals process due to Contractor failing to adhere to Appeal notice and timing requirements as stated in this Contract.

2) During the State Fair Hearing process, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice reversing the determination, if the services are not furnished while the Hearing is pending and Contractor reverses a decision to deny, limit, or delay services.

3) Contractor must pay for disputed services if the Member received the disputed services while the Hearing was pending.

B. Expedited State Fair Hearings

1) Within two (2) working days of being notified by DHCS or the California Department of Social Services (CDSS) that a Member has filed a request for State Fair Hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate CDSS administrative law judge all information and documents which either support, or which ~~the~~ Contractor considered in connection with, the action which is the subject of the expedited State Fair Hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and NOA, plus any pertinent Appeal resolution notice. If the NOA or Appeal resolution notices are not in English, fully translated copies shall be transmitted to CDSS along with copies of the original NOA and Appeal resolution notice.

2) One or more of Contractor's representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited State Fair Hearing, shall be available by phone during the scheduled Hearing.

C. Independent Medical Review (IMR)

1) Members have the right to request from DMHC an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by a Member. Contractor shall not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Fair Hearing.

3) IMRs shall be conducted by DMHC independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs shall not extend any of the time frames stated in this Contract for Appeals, and shall not disrupt the continuation of Covered Services per 42 CFR 438.420.

8. Parties to an Appeal or a State Fair Hearing

The parties to an Appeal or a State Fair Hearing include Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

Exhibit A, Attachment 15
MARKETING

1. Training and Certification of Marketing Representatives

If Contractor conducts Marketing, Contractor shall develop a training and certification program for Marketing Representatives and ensure that all staff performing Marketing activities or distributing Marketing material are appropriately certified.

A. Contractor is responsible for all Marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any Marketing Representatives. Marketing staff may not provide Marketing services for more than one Contractor. Marketing Representatives shall not engage in marketing practices that discriminate against an Eligible Beneficiary or Potential Enrollee because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

B. Training Program

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

1) An explanation of the Medi-Cal Program, including both FFS and capitated contractors, and eligibility.

2) Scope of Services

3) An explanation of the Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services, additional services, conditions of enrollment and aid categories.

4) An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency medical care through the Contractor's Provider Network and describing all precedents to receipt of care like referrals, Prior Authorizations, etc.).

5) An explanation of the Contractor's Grievance and Appeal procedures.

6) An explanation of how a beneficiary disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

7) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries including information regarding eligibility under any public welfare or social services program.

8) An explanation of how Marketing Representatives will be supervised and monitored to assure compliance with regulations.

9) An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited Marketing Representative activities and conduct.

10) An explanation that discrimination in enrollment and failure to enroll a beneficiary due to a pre-existing medical condition (except for conditions requiring Excluded Services) are illegal.

11) An explanation of the consequences of misrepresentation and Marketing abuses (i.e., discipline, suspension of Marketing, termination, civil and criminal prosecution, etc.). The Marketing Representative must understand that any abuse of Marketing requirements can also cause the termination of the Contractor's contract with the State.

2. DHCS Approval

A. Contractor shall not conduct Marketing activities presented in Provision 3, Paragraph A, Subparagraph 2), item d) below, without written approval of its Marketing plan, or changes to its Marketing plan, from DHCS. In cases where the Contractor wishes to conduct an activity not included in Provision 3, Paragraph A, Sub-paragraph 2) c) and d) below, Contractor shall submit a request to include the activity and obtain written, prior approval from DHCS. Contractor must submit the written request not later than 30 calendar days prior to the Marketing event, unless DHCS agrees to a shorter period.

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

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

3. Marketing Plan

Exhibit A, Attachment 15
MARKETING

If Contractor conducts Marketing, Contractor shall develop a Marketing plan as specified below. The Marketing plan shall be specific to the Medi-Cal program only and materials shall be distributed within the Contractor's entire service area. Contractor shall implement and maintain the Marketing plan only after approval from DHCS. Contractor shall ensure that the Marketing plan, all procedures and materials are accurate and do not mislead, confuse or defraud.

A. Contractor shall submit a Marketing plan to DHCS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe the Contractor's current Marketing procedures, activities, and methods. No Marketing activity shall occur until the Marketing plan has been approved by DHCS.

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

2) Contractor's Marketing plan shall contain the following items and exhibits:

a) Mission Statement or Statement of Purpose for the Marketing plan.

b) Organizational Chart and Narrative Description

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

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

c) Marketing Locations

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

d) Marketing Activities

Exhibit A, Attachment 15
MARKETING

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

i. Contractor shall not engage in door-to-door, telephone, e-mail, texting, or other cold call Marketing for the purpose of enrolling Potential Enrollees, or for any other purpose.

ii. Contractor shall obtain DHCS approval to perform in-home Marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home Marketing presentation or a documented telephone log entry showing the request was made.

iii. Contractor shall not conduct Marketing presentations at primary care sites.

iv. Include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.

e) Marketing Materials

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

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

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

f) Marketing Distribution Methods

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

g) Monitoring and Reporting Activities

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

h) Miscellaneous

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

B. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

4. Marketing Event Notification

Contractor shall notify DHCS at least 30 calendar days in advance of Contractor's participation in all Marketing events. In cases where Contractor learns of an event less than 30 calendar days in advance, Contractor shall provide notification to DHCS immediately. In no instance shall notification be less than 48 hours prior to the event.

Exhibit A, Attachment 16
ENROLLMENTS AND DISENROLLMENTS

1. Enrollment Program

Contractor shall cooperate with the DHCS Enrollment program and shall provide to DHCS' enrollment contractor a list of Network Providers (provider directory), linguistic capabilities of the Providers and other information deemed necessary by DHCS to assist Eligible Beneficiaries, and Potential Enrollees, in making an informed choice in health plans. The provider directory will be submitted every six (6) months and in accordance with PL 11-009.

2. Enrollment

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

A. Enrollment - General

Eligible Beneficiaries residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.

B. Coverage

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by DHCS to Contractor. The term of enrollment shall continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in provision 3. Disenrollment.

Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, Contractor shall provide Covered Services to the child during the mother's first month of Enrollment. No additional Capitation Payment will be made to Contractor by DHCS.

C. Exception to Enrollment

A Member in a mandatory aid code category is not required to enroll when a request for an exemption under Title 22 CCR Section 53887 has been approved.

D. Enrollment Restriction

Enrollment will proceed unless restricted by DHCS. Such restrictions will be defined in writing and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release. DHCS shall immediately suspend enrollment of SPD beneficiaries if DHCS determines that Contractor does not have sufficient primary or specialty Providers to meet the needs of SPD beneficiaries in accordance with W & I Code 14182(w).

3. Disenrollment

The enrollment contractor shall process a Member disenrollment under the following conditions, subject to approval by DHCS, in accordance with the provisions of Title 22 CCR Section 53891:

A. Disenrollment of a Member is mandatory when:

1) The Member requests disenrollment, subject to any lock-in restrictions on disenrollment under the Federal lock-in option, if applicable.

2) The Member's eligibility for enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.

3) Enrollment was in violation of Title 22 CCR Section 53891(a)(2), or requirements of this Contract regarding Marketing, and DHCS or Member requests disenrollment.

4) Disenrollment is requested in accordance with Welfare and Institutions Code Sections 14303.1 regarding merger with other organizations, or 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.

5) There is a change of a Member's place of residence to outside Contractor's Service Area.

6) Disenrollment is based on the circumstances described in Exhibit A, Attachment 11, Provision 17, Excluded Services Requiring Member Disenrollment.

Such disenrollment shall become effective on the first day of the second month following receipt by DHCS of all documentation necessary, as determined by DHCS, to process the disenrollment, provided

disenrollment was requested at least 30 calendar days prior to that date, except for disenrollment pursuant to Exhibit A, Attachment 11, Provision 18, regarding Major Organ Transplants, for which disenrollment shall be effective the beginning of the month in which the transplant is approved.

B. Except as provided in Paragraph A, Subparagraph 6) above, enrollment shall cease no later than midnight on the last day of the first calendar month after the Member's disenrollment request and all required supporting documentation are received by DHCS. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for persons no longer enrolled under this Contract.

C. Contractor shall implement and maintain procedures to ensure that all Members requesting disenrollment or information regarding the disenrollment process are immediately referred to the enrollment contractor.

Exhibit A, Attachment 17
REPORTING REQUIREMENTS

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure Form)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		
2. Financial Audit Reports B. 1) **or** B. 2)	Annual certified Financial Statements and DMHC required reporting forms **or** Financial Statement	Annually
2. Financial Audit Reports B. 2)	Quarterly Financial Reports	Quarterly
4. Monthly Financial Statements	Monthly Financial Statements (If applicable)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal C.	Encounter Data Submittal	Monthly
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee C.	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set (EAS) Performance Measures 2) b)	EAS Performance Measurement Rates	Annually
9. External Quality Review Requirements B. Under/Over-Utilization Monitoring	Reported rates	Annually
9. External Quality Review Requirements C. Performance Improvement Projects (PIPs)	QIP Proposals or Status Reports	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		
11. Provider Network Report	Provider Network Report	Quarterly
12. Plan Subcontractors	Plan Subcontractors Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
13. Cultural and Linguistic Program C. Group Needs Assessment 4)	Group Needs Assessment Summary Report	Every 5 years
Attachment 10 SCOPE OF SERVICES		

Exhibit A, Attachment 17
REPORTING REQUIREMENTS

Contract Section	Requirement	Frequency
5. Services for Members under Twenty-One (21) Years of Age B. Children's Preventive Services 5)	Confidential Screening/Billing Report Form, PM 160-PHP	Monthly
5. Services for Members under Twenty-One (21) Years of Age G. Behavioral Health Treatment Services	BHT Reporting Template	First Six Months: Monthly After Six Months: Quarterly
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 5)	Report of Changes to the Formulary	Annually
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 7)	Report of DUR Program Activities	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION		
4. MOU Monthly Reports	Local Health Department - MOU's County Mental Health - MOU's (If deemed necessary)	Monthly
Attachment 13 MEMBER SERVICES		
3. Call Center Reports	Call Center Reports	Quarterly
4. Written Member Information B.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEVANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report	Grievance and Appeal Report	Quarterly
Attachment 15 MARKETING		
3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENTS AND DISENROLLMENTS		
1. Enrollment Program (PL 11-009)	Provider Directory	Semi-Annually
Attachment 19 COMMUNITY BASED ADULT SERVICES (CBAS)		
5. Required Reports for the CBAS Program A.	Provision of ECM Report	Quarterly
5. Required Reports for the CBAS Program B.	CBAS Enrollment Report	Quarterly
5. Required Reports for the CBAS Program C.	Addition to Call Center Report	Quarterly

Exhibit A, Attachment 17
REPORTING REQUIREMENTS

Contract Section	Requirement	Frequency
5. Required Reports for the CBAS Program D.	Addition to Grievance and Appeal Report	Quarterly
Attachment 20 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		
3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly
3. Provider Network Reports B.	Outpatient Mental Health Services Providers Report	Monthly
Attachment 21 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)		
10. Required Reports for Managed Long Term Services and Supports A.	Support and Retention of Community Placement	Quarterly
10. Required Reports for Managed Long Term Services and Supports B.	Continuity of Care Requests	Monthly
10. Required Reports for Managed Long Term Services and Supports C.	Addition to the Provider Network Report	Quarterly
10. Required Reports for Managed Long Term Services and Supports D.	Addition to Call Center Reports	Quarterly
10. Required Reports for Managed Long Term Services and Supports E.	Addition to Grievances and Appeals Report	Monthly
10. Required Reports for Managed Long Term Services and Supports F.	PCP Assignment	Monthly
Exhibit B - BUDGET DETAIL AND PAYMENT PROVISIONS		
12. Payment of Aids Beneficiary Rates A. Compensation at the AIDS Beneficiary Rate (ABR) 1) c)	AIDS Beneficiaries Rate (ABR) Invoice	Monthly
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

The Implementation Plan and Deliverables section describes DHCS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning Operations.

Once the Contract is awarded, the Contractor has 15 calendar days after they sign the Contract to submit a Workplan for each county that describes in detail how and when the Contractor will submit and complete the deliverables to DHCS in accordance with the Implementation Plan and Deliverables section. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period (approximately 6 months after the effective date of the Contract). The Operations Period is the period of time beginning with the effective date of the first month of operations and continues on through the last month of capitation and services to Members.

The Contractor's Workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. DHCS will review and approve each of the Workplan(s). However, Contractor shall not delay the submission of deliverables required in the Workplan(s) while waiting for DHCS approval of previously submitted deliverables required by the Workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved DHCS Workplan(s). In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved DHCS Workplan(s), DHCS may impose Liquidated Damages in accordance with Exhibit E, Attachment 2 – Program Terms and Conditions, Provision 17, Liquidated Damages Provisions.

In the event that this section omits a deliverable required by the Contract, the Contractor will still be responsible to assure that all contract requirements are met. Upon successful completion of the Implementation Plan and Deliverables section requirements, DHCS will authorize, in writing, that the Contractor may begin the Operations Period.

Knox-Keene Licensure

If not currently licensed to operate in awarded service area, a complete material modification to operate in the service area must be submitted to the DMHC within 30 working days of award of contract. Submit proof of the material modification submission to DHCS concurrently. Operation shall not begin until the material modification is approved by DMHC. Contractor shall submit a copy of their Knox-Keene license.

Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

1. Organization and Administration of Plan

A. Submit documentation of employees (current and former State employees) who may present a conflict of interest.

B. Submit a complete organizational chart.

C. If the Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.

D. Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.

E. Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's Public Policy Advisory Committee.

F. Submit the following Knox-Keene license exhibits and forms reflecting current operation status:

1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.

i. Corporation: Exhibits F-1-a-i through F-1-a-iii as referenced in Title 28 CCR 1300.51

ii. Partnership: Exhibits F-1-b-i and F-1-b-ii as referenced in Title 28 CCR 1300.51

iii. Sole Proprietorship: Exhibit F-1-c as referenced in Title 28 CCR 1300.51

iv. Other Organization: Exhibits F-1-d and F-1-d-ii as referenced in Title 28 CCR 1300.51

v. Public Agency: Exhibits F-1-e-I through F-1-e-iii as referenced in Title 28 CCR 1300.51.

Title 28, CCR, Section 1300.51(d)(F)(1)(a) through (e)

2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above. Title 28, CCR, Section 1300.51(d)(F)(1)(f)

3) Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal

Creditors and Providers of Administrative Services.

4) Exhibit F-3 Other Controlling Persons.
Title 28, CCR, Section 1300.51(d)(F)

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

G. Submit Exhibit M-2: Statements as to each person identified in Section L. Technical Proposal Requirements, Provision 1. Organization and Administration, a. 2) (Exhibit L) and 3). (Exhibit M-1)

Title 28, CCR, Section 1300.51(d)(M)(2)

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

Title 28, CCR, Section 1300.51(d)(N)(2)

I. If, within the last five (5) years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor shall submit a summary of the circumstances surrounding the termination or non-renewal. Describe the parties involved, including address(es) and telephone number(s). Describe the Contractor's corrective actions to prevent future occurrences of any problems identified.

J. Contractor shall describe provisions and arrangements, existing, and proposed, for including Medi-Cal Members in their Public Policy Advisory Committee development process. Identify the composition and meeting frequency of any committee participating in establishing the Contractor's public policy. Describe the frequency of the committee's report submission to the Contractor's Governing Body, and the Governing body, and the Governing Body's process for handling reports and recommendations after receipt.

K. Contractor shall submit policies and procedures for ensuring that all appropriate staff receives sensitivity training relating to SPD beneficiaries.

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of

exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

A. Submit most recent audited annual financial reports

B. Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.

C. Submit the following Knox-Keene license exhibits reflecting projected financial viability:

1) Exhibit HH-1

2) Exhibit HH-2

Title 28, CCR, Section 1300.76

3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.

D. Submit Knox-Keene license Exhibit HH-6. Include the following:

1) Exhibit HH-6-a

2) Exhibit HH-6-b

3) Exhibit HH-6-c

4) Exhibit HH-6-d

5) Exhibit HH-6-e

Title 28, CCR, Section 1300.51(d)(HH)

E. Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with DHCS. Also describe any reinsurance and risk-sharing arrangements with any Subcontractors shown in this Contract. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22 CCR Sections 53863 and 53868.

F. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:

1) Exhibit II-1

2) Exhibit II-2

3) Exhibit II-3

Title 28, CCR, Section 1300.51(d)(II)

G. Describe systems for ensuring that Subcontractors, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a Subcontract, have the administrative and financial capacity to meet its contractual obligations. Title 28, CCR Section 1300.70(b)(2)(H)1. Title 22 CCR Section 53250.

H. Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.

I. Describe process to ensure timely filing of required financial reports. The description should include mechanisms for systems oversight for generating financial and operational information, including a tracking system with lead times and due dates for quarterly and annual reports. Describe how this process coincides with the organization's management information system. Additionally, Contractor shall describe how it will comply with the Administrative cost requirements in Title 22 CCR Section 53864(b).

J. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

3. Management Information System (MIS)

A. Submit a completed MCO Baseline Assessment Form.

B. If procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:

1) Outline of the tasks required;

2) The major milestones;

3) The responsible party for all related tasks;

The implementation plan must also include:

1) A full description of the acquisition of software and hardware, including the schedule for implementation;

2) Full documentation of support for software and hardware by the manufacturer or other contracted party;

3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;

4) Documentation of system changes related to Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements.

C. Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data from origination at the Provider level to Contractor, through submission to DHCS.

D. Submit an Encounter Data test produced using real or proxy data processed by a new or modified MIS to DHCS. Monthly encounter submissions from a new or modified MIS may not take place until this test has been successfully completed and approved by DHCS.

E. Submit policies and procedures for the submission of complete, accurate, timely, and reasonable Encounter Data.

F. Submit a work plan for compliance with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA).

G. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.

H. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems;

1) Financial

2) Member/Eligibility

3) Provider

4) Encounter/Claims

5) Quality Management/Utilization

I. Submit a sample and description of the following reports generated by the MIS;

1) Member roster

2) Provider Listing

3) Capitation Payments

4) Cost and Utilization

5) System edits/audits

6) Claims payment status/processing

7) Quality Assurance

8) Utilization

9) Monitoring of Complaints

4. Quality Improvement System

A. Submit a flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.

B. Submit policies that specify the responsibility of the governing body in the QIS.

C. Submit policies for the QI Committee including membership, activities, roles and responsibilities.

D. Submit procedures outlining how Providers will be kept informed of the written QIS, its activities and outcomes.

E. Submit policies and procedures related to the delegation of the QIS activities.

F. Submit boilerplate Subcontract language showing accountability of delegated QIS functions and responsibilities.

G. Submit a written description of the QIS.

H. Policies and procedures to address how the Contractor will meet the requirements of:

1) External Accountability Set (EAS) Performance Measures

2) Performance Improvement Projects

3) Consumer Satisfaction Survey

I. Submit policies and procedures for performance of Facility Site and Medical Record reviews (FSR Attachments A and B), and for performance of Facility Site Physical Accessibility reviews (FSR Attachment C).

J. Submit a list of sites to be reviewed prior to initiating plan operation

K. Submit the aggregate results of pre-operational site review to DHCS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by DHCS.

L. Submit policies and procedures for reporting any disease or condition to public health authorities.

M. Submit policies and procedures for credentialing and re-credentialing.

N. Submit policies and procedures for appropriate handling and maintenance of medical records regardless of form (electronic, paper, etc.).

5. Utilization Management (UM)

A. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical, mental health, and substance use disorder services to demonstrate compliance with mental health parity. Also include the processes to be used for the provision of Medically Necessary Behavioral Health Treatment (BHT) services.

B. Submit policies and procedures for Prior Authorization, concurrent review, and retrospective review.

C. Submit a list of services requiring Prior Authorization and the utilization review criteria.

D. Submit policies and procedures for the utilization review appeals process for Providers and Members.

E. Submit policies and procedures that specify timeframes for medical authorization.

F. Submit policies and procedures to detect both under- and over-utilization of health care services.

G. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.

6. Provider Network

A. Submit complete Provider Network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries, including SPD beneficiaries, in the county pursuant to the Contract.

B. Submit policies and procedures describing how Contractor will monitor Provider to patient ratios to ensure they are within specified standards.

C. Submit policies and procedures regarding physician supervision of Non-Physician Medical Practitioners.

D. Submit policies and procedures for providing emergency services.

E. Submit a complete list of Specialists by type within the Contractor's Network.

F. Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement to Network and/or out-of-Network Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birthing Center (FBC) services.

G. Submit a GeoAccess report (or similar) showing that the proposed Provider Network meets the appropriate time and distance standards set forth in the Contract.

H. Submit a policy regarding the availability of a health plan physician 24-hours-a-day, 7-days-a-week, and procedures for communicating with emergency room personnel.

I. Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS patients.

J. Submit a report containing the names of all subcontracting Provider groups (see Exhibit A, Attachment 6, Provision 11).

K. Submit an analysis demonstrating the ability of the Contractor's Provider Network to meet the ethnic, cultural, and linguistic needs of Contractor's Members.

L. Submit policies and procedures for ensuring Subcontractors fully comply with all terms and conditions of this Contract.

M. Submit all boilerplate Subcontracts.

N. Submit policies and procedures that establish Traditional and Safety-Net

Provider participation standards.

O. Submit an attestation as to the percentage of Traditional and Safety-Net Providers in the Contractor's Network and agreement to maintain that percentage.

7. Provider Relations

A. Submit policies and procedures for Provider grievances.

B. Submit a written description of how Contractor will communicate the Provider grievance process to subcontracting and non-contracting Providers.

C. Submit protocols for payment and communication with non-contracting Providers.

D. Submit copy of Contractor's provider manual.

E. Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.

F. Submit policies and procedures for ensuring Network Providers receive training on a continuing basis regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for SPD beneficiaries.

G. Submit policies and procedures for ensuring Out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.

H. Submit protocols for communicating and interacting with all emergency departments in the Service Area.

8. Provider Compensation Arrangements

A. Submit policies and procedures regarding timing of Capitation Payments to Primary Care Providers or clinics.

B. Submit description of any physician incentive plans.

C. Submit policies and procedures for processing and payment of claims.

D. Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract to any Member.

E. Submit FQHC, RHC, and American Indian Health Service Programs Subcontracts.

F. Submit policies and procedures for the reimbursement of Non-Contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).

G. Submit policies and procedures for the reimbursement to local health department and non-contracting family planning Providers for the provision of family planning service, STD episode, and HIV testing and counseling.

H. Submit policies and procedures for the reimbursement of immunization services to local health department.

I. Submit policies and procedures regarding payment to non-contracting emergency services Providers. Include schedule of per diem rates and/or FFS rates for each of the following Provider types;

1) Primary Care Providers

2) Medical Groups and Independent Practice Associations

3) Specialists

4) Hospitals

5) Pharmacies

J. Submit policies and procedures for reporting Provider-Preventable Conditions.

9. Access and Availability

A. Submit policies and procedures that include requirements for:

1) Appointment scheduling

2) Routine specialty referral

3) First prenatal visit

4) Waiting times

5) After-hours calls

6) Unusual specialty services

B. Submit policies and procedures for ensuring the timely provision of access standards for:

1) Appropriate clinical timeframes

2) Standards for timely appointments

3) Shortening or expanding timeframes

4) Arranging timely appointments with a Provider shortage.

C. Submit policies and procedures for the timely referral and coordination of Covered Service to which Contractor or Subcontractor has objections to perform or otherwise support.

D. Submit policies and procedures for standing referrals.

E. Submit policies and procedures regarding 24-hr/day access without prior authorization, follow-up and coordination of emergency care services.

F. Submit policies and procedures regarding access to Certified Nurse Midwives and Certified Nurse Practitioners.

G. Submit applicable section of Member Services Guide stating Member's right to access family planning services without prior authorization.

H. Submit policies and procedures for the provision of and access to:

1) Family planning services

2) Sexually transmitted disease treatment

3) HIV testing and counseling services

4) Pregnancy termination

5) Minor consent services

6) Immunizations

I. Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

J. Submit policies and procedures regarding Contractor and Subcontractor compliance with the Civil Rights Act of 1964.

K. Submit a written description of the Cultural and Linguistic Services

Program.

L. Submit a timeline and work plan for the development and performance of a Group Needs Assessment.

M. Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff, Providers, and Subcontractors.

N. Submit policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.

O. Submit policies and procedures for the provision of 24-hour interpreter services at all Provider sites.

P. Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how Contractor will ensure the CAC will be involved in appropriate policy decisions.

Q. Submit policies and procedures for providing medically necessary services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated Provider.

R. Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a Provider.

10. Scope of Services

A. Submit policies and procedures for ensuring the provision of the Initial Health Assessments (IHA) for adults and children, including the Individual Health Education Behavioral Health Assessment (IHEBA) of the IHA.

B. Submit policies and procedures for administering the Health Risk Stratification and Assessment to SPD beneficiaries, including other health information used for risk stratification.

C. Submit Contractor’s risk stratification mechanism or algorithm designed for the purpose of identifying newly enrolled SPD beneficiaries as high or low risk.

D. Submit the plan's risk assessment tool to be used to comprehensively assess an SPD beneficiaries' current health risk and help develop individualized care management plans.

E. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:

1) Children's preventive services

2) Immunizations

3) Blood Lead screens

4) Screening for Chlamydia

5) EPSDT services

F. Submit policies and procedures for the provision of adult preventive services, including immunizations.

G. Submit policies and procedures for the provision of services to pregnant women, including:

1) Prenatal care

2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines

3) Comprehensive risk assessment tool for all pregnant women

4) Referral to Specialists

H. Submit a list of appropriate hospitals available within the Provider Network that provide necessary high-risk pregnancy services.

I. Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration and oversight.

J. Provide a list and schedule of all health education classes and/or programs.

K. Submit policies and procedures for the distribution and use of the Health Information Form (HIF) data submitted through the Member Evaluation Tool (MET).

L. Submit policies and procedures for the provision of:

1) Hospice care

2) Vision care – Lenses

3) Mental health services

4) Tuberculosis services

5) NEMT/NMT

M. Submit standards and guidelines for the provision of pharmaceutical services and prescribed drugs, including providing at least a 72-hour supply of a covered outpatient drug when prescribed in an emergency.

N. Submit a complete drug formulary.

O. Submit a process for review of drug formulary.

P. Submit policies and procedures for conducting a Drug Utilization Review (DUR).

Q. Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR 438.900 et. seq.

11. Case Management Including Coordination of Care

A. Submit procedures for monitoring the coordination of care provided to Members. Include procedures used to monitor the provision of Basic Case Management.

B. Submit procedures for administering and monitoring the provision of Complex Case Management to Members. Include procedures to identify members who may benefit from complex case management services.

C. Submit policies and procedures for ensuring the provision of Person-Centered Planning for SPD beneficiaries as part of case management and coordination of care.

D. Submit policies and procedures for ensuring the provision of Discharge Planning.

E. Submit policies and procedures for coordinating care of Members who are receiving services from a Targeted Case Management Provider.

F. Submit policies and procedures for the referral of Members under the age of 21 years that require complex case management services.

G. Submit policies and procedures for administration of a disease management program, including procedures for identification and referral of Members eligible to participate in the disease management program.

H. Submit policies and procedures for referral and coordination of care for

Members in need of Specialty Mental Health Services from the county mental health plan or other community resources.

I. Submit policies and procedures for resolving disputes between Contractor and the county mental health plan.

J. Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance use treatment services from both within and, if necessary, outside Contractor's Service Area.

K. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

L. Submit policies and procedures for identifying and referring children to the local CCS program.

M. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver Program. Include the duties of the Regional Center Liaison.

N. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.

O. Submit policies and procedures for case management coordination of care of LEA services, including Primary Care Physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.

P. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

Q. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the Subcontracts or written protocols/guidelines, if applicable.

R. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.

S. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.

T. Submit policies and procedures for the provision of dental screening and

covered medical services related to dental services.

U. Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.

V. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

W. Procedures to identify and refer eligible Members for WIC services.

X. Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for the following services:

1) Major organ transplants

2) Waiver Programs

Y. Submit policies and procedures for assessment of transitional needs of members into and out of Complex Case Management services:

1) At the request of PCP or Member

2) Achievement of targeted outcomes

3) Change of healthcare setting

4) Loss or change in benefits

5) Member non-compliance

12. Local Health Department Coordination

A. Submit executed Subcontracts or documentation substantiating Contractor's efforts to enter into Subcontracts with the LHD for the following public health services:

1) Family planning services

2) STD services

3) HIV testing and counseling

4) Immunizations

B. Submit executed Subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an

agreement with the following programs or agencies:

1) California Children Services (CCS)

2) Maternal and Child Health

3) Child Health and Disability Prevention Program (CHDP)

4) Tuberculosis Direct Observed Therapy

5) Women, Infants, and Children Supplemental Nutrition Program (WIC)

6) Regional Centers for Services for Persons with Developmental Disabilities.

7) Local Governmental Agencies for Targeted Case Management services.

8) County department for alcohol and substance use disorder treatment services.

C. Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the county mental health plan.

13. Member Services

A. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.

B. Submit policies and procedures for providing communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English-proficient (LEP), or non-English speaking.

C. Submit the following consistent with the requirements of Exhibit E, Attachment 2, Provision 21, Confidentiality of Information. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.

D. Submit policies and procedures for addressing advance directives.

E. Submit policies and procedures for the training of Member Services staff.

F. Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.

G. Submit final draft of Member Identification Card and Member Services Guide.

H. Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.

I. Submit policies and procedures for Member selection of a Primary Care Physician or Non-Physician Medical Practitioner. Include the mechanism used for allowing SPD beneficiaries to request a Specialist to serve as their PCP.

J. Submit policies and procedures for Member assignment to a Primary Care Physician. Include the use of utilization data and other data in linking a SPD beneficiary to a PCP.

K. Submit policies and procedures for notifying Primary Care Provider that a Member has selected or been assigned to the Provider within 7-days.

L. Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and their patients is not disrupted, to the maximum extent possible.

M. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.

14. Member Grievance and Appeal System

A. Submit policies and procedures relating to Contractor's Member Grievance and Appeal System.

B. Submit policies and procedures for Contractor's oversight of their Grievance and Appeal System for the receipts, processing and distribution including the expedited review of Appeals. Include a flow chart to demonstrate the process.

C. Submit format for Quarterly Grievance and Appeal Log and Report.

D. Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in expedited Appeals and State Fair Hearings.

15. Marketing

A. Submit policies and procedures for training and certification of Marketing Representatives.

B. Submit a description of training program, including the marketing representative's training/certification manual.

C. Submit Contractor's marketing plan.

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

16. Enrollments and Disenrollments

A. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.

B. Submit policies and procedures for how Contractor will access and utilize enrollment data from DHCS.

C. Submit policies and procedures relating to Member disenrollment.

17. Health Insurance Portability and Accountability Act (HIPAA)

Submit the following consistent with the requirements of Exhibit G.

A. Submit policies and procedures for compliance with the Health Insurance Portability and Accountability Act of 1996.

18. Community Based Adult Services (CBAS)

Submit the following consistent with the requirements of Exhibit A, Attachment 19.

A. Submit policies and procedures for referring a Member to a CBAS Provider.

B. Submit policies and procedures on arranging for the provision of CBAS unbundled services.

C. Submit policies and procedures for providing Enhanced Case Management services.

D. Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS.

E. Submit policies and procedures for an expedited assessment process.

F. Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.

19. Mental Health and Substance Use Disorder Benefits

Submit the following consistent with the requirements of Exhibit A, Attachment 20.

A. Submit policies and procedures for adding licensed mental health Providers to the Network, including which services shall be offered by licensed mental health Providers.

B. Submit policies and procedures for ensuring timely access to Outpatient Mental Health Services.

C. Submit any Subcontract boilerplate developed for a county mental health plan.

D. Submit policies and procedures for subcontracting with county mental health plans in order to comply with access standards.

E. Submit policies and procedures for verifying the credentials of licensed mental health Providers of Outpatient Mental Health Services.

F. Submit policies and procedures for contracting with out-of-Network and Tele-health mental health services Providers.

G. Submit policies and procedures for exchanging Member information with the county mental health plan.

H. Submit policies and procedures for handling of psychiatric emergencies during non-business hours.

I. Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.

J. Submit policies and procedures for when a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services.

K. Submit policies and procedures for the provision of Alcohol Misuse Screening and Counseling (AMSC) services, including:

1) Provision of AMSC by a Member's PCP to identify, reduce, and

prevent problematic substance use;

2) Referral, without requiring Prior Authorization, to AMSC services for Members whose PCPs do not offer AMSC; and

3) Referral, without requiring Prior Authorization, of Members to substance use disorder treatment when there is a need beyond AMSC.

20. Managed Long-Term Services and Supports

Submit the following consistent with the requirements of Exhibit A, Attachment 21.

A. Submit policies and procedures for the provision of services at non-contracted Long Term Care (LTC) facilities.

B. Submit an addition to the policies and procedures related to Provider training required in Provision 7 of this Attachment that includes key elements of operating a successful program for administering MLTSS.

C. Submit policies and procedures for the provision of LTC, and the Multipurpose Senior Services Program (MSSP), as Covered Services.

E. Submit policies and procedures for the provision of continuity of care through continued access to either a CBAS Provider with whom there is an existing relationship for up to 12 months after Full Benefit Dual Eligible Member enrollment or an LTC Provider with whom there is an existing relationship until December 31, 2016.

F. Submit policies and procedures for the risk stratification process conducted for Full Benefit Dual Eligible, Partial Dual Eligible, and Medi-Cal Only Members.

G. Submit policies and procedures for the development of an Individual Care Plan (ICP) and assembling an Interdisciplinary Care Team (ICT) for Medi-Cal Only Members who are assessed to be high risk.

H. Submit policies and procedures for using utilization data to establish existing Provider relationships for Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members.

21. Budget Detail and Payment Provisions

Submit documentation of the Coordination of Benefits Agreement (COBA) that Contractor has entered into with Medicare.

Exhibit A, Attachment 18
IMPLEMENTATION PLAN AND DELIVERABLES

22. Program Terms and Conditions

A. Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.

B. Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of Overpayments.

Exhibit A, Attachment 19
COMMUNITY BASED ADULT SERVICES (CBAS)

1. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

A. Contractor shall ensure that every ADHC Provider within their service area that has been approved by the California Department of Aging as a CBAS Provider as of July 1, 2012, is included in their Network, to the extent that the CBAS Provider remains licensed, certified, operating, and is willing to enter into a subcontract with Contractor on mutually agreeable terms and meets the Contractor's credentialing and quality standards.

B. If Contractor determines that additional CBAS Providers are necessary to meet the needs of its Members, Contractor may extend a contract to any CBAS Provider certified by the California Department of Aging after July 1, 2012. Contractor shall consider a Member's relationship with previous CBAS Providers when ensuring access to CBAS. Contractor shall not be required to include CBAS Providers that were certified by the California Department of Aging after July 1, 2012 in their Provider Network.

C. If Contractor determines that Member needs for CBAS exceeds Contractor's CBAS Provider capacity, Contractor shall arrange for access to unbundled services in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m.

D. Contractor shall include CBAS Provider information within the quarterly Provider Network Report submission in Exhibit A, Attachment 6, Provision 11.

E. Contractor may exclude any CBAS Provider from its Network, to the extent that the Contractor and CBAS Provider cannot agree to terms, the CBAS Provider does not meet Contractor's credentialing or quality standards, is terminated pursuant to the terms of the CBAS Provider's contract with Contractor, or otherwise ceases its operations as a CBAS Provider.

F. Contractor shall notify DHCS when unable to contract with a certified CBAS Provider or upon termination of a CBAS Provider contract:

1) If Contractor and a CBAS Provider cannot agree on mutually agreeable terms, the Contractor must notify DHCS within five (5) working days of the Contractor's decision to exclude the CBAS Provider from its Provider Network. DHCS will attempt to resolve the contracting issue when appropriate.

2) Contractor shall provide DHCS with notice of its termination of a CBAS Provider contract at least 60 days prior to the contract

termination effective date.

2. Covered Services

In addition to Exhibit A, Attachment 10, Provision 1, Covered Services and in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.f. and g., Contractor agrees to provide CBAS from October 1, 2012 through August 31, 2014, and shall:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS in accordance with Provision 4, Assessment and Reassessment of Community Based Adult Services.

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider.

C. Seek to offer CBAS as a bundled service through a certified CBAS Provider.

D. Arrange for the provision of unbundled services based on the assessed needs of the Member eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area. In accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m. unbundled services are limited to:

1) Services authorized by Contractor

a) Professional Nursing Services

b) Nutrition

c) Physical Therapy

d) Occupational Therapy

e) Speech and Language Pathology Services

f) NEMT only between the Member's home and the CBAS unbundled service Provider

2) Services coordinated by Contractor. In addition to the requirements for unbundled CBAS contained in this provision, and in accordance with Exhibit A, Attachment 11, Provision 5, Out-of-Network Case Management and Coordination of Care, Contractor shall coordinate care for unbundled CBAS, based on the assessed needs of the member eligible for CBAS, that are not covered services, including:

a) Personal Care Services

b) Social Services

c) Physical and Occupational Maintenance Therapy

d) Meals

e) Mental Health Services

E. If a Member has been determined CBAS eligible by DHCS and is receiving care from a CBAS Provider pending assessment by the Contractor, Contractor shall continue the provision of CBAS until an assessment has been completed in accordance with Provision 4, Assessment and Reassessment of Community Based Adult Services.

F. Contractor shall not impede or delay Member access to Medicare Providers or services through its provision of CBAS or ECM.

3. Enhanced Case Management

Contractor shall provide ECM benefits in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 92.b. and in addition to Exhibit A, Attachment 11, Provision 1, Comprehensive Case Management Including Coordination of Care Services.

A. Contractor shall ensure the provision of Enhanced Case Management (ECM) services from April 1, 2012, through August 31, 2014 to Members who received Adult Day Health Care (ADHC) services from Medi-Cal at any time between July 1, 2011 and February 29, 2012 and who are determined to be ineligible for CBAS.

B. A Member determined to be eligible for ECM may at a later date be determined eligible for CBAS. If the Member receives CBAS, the Member will no longer receive ECM. If at a later time the Member no longer receives CBAS, the Member will then be eligible to receive ECM.

C. A Member eligible for ECM who receives CBAS at some time between April 1, 2012 and August 31, 2014, is eligible to receive ECM for any time

period during which they do not receive the CBAS benefit. A Member shall not receive ECM and CBAS concurrently.

D. For Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS, Contractor shall continue to approve the provision of CBAS until ECM service referrals are made, a care plan has been developed, and Contractor has referred the Member to services as advised in the care plan.

E. Contractor may contract with a CBAS Provider or other appropriate entity for the provision of ECM services to eligible Members.

F. Contractor shall attempt to contact Members who had received ADHC services between July 1, 2011 and February 29, 2012 but are ineligible to receive CBAS a minimum of three (3) separate times to initiate ECM. If the Member refuses to engage in ECM or Contractor is unable to make contact with the Member after three (3) separate attempts, Contractor's obligation will have been met. Contractor shall provide ECM services in accordance with the requirements in this provision if the Member requests it after outreach effort obligations have been met.

4. Assessment and Reassessment for CBAS

Contractor shall ensure that the initial assessment and reassessment procedures for Members requesting CBAS, or who have previously been deemed eligible to receive CBAS, meet the following minimum requirements:

A. Contractor shall ensure appropriate staff responsible for conducting, managing, and/or training for an initial assessment or reassessment of Members for CBAS shall receive training from DHCS on using the approved assessment tool.

B. Contractor shall conduct the CBAS eligibility determination of a Member requesting CBAS using the assessment tool approved by DHCS. CBAS eligibility determinations shall include a face-to-face review of the Member. Contractor shall include a Registered Nurse with level of care experience and a social worker on the assessment team, either as an employee or as a sub-contractor.

C. Contractor shall develop and implement an expedited assessment process to determine CBAS eligibility when informed of Members in a hospital or skilled nursing facility whose discharge plan includes CBAS, or who are at high risk of admission to a skilled nursing facility.

D. Contractor shall reassess and redetermine the Member's eligibility for CBAS at least every six (6) months after initial assessment, or whenever a change in circumstances occurs that may require a change in the

Member's CBAS benefit.

E. If Member is already receiving CBAS and requests that services remain at the same level or be increased due to a change in level of need, Contractor may conduct the reassessment using only the Member's IPC, including any supporting documentation supplied by the CBAS Provider.

F. Contractor shall not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review performed by a Registered Nurse with level of care experience and utilizing the assessment tool approved by DHCS.

G. Contractor shall notify Members in writing of the CBAS assessment determination in accordance with the timeframes identified in Exhibit A, Attachment 13, Provision 8, Denials, Deferrals, or Modifications of Prior Authorization Requests. Contractor's written notice shall be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment 14, Member Grievance and Appeal System.

H. Contractor shall require that CBAS Providers complete a CBAS Discharge Plan of Care for any Members who have been determined to no longer need CBAS.

5. Required Reports for the CBAS Program

Contractor shall submit to DHCS the following reports 30 calendar days following the end of the reporting quarter and in a format specified by DHCS.

A. Contractor shall report to DHCS the number of Members who received ADHC services from July 1, 2011 to February 29, 2012 and have been determined ineligible to receive CBAS and have received ECM services, within the specified reporting time period.

B. Contractor shall report to DHCS how many Members have been assessed for CBAS, the total number of Members currently being provided with CBAS, both as a bundled or unbundled service.

C. In addition to the requirements set forth in Exhibit A, Attachment 13, Provision 3, Call Center Reports, Contractor shall also include a review of any complaints surrounding the provision of CBAS benefits.

D. In addition to the requirements set forth in Exhibit A, Attachment 14, Provision 3, Grievance Log and Grievance Quarterly Reports, Contractor shall also include reports on the following areas:

1) Appeals related to requesting CBAS and inability to receive those

services or receiving more limited services than requested

2) Appeals related to requesting a particular CBAS Provider and inability to access that Provider

3) Excessive travel times to access CBAS

4) Grievances regarding CBAS Providers

5) Grievances regarding Contractor assessment and/or reassessment.

6. Payment Rates to CBAS Providers

A. All CBAS Providers, whether contracted or not, will be reimbursed for providing the CBAS benefit between July 1, 2012 and August 31, 2014 at the rate described below, minus ten percent, except in exempted Medical Service Study Areas, which will receive the rates below:

1) Comprehensive multidisciplinary evaluation - $80.08 per evaluation.

2) Community-Based Adult Services, adult - $76.27 per day.

3) Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter - $64.83 per encounter.

B. Contractor shall not be required to pay more than the Medi-Cal fee schedule as detailed in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91.m. for unbundled CBAS.

Exhibit A, Attachment 20
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

1. Outpatient Mental Health Services Providers

In addition to Exhibit A, Attachment 6, Provider Network, Provision 1. Network Capacity, Contractor shall also include Outpatient Mental Health Services Providers in its Provider Network in accordance with 42 CFR 438.206, 207, and 208, as applicable. The number of Outpatient Mental Health Services Providers shall be adequate to serve Members within its Service Area and provide covered Outpatient Mental Health Services benefits. Contractor's Outpatient Mental Health Services Providers shall support current and desired service utilization trends for its Members.

A. Contractor shall increase the number of Outpatient Mental Health Services Providers within its Network as necessary to accommodate enrollment growth. Contractor may subcontract with any mental health care Provider within their scope of practice.

B. The number of Outpatient Mental Health Services Providers available shall be sufficient to meet referral and appointment access standards for routine care and shall meet the Timely Access Regulation per Healthy and Safety Code, Section 1367.03, Rule 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 4. Access Standards.

1) Contractor may subcontract with a county mental health plan to ensure access to Outpatient Mental Health Services. A subcontracted Network shall be deemed adequate upon submission and approval of Contractor's subcontract boilerplate for a county mental health plan.

2) In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12, Credentialing and Recredentialing, Contractor shall consider Outpatient Mental Health Services Providers as credentialed if the Provider has accreditation from NCQA.

3) In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12, Credentialing and Recredentialing, Contractor shall develop and maintain policies and procedures that ensure that the credentials of licensed Outpatient Mental Health Services Providers have been verified in accordance with 42 CFR 438.214 and APL 16-012.

4) Any time that a Member requires a Medically Necessary Outpatient Mental Health Service that is not available within the Provider Network, Contractor shall ensure access to Out-of-Network Providers and Telehealth mental health Providers as necessary to meet access requirements.

5) Contractor shall develop and implement policies and procedures for the exchange of Member information with the county mental health plan in order to facilitate referrals and care coordination. The policies and procedures shall cover:

a) Protected Health Information (PHI) with the county mental health plan for Specialty Mental Health Services, and if separate, the county department responsible for substance use treatment, including Member release of information forms that allow treatment history, active treatment, and health information.

b) Data sharing agreements with the county mental health plan for Specialty Mental Health Services, and if separate, the county department responsible for substance use treatment, including a Business Associate Agreement that addresses coordination of information related to mental health services and AMSC.

c) Data tracking of Members receiving Medi-Cal Outpatient Mental Health Services

2. Emergency Services

A. In addition to the requirements set forth in Exhibit A, Attachment 12, Local Health Department Coordination, Contractor shall have a Memorandum of Understanding (MOU) with the county mental health plan to refer Members in need of urgent and emergency care, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU shall be executed in accordance with the requirements specified in Exhibit A, Attachment 10, Scope of Services, and Exhibit A, Attachment 11, Case Management and Coordination of Care.

B. In addition to the requirement in the above provision, Contractor shall also ensure a Member access to a first response by their existing mental health Provider during an urgent care situation, when possible. Contractor shall allow the Member's mental health Provider to coordinate care with the county mental health plan or emergency room personnel for urgent care.

C. Contractor shall develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

3. Provider Network Reports

A. In addition to the requirements set forth in Exhibit A, Attachment 6, Provider Network, Provision 11. Provider Network Report, the Provider Network report shall identify the number of licensed mental health care Providers. The report shall include:

1) Mental health care Provider deletions and additions.

2) The percentage of Providers who deliver services through the Telehealth method, if applicable.

B. Contractor shall submit monthly reports on Outpatient Mental Health Services Providers for the first six (6) months of the implementation of this Amendment, or a new contract, and in a format specified by DHCS. Subsequent reports shall be consistent with the requirements of this Contract.

4. Outpatient Mental Health Care Services

A. Outpatient Mental Health Services are those services set forth in the Welfare and Institutions Code, Article 5.9, Section 14189, unless otherwise specifically excluded under the terms of this Contract.

B. In order to determine whether Outpatient Mental Health Services and substance use disorder services are Medically Necessary, Contractor shall apply the criteria of Medical Necessity as stated in APL 17-016 and 17-018.

C. Contractor shall cover Outpatient Mental Health Services and substance use disorder services that are within the scope of practice for licensed mental health care Providers as follows:

1) Individual/group mental health evaluation and treatment (psychotherapy);

2) Psychological testing when clinically indicated to evaluate a mental health condition;

3) Outpatient services for the purpose of monitoring drug therapy;

4) Psychiatric consultation;

5) Outpatient laboratory, supplies, and supplements; and

6) AMSC for alcohol use disorders.

D. Contractor shall cover an initial mental health assessment without requiring Prior Authorization and follow the authorization criteria outlined in

Exhibit A, Attachment 5 of this Contract for authorizing additional mental health and substance use disorder services.

E. Contractor shall develop and implement policies and procedures for mental health services provided by a PCP, including the following services:

1) AMSC for alcohol use disorders; and

2) Referrals for additional assessment and treatment.

F. Contractor shall develop and implement policies and procedures to define and describe what services are to be provided by a PCP or a licensed mental health care Provider. These policies and procedures shall cover the provision of the following services:

1) Individual/group mental health evaluation and treatment (psychotherapy);

2) Psychological testing when clinically indicated to evaluate a mental health condition;

3) Outpatient services for the purpose of monitoring drug therapy;

4) Psychiatric consultation, outpatient laboratory, supplies, and supplements; and

5) AMSC for alcohol use disorders.

G. If a Member becomes eligible for Specialty Mental Health Services during the course of receiving medically necessary Outpatient Mental Health Services, Contractor shall continue the provision of non-duplicative, Medically Necessary Outpatient Mental Health Services.

5. Alcohol and Substance Use Disorder Treatment Services

Contractor shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

Exhibit A, Attachment 21
MANAGED LONG-TERM SERVICES AND SUPPORTS

1. Extent of Requirements

This Attachment and the requirements herein are hereby incorporated in full into the Contract. The requirements included in this Attachment are specific to Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members receiving Medi-Cal benefits under the terms of this Contract. Neither Contractor nor DHCS shall interpret any of the requirements in this Attachment to apply to any Member that is not defined as a Full Benefit Dual Eligible Member, Partial Dual Eligible Members, and Medi-Cal Only Members.

2. Quality Improvement System

In addition to Exhibit A, Attachment 4, Quality Improvement System, Provision 12. Credentialing and Recredentialing, Contractor is not responsible for credentialing Multipurpose Senior Services Program (MSSP) Providers. Credentialing MSSP Providers is the responsibility of the California Department of Aging (CDA).

3. Utilization Management

Notwithstanding Exhibit A, Attachment 5, Utilization Management, Provision 2. Prior Authorizations and Review Procedures, Contractor shall not authorize MSSP services. Contractor shall refer Members who are potentially eligible for MSSP to MSSP Providers for authorization. Contractor shall collaborate and coordinate MSSP care management services with MSSP Providers.

4. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

A. Contractor shall ensure that every contracted Long Term Care (LTC) Provider and MSSP site within the Service Area approved by the California Department of Public Health (CDPH) and CDA as a qualified Provider is included in their Network, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a subcontract with Contractor on mutually agreeable terms and meets the Contractor's credentialing and quality standards.

B. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor may extend a contract or letter of agreement to any additional Providers certified by CDPH.

C. If Contractor determines that Member needs for LTC services exceed Contractor's Network capacity, Contractor shall arrange for access to Out-of-Network Providers in accordance with the requirements of this Contract as stated in Exhibit A, Attachment 9, Access and Availability, Provision 16.

Out-of-Network Providers.

D. In addition to the subcontract termination requirements in Exhibit A, Attachment 6, Provision 14. Subcontracts, and the Member notification requirements in Exhibit A, Attachment 13, Member Services, Provision 5. Notification of Changes in Access to Covered Services, Contractor shall notify DHCS upon termination of an LTC Provider contract:

1) If Contractor and an LTC Provider cannot agree on mutually agreeable terms, Contractor must notify DHCS within five (5) working days of Contractor's decision to exclude the LTC Provider from its Provider Network. DHCS will attempt to resolve the contracting issue when appropriate.

2) Contractor shall provide DHCS with notice of its termination of a contract with an LTC Provider at least 60 days prior to the contract termination effective date.

3) If termination of an LTC Provider contract is for a cause related to quality of care or patient safety concerns, Contactor may expedite termination of the LTC Provider contract and transfer Members to an appropriate, contracted LTC facility in an expeditious manner. DHCS shall be notified of the termination within 72 hours of said termination.

4) Contractor shall not continue to assign or refer Members to an LTC Provider during the 60 days between notifying DHCS and the contract termination effective date.

E. Any subcontract that Contractor enters into with a CDA qualified MSSP site, for either the provision of health care service or to perform an administrative function, shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the contract. DHCS shall acknowledge in writing the receipt of any subcontract sent to DHCS by Contractor for approval within five (5) working days of receipt. These subcontracts shall not be effective until written approval is provided by DHCS and CDA or by operation of law where DHCS has acknowledged receipt of the proposed subcontract, and has neither approved nor rejected the proposed subcontract within 60 calendar days of receipt.

1) Contractor shall also submit a subcontract for MSSP to DHCS for approval even if the Subcontractor has been previously approved by DHCS and CDA for another program.

2) Any new or updated subcontract that makes a material change to the subcontract must be re-submitted to DHCS. Previous subcontract approval shall be valid only until such time as the new or amended

subcontract is approved by DHCS and CDA.

F. Subcontract amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor rejected by DHCS and CDA shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the subcontract amendment, whichever is later.

5. Provider Relations

In addition to Exhibit A, Attachment 7, Provider Relations, Contractor shall include in regular Provider training key elements of operating a successful program for administering MLTSS, including such topics as the applicable assessment tools and processes, Person-Centered Planning, population specific training and self-direction, information technology, billing, and systems operations.

6. Provider Compensation Arrangements

In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements, Contractor also agrees to the following:

A. Skilled Nursing Facilities and Nursing Facilities (SNF/NF) claims are to be paid in accordance with Welfare and Institutions (W&I) Code Sections 14182.16 and 14186.3.

B. MSSP invoices submitted by subcontracted MSSP sites for MSSP services are to be paid in a timely manner upon verification of the accuracy and validity of the services invoiced therein, and in accordance with Contractor's subcontract with the MSSP site.

C. For MSSP services, Contractor must follow the processes pursuant to W&I Code Section 14186.3 (b)(7)(A).

7. Covered Services

Contractor shall provide MLTSS based on a Member's current assessment, conducted in accordance with the requirements of this Contract, and consistent with Person-Centered Planning. LTC, and MSSP are Covered Services under this Contract. In addition to Exhibit A, Attachment 10, Scope of Services, Contractor shall also cover MSSP and LTC in accordance with the following requirements:

A. Contractor shall cover Medically Necessary LTC from the time of admission into an appropriate facility to either the Member's release from the facility or to the Member electing to receive hospice services.

1) Contractor shall ensure that Members in need of LTC are placed in a facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include SNF/NF, subacute facilities, and Intermediate Care Facilities.

2) Contractor shall base decisions on the appropriate level of care on the definitions set forth in Title 22 CCR Sections 51118, 51120, 51120.5, 51121, 51124.5, and the criteria for admission set forth in Title 22 CCR Sections 51335, 51335.5, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22 CCR Section 51003(e).

3) Upon admission to an appropriate facility, Contractor shall assess the Member's health care needs and estimate the potential length of stay of the Member.

4) Contractor shall provide continuity of care for all Medically Necessary LTC services at non-contracting LTC facilities for those Full Benefit Dual Eligible Members, Partial Dual Eligible Members, and Medi-Cal Only Members residing in an LTC facility at the time of enrollment into Medi-Cal managed care. Contractor shall not require said Members residing in non-contracted facilities to relocate unless it is determined that relocation is Medically Necessary or if the non-contracted LTC facility does not meet the requirements set forth in Provision 8, Paragraph B of this Attachment.

B. Contractor shall cover MSSP in accordance with the eligibility determination as performed by the appropriate MSSP site, and ensure the provision of these services in accordance with the requirements set forth below in Provision 8. Coordination of Care.

1) Contractor shall not be required to determine Member eligibility to receive MSSP.

2) Contractor shall refer MSSP eligibility determination to the MSSP site for approval.

3) Contractor shall refer to the MSSP site for confirmation of Member eligibility and to verify if the Member has been enrolled in MSSP.

C. Contractor shall continue to cover MSSP for 19 months after the commencement of MSSP as a managed care benefit.

8. Coordination of Care

Exhibit A, Attachment 21
MANAGED LONG-TERM SERVICES AND SUPPORTS

In addition to Exhibit A, Attachment 11, Case Management and Coordination of Care, Contractor also agrees to the following:

A. Contractor shall maintain continuity of care for Members by recognizing any prior treatment authorization made by DHCS for not less than six (6) months following Member enrollment, in accordance with W&I Code Section 14186.3(c)(3).

B. Contractor shall provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member enrollment, or a LTC Provider with whom there is an existing relationship. This requirement shall include Out-of-Network Providers if there are no quality of care issues and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, per the continuity of care requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 16. Out-of-Network Providers.

C. Contractor shall assess risk level and needs for each new Full Benefit Dual Eligible and Partial Dual Eligible Member, as well as current Full Benefit Dual Eligible and Partial Dual Eligible Members upon request, by performing a risk stratification process in accordance with APL 17-012 and, with a particular focus on identifying those Members who may need CBAS, LTC and MSSP.

D. Contractor shall also assess risk level for each new Medi-Cal Only Member, as well as current Medi-Cal Only Members upon request, by performing a risk stratification process as set forth in APL 17-013 and in accordance with APL 17-012.

E. Contractor shall develop a health risk assessment for Medi-Cal Only Members as set forth in APL 17-013 and in accordance with APL 17-012.

F. Contractor shall retain and compile a copy of each assessment conducted on behalf of Full Benefit Dual Eligible and Partial Dual Eligible Members through MSSP, CBAS, and/or LTC. Contractor shall review these assessments and determine if any further care coordination of services for the Member is appropriate.

G. In accordance with W&I Code Section 14182.17(d)(3)(A), Contractor shall not assign a Full Benefit Dual Eligible Member to a PCP, unless it is determined through the risk stratification and assessment process that PCP assignment is necessary in order to properly coordinate the care of the beneficiary or upon the beneficiary's request. The determination to assign a Full Benefit Dual Eligible Member to a PCP shall be done in accordance with APL 14-015.

H. Contractor shall ensure that coordination of care services for Partial Dual

Exhibit A, Attachment 21
MANAGED LONG-TERM SERVICES AND SUPPORTS

Eligible Members and Medi-Cal Only Members reflect a person-centered, outcome-based approach and shall:

1) Follow the Member's direction about the level of involvement of their caregivers or medical Providers;

2) Coordinate medical care and CBAS, MSSP, IHSS, and LTC with a focus on transitions;

3) Coordinate with county agencies and Providers, if applicable, for necessary and appropriate behavioral health services; and

5) Follow the requirements for Person-Centered Planning set forth for SPD Beneficiaries in this Contract as stated in Exhibit A, Attachment 11, Case Management and Coordination of Care, Provision 1, Comprehensive Case Management Including Coordination of Care Services.

I. In accordance with applicable State quality assurance and utilization review standards as stated in this Contract, Contractor shall develop an Individual Care Plan (ICP) for newly enrolled and reassessed Medi-Cal Only Members who are high-risk, and shall also review ICPs developed by the MSSP for Full Benefit Dual Eligible Members and Partial Dual Eligible Members to determine if any further coordination or delivery of services is appropriate, pursuant to APL 17-012.

J. Contractor shall offer an Interdisciplinary Care Team (ICT) to all high-risk Medi-Cal Only Members when a need is demonstrated and in accordance with the Member's functional status, assessment, and the ICP. The ICT shall be offered in a manner as specified by DHCS in APL 17-012.

K. Contractor shall provide coordination of care services or ensure that they are performed by the health plan or delegated Provider care coordinators, in conjunction with the appropriate Network Providers including, but is not limited to Providers for behavioral health, CBAS, MSSP, and LTC.

L. Contractor shall coordinate referral with timely access to appropriate health care services and community resources through a system that is person and family centered, and allows Members to attain or maintain personal health goals per W&I Code Section 14132.275(f)(7). Contractor shall facilitate a Member's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services such as mental health and substance use disorders treatment services, and other needed medical or social services outside the managed care health plan's responsibilities in accordance with W&I Code Sections 14182.17(d)(4)(G) and (6)(B).

M. Contractor shall monitor skilled nursing utilization, and focus on providing services in the least restrictive setting and transitioning between facilities and the community.

N. Contractor shall coordinate with Medicare Providers as needed in the provision of CBAS, MSSP, or LTC, to the extent that Contractor is able.

O. DHCS shall authorize Contractor to receive Medicare claims data for any Full Benefit Dual Eligible Members and Partial Dual Eligible Members for the purpose of coordination of care and claims reimbursement.

1) DHCS shall provide the Medicare claims data through its Benefits Coordination and Recovery Center (BCRC).

2) Contractor shall be responsible for any coordination, testing, and implementation activities necessary to ensure that it is able to receive Medicare claims data from BCRC.

3) DHCS shall provide ongoing support through BCRC to aid Contractor in preparing and continuing to receive Medicare claims data.

4) Use of data is limited to the coordination and reimbursement of Med-Cal benefits and services provided to Members and not covered by Medicare in accordance with APL 13-001.

P. For the purpose of Care Coordination with Members receiving IHSS from the county, Contractor shall make best efforts to work with the county and CDSS to share confidential Member data, and to receive Member and Provider data related to the IHSS program when applicable. Data shall be shared and received only as legally authorized by the Member and to promote understanding of the Member's needs.

9. Member Services

A. In addition to Exhibit A, Attachment 13, Member Services, Provision 4, Written Member Information, Contractor shall include in its Provider Directory MSSP Provider sites and all contracted LTC Providers.

B. In addition to Exhibit A, Attachment 13, Member Services, Provision 7, Primary Care Provider Assignment, Contractor shall use FFS utilization data or other data sources, including electronic data, to establish existing Provider relationships for Partial Dual Eligible Members in order to arrange linkage to a Provider of Medicare outpatient services, should the Member not receive a Primary Care Provider, either through selection or assignment.

Exhibit A, Attachment 21
MANAGED LONG-TERM SERVICES AND SUPPORTS

10. Required Reports for Managed Long Term Services and Supports

Contractor shall submit to DHCS the following reports:

A. Contractor shall provide to DHCS a quarterly report on MLTSS. Contractor shall submit these reports in templates provided by DHCS. Templates are subject to revisions; DHCS will communicate updates via email to Contractor.

B. Contractor shall report to DHCS, on a monthly basis and in a format specified by DHCS, the number of continuity of care requests, and the outcomes of those requests, for Full Benefit Dual Eligible, Partial Dual Eligible, and Medi-Cal Only Members.

C. In addition to the requirements in Exhibit A, Attachment 6, Provider Network, Provision 11. Provider Network Report, Contractor shall include LTC Providers added to or deleted from Contractor's Provider Network, within the quarterly Provider Network Report submission.

D. In addition to the requirements set forth in Exhibit A, Attachment 13, Member Services, Provision 3. Call Center Reports, Contractor shall report to DHCS on calls related to Member satisfaction with LTC, CBAS, and MSSP within the quarterly Call Center Report submission. The quarterly Call Center Report shall also include calls related to MSSP Grievances and Appeals, and whether Contractor has referred any Grievances or Appeals to the MSSP site.

E. In addition to the requirements set forth in Exhibit A, Attachment 14, Member Grievance and Appeal System, Provision 3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report, Contractor shall also report to DHCS on a monthly basis the number and percentage of Grievances or Appeals that have been submitted in relation to a Member receiving LTC services. Contractor shall not be responsible for reporting Grievances, Appeals, or resolutions related to a Member receiving MSSP if they were reported to the MSSP site.

F. Contractor shall report to DHCS the number of Partial Dual Eligible or Medi-Cal Only Members who were assigned to a Primary Care Provider on a monthly basis and in a format specified by DHCS.

11. Risk Corridor

A. A risk corridor shall be established for a period of 24 months, effective April 1, 2014 and ending on March 31, 2016 for Full Benefit Dual Eligible Members, and applies to the provision of all Covered Services for Full Benefit Dual Eligible Members.

B. A risk corridor shall also be established for a period of 24 months, effective July 1, 2014 and ending on June 30, 2016 for Partial Dual Eligible Members and Medi-Cal Only Members, and applies only to the provision of MLTSS Covered Services and IHSS for Partial Dual Eligible Members and Medi-Cal Only Members.

C. Gains and losses are defined as the Capitated Revenues minus the sum of Adjusted Service Expenditures for applicable services, as described in Paragraphs A and B of this Provision, and Adjusted Non-Service Expenditures, with positive figures defined as gains and negative figures defined as losses. The risk sharing of the gains and losses shall be constructed by DHCS so that it is symmetrical with respect to risk and profit, and so that all of the following apply:

1) Contractor is fully responsible for any losses up to 1 percent of Capitated Revenues.

2) Contractor shall fully retain any gains up to 1 percent of Capitated Revenues.

3) Contractor and DHCS shall equally share responsibility for any losses in excess of 1 percent, but less than 2.5 percent, of Capitated Revenues.

4) Contractor and DHCS shall equally share any gains greater than 1 percent, but less than 2.5 percent, of Capitated Revenues.

5) DHCS shall be fully responsible for all losses in excess of 2.5 percent of Capitated Revenues.

6) DHCS shall fully retain all gains in excess of 2.5 percent of Capitated Revenues.

D. The risk-sharing arrangement described in this Provision may result in payment by DHCS to Contractor or by Contractor to DHCS. All payments to be made by DHCS to Contractor or by Contractor to DHCS will be calculated and determined by DHCS. All calculations determined by DHCS will be based on Contractor's capitation rate and enrollment data provided by DHCS for applicable Members as described in Paragraphs A and B of this Provision, and Contractor's Adjusted Services Expenditures and Adjusted Non-Service Expenditures for providing applicable services, as described in Paragraphs A and B of this Provision, to these Members.

1) All financial reporting will be subject to review and/or audit at DHCS' discretion. As applicable, all calculations will sum Capitated Revenues, Adjusted Services Expenditures and Adjusted Non-Service Expenditures for applicable services as described in

Paragraphs A and B of this Provision, across all counties in which Contractor operates as a Medi-Cal Managed Care Health Plan.

2) DHCS will determine Contractor's Adjusted Service Expenditures and Adjusted Non-Service Expenditures for applicable services as described in Paragraphs A and B of this Provision, based on Contractor's Actual Services Expenditures and Actual Non-Service Expenditures for these applicable services, Encounter Data, cost data, and financial reporting data, or other data submitted by Contractor either as required in this Contract or by DHCS for the risk-sharing arrangement described in this Provision.

3) DHCS and Contractor agree that, to the extent there are differences in Adjusted Services Expenditures and Adjusted Non-Service Expenditures for applicable services as described in Paragraphs A and B of this Provision, and Contractor's Actual Service Expenditures and Actual Non-Service Expenditures for these services across various sources, including the Encounter Data, cost data, financial reporting data, or other data submitted by Contractor, DHCS and Contractor will confer and make a good faith effort to reconcile those differences before the calculation of settlements.

4) Review procedures may include a review and/or audit of Contractor's Encounter Data to be performed by DHCS, or either party's authorized agents, to verify that all paid claims for Members by Contractor are for providing services to the population identified in this Provision and/or that Provider reimbursement is not excessive. DHCS will have the final decision on the resolution of any differences in the expenditures.

5) DHCS reserves the right to adjust expenditures for services that are reimbursed at more than 10 percent above the median reimbursement rate of all other Contractors within a region.

   a) For the purposes of this Contract, the region is defined as The Southern Counties Region, which includes Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties.

   b) If two (2) or fewer counties are operational within a region, experience from other counties would be considered in the establishment of the median rate.

E. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated parties within the same county for the purpose of determining actual expenditures.

Related parties are defined by Generally Accepted Accounting Principles.

12. Capitation Rate Structure for Full Benefit Dual Eligible Members

A. Underlying Rate Structure

The capitation rate will be paid as a single, blended capitation rate that accounts for the relative risk of Contractor's Full Benefit Dual Eligible Members and is weighted accordingly. These Members shall be segmented into three (3) separate and distinct population segments based on eligibility for rate setting purposes. These population segments are as follows:

1) Members eligible for Cal MediConnect, the State's duals demonstration;

2) Members covered by Contractor and under Medicare managed care; and

3) Members ineligible for Cal MediConnect, such as SPD beneficiaries determined to be high-risk.

B. Full Benefit Dual Eligible Members shall also be grouped into four (4) Member mix categories representing differing levels of risk. Effective January 1, 218, these categories are defined as follows:

1) Institutionalized: Members in LTC aid codes and/or residing in an LTC facility for 90 days or more;

2) CBAS and MSSP: Members meet one (1) or more of the following criteria:

a) Members who receive CBAS; or

b) Members who are clients of MSSP sites

3) IHSS Only (no CBAS or MSSP): Members who receive IHSS, but do not receive CBAS and are not clients of a MSSP site; and

4) Community Well: Members living in the community with no covered HCBS, are not residents in LTC facilities, and do not utilize CBAS, MSSP, or IHSS services.

C. The capitation rate will utilize the following payment methodology:

1) DHCS shall initially pay an estimated rate based on the assumed mix across the three (3) population segments and four (4) Member

mix categories. This assumed mix is impacted by a DHCS assumption related to the percentage of Members who will opt out of Cal MediConnect.

2) DHCS shall recalculate the blended rate based on the actual Full Benefit Dual Eligible Member distribution beginning no later than January 1, 2015 when actual Full Benefit Dual Eligible Member enrollment is known. The final rate based on the actual enrollment distribution will incorporate the same base rates by population segment and Member mix category as the original estimated rate. DHCS shall retain the ability to group Members into the three (3) population segments and four (4) Member mix categories.

3) The final Member mix calculations will be completed after the recalculation time frames, either monthly, quarterly, or annually as referenced in each respective Phase identified in Paragraph D of this Provision.

4) Once DHCS has recalculated the blended rate, there may be additional payments by DHCS to Contractor or a recoupment of Overpayment from Contractor to DHCS.

D. The payment process will vary over three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.

1) Phase I: The recalculation of the final rate will be applied monthly and retroactively to match Contractor's actual enrollment. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the following fiscal quarter. For example, if Contractor operates in a county with a 12-month phase-in that began enrollment in April 2014, this phase would last through the end of March 2015.

2) Phase II: This phase will be for one (1) fiscal quarter. The recalculation of the final rate will be prospectively applied at the start of the quarter. Weighting of the three (3) population segments and four (4) Member mix categories will be based on the month preceding the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, if Contractor operates in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability.

3) Phase III: Contractor's capitation rates are based on a targeted, relative mix of Members and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year.

   a) Specific to Phase III, a targeted, relative mix will be projected by DHCS and its actuaries. This mix is designed to be achievable by Contractor, based on assumptions about Contractor's ability to promote community services and prevent or delay institutional placement.

   b) If the projected Member mix for Contractor for the year results in a greater than 2.5 percent impact to the Medi-Cal component of the capitation rate paid as compared to the capitation rate that would have been paid based on the actual Member mix, then Contractor and DHCS would share equally in any increases or decreases beyond the 2.5 percent. Contractor's actual gain or loss does not factor into this calculation.

E. With the structure as described above, DHCS and its actuaries will establish actuarially sound capitation rates for this Contract for Full Benefit Dual Eligible Members eligible for MLTSS. These capitation rates will be consistent with 42 CFR 438.6(b)(1) and reviewed by the CMS. Capitation rates approved by CMS will serve as the baseline Medi-Cal costs.

F. DHCS and its actuaries will provide to CMS the underlying data for the capitation rate calculations associated with this Contract.

G. As allowed under the capitation rates for this Contract, DHCS and its actuaries will calculate a range of actuarially sound capitation rates, including lower bound and upper capitation rates.

H. Limited risk corridors will be applied as described for Contractor and be reconciled after application of any risk adjustment methodologies and any other adjustments.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Budget Detail and Payment Provisions

1. Budget Contingency Clause
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Capitation Rates
5. Capitation Rates Constitute Payment in Full
6. Determination of Rates
7. Redetermination of Rates-Obligation Changes
8. Reinsurance
9. Catastrophic Coverage Limitation
10. Financial Performance Guarantee
11. Recovery of Capitation Payments
12. Payment of Aids Beneficiary Rate
13. Medical Loss Ratio (MLR)
14. Adult Expansion Medical Loss Ratio and Risk Corridor
15. Supplemental Payments
16. Special Contract Provisions Related to Payment
17. Medicare Coordination

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

1. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor shall not be obligated to perform any provisions of this Contract. Further, should funding for any fiscal year be reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to:

1) Cancel this Contract with no liability occurring to the State and no further obligation by Contractor to perform, or

2) Offer an Agreement amendment to Contractor to reflect the reduced amount.

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

2. Amounts Payable

Any requirement of performance by the State and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

3. Contractor Risk In Providing Services

Contractor will assume the total risk of providing the Covered Services on the basis of the periodic Capitation Payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by the Contractor after having fulfilled obligations under this Contract will be retained by the Contractor.

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHCS. The capitation rate shall be the amount specified below. The payment period for health care services shall commence on the first day of operations, as determined by DHCS.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Capitation Payments shall be made in accordance with the following schedule of Capitation Payment rates at the end of the month. For aid codes see DEFINITIONS, Eligible Beneficiary:

For the period 07/01/15 – 06/30/16	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
Aged & Disabled Medi-Cal Only	
Disabled/Dual Eligible	
Aged/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
AIDS/Dual Eligible	
AIDS/Medi-Cal Only	
Maternity	
Adult Expansion	
Maternity Expansion	

For the period 07/01/16 – 06/30/17	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
Aged & Disabled Medi-Cal Only	
Disabled/Dual Eligible	
Aged/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
AIDS/Dual Eligible	
AIDS/Medi-Cal Only	
Maternity	
Adult Expansion	
Maternity Expansion	

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

For the period 07/01/17 – 06/30/18	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
SPD	
SPD/Dual Eligible	
Long Term Care/Full Dual Eligible	
Long Term Care/Non-Full Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
Hepatitis C/340B	
Hepatitis C/Non-340B	
HCBS High	
HCBS Low	
BHT/Ages 0-6	
BHT/Ages 7-20	

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

C. Pursuant to 42 CFR 438.6(b)(1), the actuarial basis for the computation of the Capitation Payment rates shall be set forth in DHCS' most recent version of the annually-published Rate Manual for the rate period that is identified above. Said Rate Manual is incorporated by reference in Exhibit E, Provision 1.

D. For Dual payment rates that are not identified in the schedule of Capitation Payment rates above, DHCS shall pay a capitated rate as stated in an M Letter sent to Contractor by DHCS. The M Letter shall serve as notification from DHCS to Contractor of the capitated rates for Dual payment rates not stated in this Contract, and the time period for which these rates will be applied. The M Letter shall not be considered exempt from any requirement of this Contract. The rates supplied in the M Letter will be adjusted within 30 days from the date of release.

E. By January 1, 2015, and annually thereafter, DHCS shall provide an amendment to this Contract to add Dual payment rates that have been sent to Contractor through the M Letter.

5. Capitation Rates Constitute Payment In Full

Capitation rates for each rate period, as calculated by DHCS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. DHCS is not responsible for making payments for recoupment of losses.

6. Determination Of Rates

A. DHCS shall determine the capitation rates for the initial period October 1, 2004 or the Contract effective date of Operations, through September 30, 2005 subsequent to September 30, 2005 and through the duration of the Contract. DHCS shall make an annual redetermination of rates in accordance with Title 22 CCR Section 53869 for each rate year defined as the 12-month period from July 1 through June 30. DHCS reserves the right to establish rates on an actuarial basis for each rate year. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Once DHCS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by DHCS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through an amendment/change order to this Contract in accordance with the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements, subject to the following provisions:

1) The amendment/change order shall be effective as of July 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that an amendment/change order may not be processed in time to permit payment of new rates commencing July 1, the payment to Contractor shall continue at the rates stated in an R Letter sent to the Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be

applied. The R Letter shall not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon CMS final approval of the amendment/change order and rate certification, providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

   a) Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval of the new rates.

   b) Any Overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the Capitation Payment for that month, amounts up to 25 percent shall be withheld from successive Capitation Payments until the Overpayment is fully recovered by the State.

4) If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 2005 resulting from a rate change pursuant to this Provision 6 or Provision 7 below, Contractor shall retain the right to terminate the Contract, but no earlier than September 30, 2006. Notification of intent to terminate a Contract shall be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor. DHCS shall pay the capitation rates last offered for that rate period until the Contract is terminated.

5) DHCS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or Provision 7, below at the earliest possible time prior to implementation of the new rate.

7. Redetermination Of Rates - Obligation Changes

The capitation rates may be adjusted during the rate year to provide for a change in obligations that results in an increase or decrease of more than one percent of

cost (as defined in Title 22 CCR Section 53869) to the Contractor. Any adjustments shall be effectuated through a change order to the Contract subject to the following provisions:

A. The change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS.

B. In the event DHCS is unable to process the change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the change order providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made.

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

8. Reinsurance

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

9. Catastrophic Coverage Limitation

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

10. Financial Performance Guarantee

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

11. Recovery Of Capitation Payments

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

A. If DHCS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area, or pursuant to Title 22, Section 53891(a)(2), or should have been disenrolled with an effective date in a prior month, DHCS may recover the Capitation Payments made to Contractor for the Member for the months in question. To the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor shall inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

   Upon request by Contractor, DHCS may allow Contractor to retain the Capitation Payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision 18. Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by DHCS. If Contractor retains the Capitation Payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, Provision 3, Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory Federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. DHCS may recover the amounts disallowed by DHHS by an offset to the Capitation Payments made to Contractor. If recovery of the full amount at

one time imposes a financial hardship on Contractor, DHCS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

C. If DHCS determines that any other erroneous or improper payment not mentioned above has been made to Contractor, DHCS may recover the amounts determined by an offset to the Capitation Payment made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, DHCS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. At least 30 calendar days prior to seeking any such recovery, DHCS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

12. Payment Of AIDS Beneficiary Rate

A. Compensation at the AIDS Beneficiary Rate (ABR)

Subject to Contractor's compliance with the requirements contained in Subparagraph 1) below, Contractor shall be eligible to receive compensation at the ABR for AIDS Beneficiaries. Compensation to Contractor at the ABR for each AIDS Beneficiary shall consist of payment at the ABR less the capitation rate initially paid for the AIDS Beneficiary.

1) Compensation at the ABR shall be subject to the conditions listed below. Contractor's failure to comply with any of the conditions listed below for any request for compensation at the ABR on behalf of an individual AIDS Beneficiary for a specific month of enrollment shall result in DHCS' denial of Contractor's claim for compensation at the ABR for that individual AIDS Beneficiary for that specific month of enrollment. Contractor may submit a corrected claim, within the timeframes specified in Paragraph d. below, that complies with all the conditions listed below and DHCS shall reimburse Contractor at the ABR.

a) The ABR shall be in lieu of any other compensation for an AIDS Beneficiary in any month.

b) For AIDS Beneficiaries, Contractor shall be eligible to receive compensation at the ABR commencing in the month in which a diagnosis of AIDS is made and recorded, dated and signed by the treating physician in the AIDS Beneficiary's Medical Record.

c) Contractor shall submit an invoice to DHCS by the 25th day

of each month for claims for compensation at the ABR for AIDS Beneficiaries. The invoice shall include the following:

i. A list of all AIDS Beneficiaries identified by Medi-Cal numbers only for whom the Contractor is claiming compensation at the ABR. Member names shall not be used.

ii. The month(s) and year(s) for which compensation at the ABR is being claimed for each AIDS Beneficiary listed, sorted by month and year of service.

iii. The capitation rate initially paid for the AIDS Beneficiary for each month being claimed by the Contractor, the ABR being claimed, and the difference between the ABR and the capitation rate initially paid for the AIDS Beneficiary.

iv. The total amount being claimed on the invoice.

d) Invoices, containing originally submitted claims or corrected claims, for compensation at the ABR for any month of eligibility during the rate year beginning April 1, 2005, and ending September 30, 2005, or any rate year thereafter beginning October 1 and ending September 30, must be submitted by Contractor to DHCS no later than six (6) months following the end of the subject rate year.

e) Invoices shall include the Agreement Number and shall be submitted to:

California Department of Health Care Services
Managed Care Operations Division
Attn: Fiscal Analysis Unit
Mailing Address: See Exhibit A, Scope of Work, Provision 4

In addition, invoices shall:

i. Be prepared on company letterhead.

ii. Bear the Contractor's name as shown on the agreement.

iii. Be signed by an authorized official, employee or agent.

2) Contractor shall confirm Medi-Cal eligibility of AIDS Beneficiaries

prior to submission of the monthly invoice to DHCS. DHCS may verify the Medi-Cal eligibility of each Member for whom the ABR is claimed and adjust the invoiced amounts to reflect any capitation payments that have been previously made to Contractor for each Member prior to submission of the invoice required under Paragraph 1) c), above.

3) If DHCS determines that a Member for whom compensation has been paid at the ABR did not meet the definition of an AIDS Beneficiary, in a month for which the ABR was paid, DHCS shall recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Provision 11. Recovery of Capitation Payments, Paragraph C in this exhibit, DHCS shall give Contractor 30 calendar days prior written notice of any such offset.

B. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Chapter 4.5 (commencing with Section 927), Part 3, Division 3.6, of Title 2 of the Government Code.

C. Timely Submission of Final Invoice

1) A final undisputed ABR invoice shall be submitted for payment no more than 90 calendar days following the expiration or termination date of this Agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said ABR invoice should be clearly marked “Final Invoice - ABR”, thus indicating that all payment obligations of the State under this Agreement have ceased and that no further payments are due or outstanding.

2) The State may, at its discretion, choose not to honor any delinquent final ABR invoice if the Contractor fails to obtain prior written State approval of an alternate final ABR invoice submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.

3) The Contractor is hereby advised of its obligation to submit, with the final ABR invoice, a “Contractor’s Release (Exhibit F)” acknowledging submission of the final ABR invoice to the State and certifying the approximate percentage amount, if any, of recycled products used in performance of this agreement.

13. Medical Loss Ratio (MLR)

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

The Medical Loss Ratio (MLR) as described in this Provision shall be done in accordance with 42 CFR 438.8, and shall be considered separate and distinct from the Adult Expansion Medical Loss Ratio (AE-MLR) and risk corridor as required in Exhibit B, Provision 14 of this Contract.

A. Beginning July 1, 2017, Contractor shall calculate and report a MLR as stated in 42 CFR 438.8 and 438.604(a)(3), in a form and manner specified by DHCS.

B. The MLR experienced by Contractor in a MLR Reporting Year is the ratio of the numerator, as stated in Paragraph C of this Provision, to the denominator, as stated in Paragraph D of this Provision. A MLR may be increased by a Credibility Adjustment, in accordance with Paragraph F of this Provision.

C. The numerator of Contractor's MLR for a MLR Reporting Year is the sum of Contractor's incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities.

1) Contractor's Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract and meeting the requirements of 42 CFR 438.3(e).

ii. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

iii. Withholds from payments made to Network Providers.

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

v. Claims payments recoveries received due to subrogation.

vi. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

vii. Changes in other claims-related reserves.

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

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

i. Overpayment recoveries received from Network Providers.

ii. Prescription drug rebates received and accrued.

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

i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers.

ii. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in Section C, Paragraph 3 of this Provision.

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

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

i. Non-Claims Costs, which include (1) the amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and UM; and (3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR 438.3(e) and provided to Members. Also included are fines and penalties assessed by regulatory authorities.

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

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

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

a) Contractor activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).

b) Contractor activity related to any External Quality Review-related activity as described in 42 CFR 438.358(b) and (c).

c) Any Contractor expenditure that is related to health information technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in this Provision.

3) Contractor expenditures on activities related to fraud prevention as described in 45 CFR part 158, and not including expenses for fraud reduction efforts as stated in Section C, Paragraph 1.c) ii) of this Provision.

D. The denominator of Contractor's MLR for a MLR Reporting Year must equal the adjusted premium revenue. The adjusted premium revenue is Contractor's premium revenue minus Contractor's federal, state, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this Provision.

1) Premium revenue includes the following for the MLR Reporting Year:

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

b) One-time payments for Member life events as specified in this Contract.

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

d) All changes to unearned premium reserves.

e) Net payments or receipts related to risk sharing mechanisms

developed in accordance with 42 CFR 438.5 or 438.6.

2) Taxes, licensing, and regulatory fees for the MLR Reporting Year shall include:

   a) Statutory assessments to defray the operating expenses of any state or federal department.

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

   c) Federal taxes and assessments allocated to Contractor, excluding federal income taxes on investment income, capital gains, and federal employment taxes.

   d) State and local taxes and assessments including:

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

      ii. Guaranty fund assessments.

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

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

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

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

      i. Three percent (3%) of earned premium; or

      ii. The highest premium tax rate in the State, multiplied by Contractor’s earned premium in the State.

3) If Contractor is later assumed by another entity that becomes the new Contractor under this Contract, the new Contractor must report

the total amount of the denominator for the entire MLR Reporting Year, and no amount under this Paragraph for that year may be reported by the ceding Contractor.

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

1) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

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

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

F. Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible.

1) Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.

2) If a Contractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards in this Provision.

3) Contractor shall fulfill these requirements by using the base credibility factors that CMS publishes annually in accordance with 438.8(h)(4).

G. Contractor shall aggregate data by Eligible Beneficiary groups identified in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

H. MLR Reporting requirements.

1) Contractor shall submit a report to DHCS that includes at least the following information for each MLR Reporting Year:

a) Total incurred claims.

b) Expenditures on quality improvement activities.

c) Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5), (7), (8) and (b).

d) Non-Claims Costs.

e) Premium revenue.

f) Taxes, licensing, and regulatory fees.

g) Methodology(ies) for allocation of expenditures.

h) Any Credibility Adjustment applied.

i) The calculated MLR.

j) Any remittance owed to DHCS, if applicable.

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

l) A description of the method used to aggregate data.

m) The number of Member months.

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

3) Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days from the end of the MLR Reporting Year, or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current subcontracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor shall attest to the accuracy of the MLR calculation in accordance with requirements of this Provision when submitting the MLR report.

I. Contractor may be excluded from the requirements in this Provision in the first MLR Reporting Year of its operation. Contractor must then comply

with these requirements beginning with the next MLR Reporting Year in which it contracts with DHCS, even if the first MLR Reporting Year was not a full 12 months.

J. In any instance where there is a retroactive change to the Capitation Payments for a MLR Reporting Year and the MLR report has already been submitted to DHCS, Contractor shall re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new report meeting the reporting requirements in this Provision.

14. Adult Expansion Risk Corridor

A. Establishment of an Adult Expansion Risk Corridor (AE Risk Corridor), based on an Adult Expansion Medical Loss Ratio (AE-MLR)

For Adult Expansion Members, DHCS shall make additional assumptions to the benefit of both the State and Contractor for this AE Risk Corridor provision using an AE-MLR. DHCS shall perform AE-MLR calculations for the incurred periods stated below. Incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses.

1) DHCS shall perform AE-MLR calculations for the incurred periods of January 1, 2014 to June 30, 2015, the first period, July 1, 2015 to June 30, 2016, the second period, and July 1, 2016 to June 30, 2017, the third period, and July 1, 2017 to June 30, 2018, the fourth period.

2) For the first and second periods, DHCS or its designee will initiate the AE-MLR calculation no sooner than 12 months after the end of each incurred period. For the third period, DHCS or its designee will initiate the AE-MLR calculation no sooner than January 1, 2019. For the fourth period, DHCS or its designee will initiate the AE-MLR calculation on April 1, 2020.

3) DHCS will give consideration to paid claims data at least through June 30, 2016, for services incurred during the first period, at least through June 30, 2017, for the second period, and at least through December 31, 2018, for the third period, and at least through March 31, 2020, for the fourth period.

4) Contractor shall provide and certify the AE Risk Corridor data and shall be subject to review or audit by DHCS or its designee

a) For the fourth period, attestations will not be considered acceptable forms of documentation except when determined appropriate by DHCS in the following limited instances:

i. Attestations specific to the methodology used to calculate Excluded Federal Taxes and Assessments and Excluded State Taxes and Assessments; and

ii. Attestations specific to the classification of related and non-related party expenses.

b) All other attestations will be disallowed for this period. This documentation expectation does not impact the requirement for Contractor's Chief Executive Officer or Chief Financial Officer to certify that data, documentation, and information submitted for the AE Risk Corridor data is accurate, complete, and truthful for the MLR period.

5) The AE Risk Corridor provision applies to this Contract only and will end with capitation and incurred dates as of June 30, 2018.

B. AE-MLR

This Contract shall provide an AE Risk Corridor pertaining to AE-MLR for Adult Expansion Members.

1) Contractor shall be required to expend at least 85 percent of Net Capitation Payments received on Allowed Medical Expenses for Adult Expansion Members, for each rating region. If Contractor does not meet the minimum 85 percent AE-MLR threshold for a given rating region, then Contractor shall return to the State the difference between 85 percent of total Net Capitation Payments and actual Allowed Medical Expenses incurred for each rating region as directed by DHCS.

2) After completion of the AE-MLR calculation, if it is determined that Contractor's AE-MLR is less than 85 percent for a given rating region, then DHCS will notify Contractor of the Capitation Payments to be returned to the State.

3) Contractor shall remit to the State the full amount due within 90 calendar days of the date DHCS provides notice to Contractor of that amount.

4) Contractor protection is included for Allowed Medical Expenses above 95 percent of the total Net Capitation Payments received by Contractor for Adult Expansion Members, for each rating region.

a) If Contractor's AE-MLR exceeds 95 percent of total Net Capitation Payments under this Contract for a given rating region, then DHCS shall make additional payment to

Contractor.

b) This additional payment from DHCS to Contractor will be the difference between the Contractor's Allowed Medical Expenses and 95 percent of Net Capitation Payments received for that rating region.

c) DHCS shall remit this payment to Contractor within 90 days of completion of this calculation or within 90 days of approval to claim the additional federal funds, whichever is later.

5) If the AE-MLR is between 85 percent and 95 percent, then there will not be an AE Risk Corridor adjustment from Contractor to DHCS or from DHCS to Contractor.

C. Final Rates of Payment

For Adult Expansion Members, the actual payment rate for providing Covered Services under this Contract may differ from the rates initially included in this Contract, or the negotiated rate.

1) Actual payments may be adjusted if an adjustment is required subject to the provisions of this AE Risk Corridor methodology. Both Contractor and DHCS agree to accept the final payment levels that result from the AE Risk Corridor methodology calculation.

2) As a payment corridor, it is explicitly provided that this payment provision may result in payment by Contractor to DHCS or by DHCS to Contractor.

3) In the event of a change in capitation rate for Adult Expansion Members, for each period provided in this Provision, an AE Risk Corridor calculation in accordance with the requirements of this Provision shall be re-determined.

4) Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by Contractor to DHCS or by DHCS to Contractor.

D. AE Risk Corridor Disputes

Contractor shall have the opportunity to appeal a determination, through an appeal process defined by DHCS, that the 85 percent AE-MLR threshold has not been met and provide evidence that the required minimum has been met.

15. Supplemental Payments

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

A. Contractor shall be entitled to supplemental payments stated within this Provision, based on the payment schedules identified within Exhibit B. Contractor must maintain on file evidence of payment for qualified services entitling them to the supplemental payment. Failure to have supporting records may, upon audit, result in recoupment by DHCS of the supplemental payment.

1) On a monthly basis, by the twentieth (20th) calendar day following the end of each month and in a format specified by DHCS, Contractor shall submit a report for Medi-Cal Managed Care Supplemental Payments. This report shall identify the Members receiving services qualifying for supplemental payment and for whom the payment amount is being claimed.

2) When Contractor receives and submits data to DHCS:

a) Within 14 months of the month of service, Contractor will receive the full supplemental payment.

b) After the fourteenth month following the month of service, Contractor will not receive a supplemental payment.

B. Supplemental Maternity Payment

1) Contractor shall be entitled to receive a Supplemental Maternity Payment for Members enrolled with Contractor on the date of the delivery of a child, including retroactive enrollments.

2) The Supplemental Maternity Payment reimburses Contractor for the cost of delivery, and is in addition to the monthly Capitation Rate paid by DHCS to Contractor for the Member.

C. Hepatitis C Prescriptions

1) Contractor shall be paid a monthly supplemental payment based on a weekly rate for each Member who receives prescriptions for Hepatitis C (Hep C) drugs. Payments are based on the Member's utilization as reported by Contractor. The payment period for health care services shall commence on July 1, 2014.

2) Contractor shall receive a supplemental payment for each Member who receives prescriptions for Hep C drugs in addition to the monthly Capitation Payment.

D. Supplemental Rate Payments for Partial Dual Eligible and Medi-Cal Only Members

1) Contractor shall receive a monthly supplemental payment for each Partial Dual Eligible Member and Medi-Cal Only Member who is identified as being in one of the Member mix categories as described in this Provision.

2) Contractor shall receive a supplemental payment for each Partial Dual Eligible Member and Medi-Cal Only Member who meets the following criteria:

   a) Institutional: Members who reside in a nursing facility for 90 days or more and are identified by Contractor in a file per Section C of this Provision. Exceptions will include Members with a LTC aid code as identified in Exhibit E, DEFINITIONS, Eligible Beneficiary.

   b) HCBS High: Members who are at a high risk for institutionalization based on an IHSS classification of "Severely Impaired", or are in the MSSP 1915(c) Waiver, or are receiving CBAS as defined by Contractor.

   c) HCBS Low: Members who have an IHSS classification of "Not Severely Impaired".

3) Supplemental payments for Partial Dual Eligible and Medi-Cal Only Members shall be made in accordance with the existing schedule of Capitation Payment rates at the end of the month. Payments for Members identified as Institutional cannot exceed the rate as stated in this Provision and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service. Payments for Members identified as HCBS High or HCBS Low will be made in addition to any other monthly rate payments sent for the Member for the same month of service.

E. Supplemental Payment for BHT Services

Contractor shall be paid a monthly supplemental payment for each Member who receives BHT services. Payments shall be based on the Member's utilization as reported by Contractor in accordance with the requirements in Exhibit B. The payment period for health care services shall commence on September 15, 2014.

16. Additional Payments

A. Contractor shall be entitled to additional payments stated within this Provision, based on the payment schedules identified within Exhibit B. Contractor must maintain on file evidence of payment for qualified

services entitling them to the payment. Failure to have supporting records may, upon audit, result in recoupment by DHCS of any additional payments.

1) On a monthly basis, by the twentieth (20th) calendar day following the end of each month and in a format specified by DHCS, Contractor shall submit a report for additional payments. This report shall identify the Members receiving services qualifying for this payment and for whom the payment amount is being claimed.

2) When Contractor receives and submits data to DHCS:

   a) Within 14 months of the month of service, Contractor will receive the full payment.

   b) After the fourteenth month following the month of service, Contractor will not receive a payment.

B. American Indian Health Service Program Payment

1) Commencing on January 1, 2018, Contractor shall be entitled to receive an American Indian Health Service Program payment for Members qualified to receive services in accordance with Exhibit A, Attachment 8, Provision 7, Paragraph C of this Contract and who utilize such services on or after January 1, 2018.

2) The payment shall reimburse Contractor for the amount paid to American Indian Health Service Programs as required in Exhibit A, Attachment 8, Provision 7, Paragraph C of this Contract. Payments shall be based on Member utilization of qualifying services at American Indian Health Service Programs as reported by Contractor.

17. Special Contract Provisions Related to Payment

Contractor shall comply with 42 CFR 438.6 in a form and manner specified by DHCS.

18. Medicare Coordination

Pursuant to 42 CFR 438.3(t), Contractor shall enter into a Coordination of Benefits Agreement with the Medicare program through CMS, and agree to participate in Medicare’s automated claims crossover process for Full Benefit Dual Eligible Members.

Exhibit E
ADDITIONAL PROVISIONS

1. Additional Incorporated Provisions

The following Attachments 1 through 24 are incorporated herein and made a part hereof by this reference:

Attachment 1 - Organization and Administration of the Plan
Attachment 2 - Financial Information
Attachment 3 - Management Information System
Attachment 4 - Quality Improvement System
Attachment 5 - Utilization Management
Attachment 6 - Provider Network
Attachment 7 - Provider Relations
Attachment 8 - Provider Compensation Arrangements
Attachment 9 - Access and Availability
Attachment 10 - Scope of Services
Attachment 11 - Case Management and Coordination of Care
Attachment 12 - Local Health Department Coordination
Attachment 13 - Member Services
Attachment 14 - Member Grievance System
Attachment 15 - Marketing
Attachment 16 - Enrollments and Disenrollments
Attachment 17 - Reporting Requirements
Attachment 18 - Implementation Plan and Deliverables
Attachment 19 - Community Based Adult Services (CBAS)
Attachment 20 – Mental Health and Substance Use Disorder Benefits
Attachment 21 – Managed Long Term Services and Supports

2. Priority of Provisions

In the event of a conflict between the provisions of Exhibit E and any other exhibit of this Contract, excluding Exhibit C, the provisions of Exhibit E shall prevail.

Exhibit E, Attachment 1
DEFINITIONS

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

Actual Non-Service Expenditures means Contractor's actual amounts incurred for non-service expenditures, including both administrative and care management costs, for Full Benefit Dual Eligible Members, or for Partial Dual Eligible Members and Medi-Cal Only Members, as applicable, and excludes costs incurred by Contractor prior to the start of this Risk Corridor. Any reinsurance costs reflected will be net reinsurance costs.

Actual Service Expenditures means Contractor's actual amount paid for providing services to Full Benefit Dual Eligible Members, or for Partial Dual Eligible Members and Medi-Cal Only Members, as applicable, priced at Contractor fee level, and shall comprise of all Provider payments for services to this population, including risk-sharing arrangements or sub-Capitation Payments.

Adjusted Non-Service Expenditures means Contractor's Actual Non-Service Expenditures, adjusted to reflect the exclusion of costs greater than 125 percent of the non-medical cost per Member per month across all participating Contractors and including any consideration given to Contractor for any significant, non-typical membership mixes that may cause this exclusion to come into effect as well as the exclusion of reinsurance costs which is the net of reinsurance premiums; and adjustments resulting from DHCS' review of Contractor's non-service expenditures to address any inappropriate or excessive non-service expenditures, including executive compensation and stop loss expenditures.

Adjusted Service Expenditures means Contractor's Actual Service Expenditures adjusted to reflect the following reductions from any recoveries of other payers outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from Providers including adjustments to claims paid, and Member contributions to care; and adjustments resulting from DHCS' review of Contractor reimbursement methodologies and levels to address any excessive pricing.

Administrative Costs means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.

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

Adult Day Health Care (ADHC) Center means a facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department

pursuant to Title 22, Section 54105 of the California Code of Regulations.

Adult Expansion Medical Loss Ratio (AE-MLR) means the Allowed Medical Expenses for the Covered Services provided to Adult Expansion Members under this Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by Contractor, by rating region. The AE-MLR will be measured by the same rating region that was used in the development of the capitation rates paid to the Contractor, under this Contract. For the first, second and third periods, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. For the fourth period, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d).

If a Staff Model Contractor does not account for Allowed Medical Expenses specifically by line of business and uses an allocation methodology, the AE-MLR shall be the average AE-MLR of all other Medi-Cal Managed Care Health Plans operating within the rating region in which Contractor operates. In such cases, the Staff Model Contractor's AE-MLR shall be excluded from the average AE-MLR.

Adult Expansion Member means a Member enrolled in aid codes L1, M1, and 7U as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y). Expenditures for services provided to Adult Expansion Members qualify for the enhanced federal medical assistance percentage described in that section.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

AIDS Beneficiary means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.

Alcohol Misuse Screening and Counseling (AMSC) means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

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

Allowed Medical Expenses means Contractor's expenses incurred and accounted for

in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to Providers, Payments required by Directed Payment Initiatives and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the the first, second, and third periods, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments, are excluded. For the fourth period, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d), are excluded.

B. Global sub-capitationpayments made by Contractor, where entire Allowed Medical Expenses are shifted to another entity, gross or net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS of the Net Capitation Payment for consideration within Allowed Medical Expenses.

C. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated party Providers within the same ration region. Related parties are defined by GAAP.

All Plan Letter (APL) means a document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

American Indian means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes membership in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

American Indian Health Service Programs means Facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population within a defined geographic area, per Title 22, Section 55000.

Ambulatory Care means the type of health services that are provided on an outpatient basis.

Exhibit E, Attachment 1
DEFINITIONS

Appeal means a review by Contractor of an adverse benefit determination, which includes one of the following actions:

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

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

C) A denial, in whole or in part, of payment for a service;

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

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

Applied Behavioral Analysis (ABA) means the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

Autism Spectrum Disorder (ASD) means a developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.

Auxiliary Aids mean supports that allow disabled Members to receive and understand information and include, but are not limited to, the use of TTY/TDD, Braille, large font of at least 18-point, and American Sign Language interpreters.

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

Behavioral Health Treatment (BHT) means services approved in the State Plan such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions to prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat ASD, and include a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

Exhibit E, Attachment 1
DEFINITIONS

Beneficiary Assignment means the act of the California Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying an Eligible Beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, Provision 2.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients which is used by Contractors and Providers to verify Medi-Cal eligibility and health plan enrollment.

California Children's Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

California Children's Services (CCS) Eligible Conditions means a physically handicapping condition defined in Title 22 CCR Section 41800.

California Children's Services (CCS) Program means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

Capitated Revenues means the amount of Medi-Cal managed care Capitation Payments/revenues paid to Contractor by DHCS for all Covered Services provided to Full Benefit Dual Eligible, or for MLTSS Covered Services and IHSS provided to Partial Dual Eligible Members and Medi-Cal Only Members, whichever is applicable, across all counties in which Contractor operates as a Medi-Cal Managed Care Health Plan.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member enrolled under this Contract and based on the actuarially sound capitation rate for the provision of Covered Services, and made regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Catastrophic Coverage Limitation means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.

Exhibit E, Attachment 1
DEFINITIONS

Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Clean Claim means a claim that can be processed without obtaining additional information form the Provider of the service or from a third party.

Cold-Call Marketing means any unsolicited personal contact by the Contractor with a potential Member for the purpose of marketing (as identified within the definition of Marketing).

Community Based Adult Services (CBAS) means an outpatient, facility based service program that delivers Skilled Nursing Care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services as defined in the Medi-Cal 2020 Waiver, to Members who meet applicable eligibility criteria.

CBAS Discharge Plan of Care means a plan of care prepared by the CBAS Provider for Members who have been determined by Contractor or DHCS to no longer be eligible for CBAS and must include:

A. The Member’s name and ID number

B. The name(s) of the Member’s physician(s)

C. Date the Notice of Action was issued

D. Date the CBAS benefit will be terminated

E. Specific information about the Member’s current medical condition, treatments, and medications

F. A statement of how Enhanced Case Management services will be provided to the Member if eligible for these services

G. A statement of the Member’s right to file a Grievance or Appeal

H. A space for the Member or the Member’s representative to sign and date the Discharge Plan

CBAS Provider means an ADHC Center that provides CBAS to eligible Members and has been certified as a CBAS Provider by the California Department of Aging.

Complex Case Management means the systematic coordination and assessment of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating

the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Comprehensive Medical Case Management Services means services provided by a Primary Care Provider in collaboration with the Contractor to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for an Eligible Beneficiary. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

Confidential Information means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

Contract means this written agreement between DHCS and Contractor.

Contracting Providers means a physician, nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.

Corrective Actions means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.

Cost Avoid means Contractor requires a Provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the Provider for the services rendered.

County Department means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

Covered Services means Medical Case Management and those services set forth in Title 22 CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17 CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

A. Services for major organ transplants as specified in Exhibit A, Attachment 11, Provision 18.

B. Home and Community Based Services (HCBS) Waiver Program Services as specified in Exhibit A, Attachment 11, provisions 14 and 21 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an EPSDT service services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.*

Exhibit E, Attachment 1
DEFINITIONS

C. California Children's Services (CCS) as specified in Exhibit A, Attachment 11, Provision 9.

D. Specialty Mental Health Services as specified in Exhibit A, Attachment 11, Provision 6.

E. Specialty Mental Health Services provided by psychiatrists; psychologists; licensed clinical social workers; or marriage, family, and child counselors.

F. Alcohol and substance use disorder treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, Provision 7.

G. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, Provision 8.

H. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, Provision 16.

I. Dental services as specified in W & I Code Sections 14132(h), 14131.10, 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in Title 22 CCR Section 51340.1(b). *However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, Provision 15 regarding dental services.*

J. Chiropractic services as specified in Title 22 CCR Section 51308.

K. Prayer or spiritual healing as specified in Title 22 CCR Section 51312.

L. Local Education Agency (LEA) assessment services as specified in Title 22 CCR Section 51360(b) provided to a Member who qualifies for LEA services based on Title 22 CCR Section 51190.1.

M. Any LEA services as specified in Title 22 CCR Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22 CCR Section 51360.

N. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of California Department of Public Health.

O. Pediatric Day Health Care.

P. Personal Care Services.

Exhibit E, Attachment 1
DEFINITIONS

Q. State Supported Services.

R. Targeted case management services as specified in Title 22 CCR Sections 51185 and 51351, and as described in Exhibit A, Attachment 11, Provision 3.

S. Childhood lead poisoning case management provided by county health departments.

T. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded psychiatric drugs.

U. Human Immunodeficiency Virus (HIV) and AIDS drugs that are listed in the Medi-Cal Provider Manual, MCP: Two-Plan Model, Capitated/Noncapitated Drugs section, which lists excluded HIV/AIDS drugs.

V. Optional benefits as set forth in Welfare and Institutions Code Section 14131.10, as implemented by the Medi-Cal Fee-For-Service program.

W. Non-medical services provided by Regional Centers to individuals with developmental disabilities, including but not limited to, respite, out-of-home placement, and supportive living.

X. End of life services as stated in Health and Safety Code Section 443 et seq., and APL 16-006.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Credibility Adjustment means an adjustment to the MLR when Contractor is Partially Credible to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Delivery means a live birth that generates a Vital Record for the State of California.

Department of Health and Human Services (DHHS) means the Federal agency responsible for management of the Medicaid program.

Directed Payment Initiative means a CMS-approved payment arrangement described in 42 CFR 438.6(c) that directs certain expenditures made by Contractor under this Contract.

California Department of Health Care Services (DHCS) means the single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention

(CHDP), and other health related programs.

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

Diagnosis of AIDS means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the Federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, (DHHS) and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

Director means the Director of the California Department of Health Care Services.

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

Disproportionate Share Hospital (DSH) means a health facility licensed pursuant to Health and Safety Code, Chapter 2, Division 2, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to Welfare and Institutions Code, Section 14105.98.

Durable Medical Equipment (DME) means Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7S, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9, 5C, 5D, E6, E7, H1, H2, H3, H4, H5, M5,	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 86, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K

Exhibit E, Attachment 1
DEFINITIONS

	T1, T2, T3, T4, T5	
Family/Dual Eligible	0E, 30, 32, 33, 34, 35, 37, 38, 39, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)		0N, 0P, 0W
Long Term Care/Full Dual Eligible	13, 23, 63	
Long Term Care/ Non-Full Dual Eligible	13, 23, 63	
SPD/Dual Eligible	10, 14, 16, 17, 1E, 1H, 1X, 1Y, 20, 24, 26, 27, 2E, 2H, 36, 60, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6W, 6X, 6Y	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusions apply to all the above:

A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.

B. Individuals who have commercial HMO coverage. Individuals with Medicare FFS coverage are not excluded from enrolling under this Contract.

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

A. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

B. Serious impairment to bodily function.

C. Serious dysfunction of any bodily organ or part.

Emergency Medical Transportation means ambulance services for an Emergency Medical Condition, and includes emergency air transportation.

Emergency Services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish those services and that are needed to evaluate or stabilize an emergency medical condition.

Encounter means any single medically related service rendered by (a) medical Provider(s) to a Member enrolled with Contractor during the date of service. It includes, but is not limited to, all services for which Contractor incurred any financial liability.

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

Enhanced Case Management (ECM) means a service for Members who received ADHC services from July 1, 2011 through February 29, 2012 but were deemed ineligible for CBAS, consisting of Complex Case Management and Person-Centered Planning services including the coordination of eligible Medi-Cal beneficiaries' individual needs for the full array of necessary long-term services and supports including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the Member and/or the Member's designees.

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

Excluded Federal Taxes and Assessments means all federal taxes and assessments allocated to health insurance coverage, including but not limited to federal income taxes and the Patient Centered Outcomes Research Institute (PCORI) Fee.

Excluded Service means a service that is covered by the Medi-Cal program but is not covered by Contractor because it is carved out of Contractor's contractual obligations for the provision of Covered Services.

Excluded State Taxes and Assessments means:

A. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State as applicable under this Contract;

B. Guaranty fund assessments;

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

D. State income, excise, and business taxes other than premium taxes;

E. State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes; and

F. Payments made by a Federal income tax exempt issuer for community benefit expenditures, to the extent allowed pursuant to 45 CFR 158.162(b)(1)(vii).

External Accountability Set (EAS) means a set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.

External Quality Review means an analysis and evaluation by the EQRO of aggregated information on quality, timeliness and access to the Covered Services that Contractor or its Subcontractors furnish to Members, as referenced for related activities in Exhibit A, Attachment 4 of this Contract.

External Quality Review Organization (EQRO) means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a state's Medicaid managed care plans, meets the competence and independence requirements set forth in 42 CFR 438.354, and is contracted with DHCS to perform External Quality Reviews and other related activities per 42 CFR 438.358.

Facility means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract, or

B. Maintained by a Provider to provide services on behalf of Contractor.

Federal Financial Participation means Federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 USC Section 1396d(l)(2)(B)).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC Section 300e).

Exhibit E, Attachment 1
DEFINITIONS

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal Providers are paid directly by the State for services not covered under this Contract.

Fee-For-Service Medi-Cal Mental Health Services (FFS/MC) means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

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

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

Financial Statements means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.

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

Full Benefit Dual Eligible Member means a Member who is 21 years of age or older, is eligible for Medi-Cal and for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) and Medicare Part B (42 U.S.C. Sec. 1395j et seq.) but who does not fall under any of the Adult Expansion aid codes.

Fully Credible means a standard, determined annually when CMS publishes base credibility factors specifying the number of Member months necessary for Contractor’s experience to be to be deemed Fully Credible, where Contractor’s experience is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. If Contractor’s experience is Fully Credible, it will not receive a credibility adjustment to its MLR.

General and Administrative Expenses means expenses as defined in Title 28 CCR Section 1300.78. These expenses are not part of Allowed Medical Expenses, but are part of Net Capitation Payments.

Grievance means an oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or Contractor’s employee, failure to respect a Member’s rights regardless of whether remedial action is requested, and the

right to dispute an extension of time proposed by Contractor to make an authorization decision.

Health Insurance Providers Fee (HIPF) means an annual fee starting in 2014 and paid by covered entities that provide health insurance for United States health risks during each year as described under Section 9010 of the Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Health Maintenance Organization (HMO) means an organization that is not a Federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

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

HEDIS® Compliance Audit means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

Individualized Plan of Care (IPC) means a written plan designed to provide the Member determined to be eligible for CBAS with appropriate treatment in accordance with the assessed needs of the Member.

In-Home Support Services (IHSS) means services provided to Members by the County in accordance with the requirements set forth in W & I Code Section 14186.1(c)(1), and Article 7 of the W & I Code, commencing with Section 12300 of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.

Intermediate Care Facility (ICF) means a Facility which is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22 CCR Section 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Joint Commission on the Accreditation of Health Care Organizations (JCAHO) means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates

HMOs and is administrated by the DMHC, commencing with, Health and Safety Code Section 1340.

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

Long-Term Care (LTC) means care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.

Managed Long Term Services and Support (MLTSS) means services and supports provided by Contractor to Members who have functional limitations and/or chronic illnesses and which have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. In this Contract, MLTSS includes CBAS, LTC, MSSP, and SNFs, to the extent Contractor is at-risk for covering SNF services.

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

Marketing Materials means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.

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

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

Medi-Cal Managed Care Health Plan means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

Medi-Cal Managed Care Plan Taxes mean the extension of the State sales tax to sellers of Medi-Cal Managed Care plans for the privilege of selling Medi-Cal related health care services at retail in California as described under Revenue and Taxation Code Sections 6174 through 6189, and any successor State managed care organization provider tax applicable to Contractor.

Medi-Cal Only Member means a Member who is eligible for only Medi-Cal and

receives CBAS, MSSP, or LTC services from Contractor.

Medi-Cal Provider Manual means the multi-part document published and maintained by DHCS at http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp. The Manual includes program overviews, eligibility requirements, billing and claiming requirements, and instructions relating to specific programs and Provider types.

Medical Home means a place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support care management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I Code 14182(c)(13)(B).

Medical Loss Ratio (MLR) Reporting Year means a period of 12 months rating period established by DHCS.

Medical Records means written documentary evidence of treatments rendered to plan Members.

Medically Necessary or **Medical Necessity** means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members receiving MLTSS, Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services.

When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v).

Member means any Eligible Beneficiary who has enrolled in the Contractor's plan. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member."

Member Evaluation Tool (MET) means the information collected from a Health Information Form (HIF), a high-level initial assessment completed by Members at the time of enrollment through which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. For newly enrolled SPD beneficiaries Contractor must use the MET as part of the health risk assessment process.

Exhibit E, Attachment 1
DEFINITIONS

Minimum Performance Level refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

A. Sexual assault, including rape.

B. Drug or alcohol abuse for children 12 years of age or older.

C. Pregnancy.

D. Family planning.

E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

Multipurpose Senior Service Program (MSSP) means the Waiver program that provides social and health care management to a Member who is 65 years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.

National Committee for Quality Assurance (NCQA) is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

NCQA Licensed Audit Organization is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

Net Capitation Payments means for the first, second and third periods Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. For the fourth period, Contractor's capitation revenues, including amounts related to Directed Payment Initiatives, less designated amounts included in capitation rates that Contractor is required to pay to Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d). For all periods. Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with GAAP.

Exhibit E, Attachment 1
DEFINITIONS

Network means PCPs, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that Subcontract with Contractor for the delivery of Medi-Cal Covered Services.

Network Provider means a Provider that subcontracts with Contractor for the delivery of Medi-Cal Covered Services.

Newborn Child means a child born to a Member during her membership or the month prior to her membership.

Non-Claims Costs means those expenses for administrative services that are not incurred claims, expenditures on activities that improve health care quality, licensing and regulatory fees, or federal and state taxes.

Non-Credible means a standard, determined annually when CMS publishes base credibility factors specifying the number of Member months necessary for Contractor's experience to be deemed Non-Credible, where Contractor's experience is determined to be insufficient for the calculation of a MLR.

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

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

Non-Physician Medical Practitioners (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

Non-Quantitative Treatment Limitation (NQTL) means a limit on the scope or duration of benefits.

Notice of Action (NOA) means the notification of an adverse benefit determination that is sent by Contractor to a Member in accordance with the notice and timing requirements set forth in 42 CFR 438.404.

Exhibit E, Attachment 1
DEFINITIONS

Not Reported means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

Nurse means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Other Healthcare Coverage Sources (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, Federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Out-of-Network Provider means a Provider that does not participate in Contractor's Network.

Outpatient Care means treatment provided to a Member who is not confined in a health care facility.

Outpatient Mental Health Services means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions requiring services not covered by the county mental health plan as specialty mental health services, including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

Overpayment means any payment made by Contractor to a Network Provider to which the Network Provider is not entitled to under Title XIX of the Act or any payment to Contractor by DHCS to which Contractor is not entitled to under Title XIX of the Act.

Partially Credible means a standard, determined annually when CMS publishes base credibility factors specifying the number of Member months necessary for Contractor's experience to be determined Partially Credible, where Contractor's experience is sufficient for the calculation of a MLR, but with a non-negligible chance that the difference between the actual and target MLRs is statistically significant. If Contractor's experience is Partially Credible, it will receive a credibility adjustment to its MLR.

Partial Dual Eligible Member means a Member who is 21 years of age or older and is eligible for Medi-Cal, and who is also eligible for benefits under either Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.).

Pediatric Subacute Care means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital

bodily function. Medical Necessity criteria are described in the Physician's Manual of Criteria for Medi-Cal Authorization.

Performance Improvement Projects (PIPs) means studies selected by Medi-Cal Managed Care Health Plans, either independently or in collaboration with DHCS and other participating Medi-Cal Managed Care Health Plans, to be used for performance improvement purposes. The studies include four (4) phases and may occur within a 24-month time frame.

Person-Centered Planning means an ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences. Person-centered planning is an integral part of Basic and Complex Case Management and Discharge Planning.

Physician means a person duly licensed as a physician by the Medical Board of California.

Physician Incentive Plan means any compensation arrangement between Contractor and a physician or a physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

Policy Letter means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated changes in State or Federal statutes or regulations, or pursuant to judicial interpretation.

Post-Payment Recovery means Contractor pays the Provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

Potential Enrollee means a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.

Prescription Drug means a drug and/or medication that can only be accessed by prescription.

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

Primary Care means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to Specialists focusing on specific needs.

Primary Care Physician (PCP) means a physician responsible for supervising,

coordinating, and providing initial and primary care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD beneficiaries, a PCP may also be a Specialist or clinic in accordance with W & I Code 14182 (b)(11).

Primary Care Provider means a person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician (PCP) or Non-Physician Medical Practitioner.

Prior Authorization means a formal process requiring a Provider to obtain advance approval of Covered Services Medically Necessary and to what amount, duration, and scope, except in the case of an emergency.

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

Provider Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Provider. DHCS considers Provider complaints and appeals the same as a Provider Grievance.

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

Quality Improvement (QI) means the result of an effective Quality Improvement System.

Quality Improvement System (QIS) means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

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

Quality Indicators means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

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

Rural Health Clinic (RHC) means an entity defined in Title 22 CCR Section 51115.5.

Exhibit E, Attachment 1
DEFINITIONS

Safety-Net Provider means any Provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the Provider. Examples of Safety-Net Providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; Rural and American Indian Health Service Programs; disproportionate share hospitals; and public, university, rural, and children's hospitals.

Seniors and Persons with Disabilities (SPD) means Medi-Cal beneficiaries who fall under specific SPD aid codes as defined by the department (See Eligible Beneficiary).

Service Area means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated zip Codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.

Service Authorization Request means a Member's request for the provision of a Covered Service.

Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

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

Skilled Nursing Facility (SNF) means, as defined in Title 22 CCR Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home," or "nursing facility."

Specialist means a Physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

Specialty Care Center means a center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

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

Exhibit E, Attachment 1
DEFINITIONS

Specialty Mental Health Service means:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

B. Psychiatric inpatient hospital services;

C. Targeted Case Management;

D. Psychiatrist services;

E. Psychologist services; and

F. EPSDT Specialty Mental Health Services.

Staff Model Contractor means a Health Maintenance Organization (HMO) that directly employs salaried Providers, and its Providers who only practice out of the HMO's buildings, and who may only provide services to its own Members.

Staff Model Providers means a Staff Model Contractor that has subcontracted with Contractor to provide Covered Services to Contractor's Members.

Standing Referral means a referral by a Primary Care Physician to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

State means the State of California

State Supported Services means those services that are provided under a different contract between the Contractor and the Department.

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

Subcontract means a written agreement entered into by the Contractor with any of the following:

A. A Provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the

Exhibit E, Attachment 1
DEFINITIONS

Contractor's obligations to DHCS under the terms of this Contract.

Subcontractor means an individual or entity who has a Subcontract with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract with DHCS.

Sub-Subcontractor means any party to an agreement with a Subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

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

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

Third Party Tort Liability (TPTL) means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

Traditional Provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital Providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

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

participating Providers. Providers contracting with the Contractor are eligible to participate in this program.

Working day(s) mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, Provision 14. Governing Law, the following provisions apply:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law. Except for Provision 16. Sanctions, and Provision 17. Liquidated Damages below, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of Provision 14, Paragraph C. Termination – Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. Unless otherwise specified in this Contract, Contractor shall comply with all applicable provisions of the California Medicaid State Plan, and any current and applicable amendments thereto. The State Plan and all State Plan Amendments can be viewed at:

www.dhcs.ca.gov/formsandpubs/laws/Pages/CalforniStatePlan.aspx

D. Contractor shall comply with all existing final PLs and APLs issued by DHCS. Final PLs and APLs can be viewed at:

www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx

1) All PLs and APLs issued by DHCS subsequent to the effective date and during the term of this Contract shall provide clarification of

Contractor's obligations pursuant to this Contract, and may include instructions to Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

2) In the event there is an inconsistency between this Contract as stated in Paragraph B above and a DHCS APL or PL, the Contract shall prevail.

E. Unless otherwise specified in this Contract, Contractor shall comply with all current and applicable provisions of the Medi-Cal Provider Manual, unless the Medi-Cal Provider Manual conflicts with this Contract, APLs, and/or any applicable federal or State laws, regulations, in which case the specific terms of this Contract, the APL, or the applicable law will apply.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

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

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the Contract. The parties agree that the

development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, Federal guidelines, or judicial interpretation, DHCS may direct the Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place.

DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

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

5. Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor

Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of the Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the Contractor to all agreements reached with DHCS.

Contractor shall designate Contractor's Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 10, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Managed Care program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or Providers to participate in the Medi-Cal Managed Care Program reside with DHCS.

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

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

7. Fulfillment of Obligations

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

8. Obtaining DHCS Approval

Contractor shall obtain written approval from DHCS, as provided in Exhibit E, Attachment 3, Provision 5. DHCS Approval Process, prior to commencement of operation under this Contract.

DHCS reserves the right to review and approve any changes to Contractor's protocols, policies, and procedures as specified in this Contract.

9. Certifications

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

A. Contractor shall certify all data, information, and documentation submitted to DHCS pursuant to 42 CFR 438.604, APL 17-005, and as listed below, in a form and manner specified by DHCS:

1) Encounter Data;

2) Data used by the State to certify actuarial soundness of capitation rates;

3) Medical Loss Ratio (MLR) data as set forth in 42 CFR 438.604(a)(3);

4) Provisions against risk of insolvency as set forth in 42 CFR 438.604(a)(4);

5) Documentation described in 42 CFR 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

6) Contractor's information on ownership and control, including its Subcontractors;

7) The annual report of Overpayment recoveries as required in 42 CFR 438.608(d)(3); and

8) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. Certification must comply with the requirements of 42 CFR 438.606 and must attest that, based on Contractor's best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 is accurate, complete, and truthful.

C. In addition to Exhibit C, Provision 11. Certification Clauses, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

10. Notices

A. All Notices

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

California Department of
Health Care Services
Managed Care Operations Division
Attn: Contracting Officer
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413

B. Notification of Intent Not to Renew

If Contractor is a Local Initiative, should either DHCS or the Local Initiative elect not to renew this Contract, this decision will be conveyed in writing to the other party at least 12 months prior to the expiration of this Contract.

11. Term

A. The Contract will become effective [redacted] and will continue in full force and effect through [redacted] subject to the provisions of Exhibit B, Provision 1. Budget Contingency Clause, the Centers for Medicare and Medicaid Services waiver approval, and Exhibit D(F), Provision 3. Federal Contract Funds.

B. If the Contractor has not already begun Operations, the term of the Contract consists of the following three periods: 1) The Implementation Period; 2) The Operations Period shall commence at the conclusion of the Implementation Period, subject to DHCS acceptance of the Contractor's readiness to begin the Operations Period. The term of the Operations Period is subject to the termination provisions of Provision 14, Termination, and Provision 16, Sanctions, and subject to the limitation provisions of Exhibit B, Provision 1, Budget Contingency Clause; and 3) The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to Provision 13, Contract Extension, in which case the Phaseout Period shall apply to the six (6) month period beginning with the first day after the end of the Operations Period, as extended.

C. If Contractor has begun Operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The Term of the Operations Period is subject to the

termination provisions of Provision 14, Termination, and Provision 16, Sanctions, below and subject to the limitation provisions of Exhibit B, Provision 1, Budget Contingency Clause. The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to Provision 13, Contract Extension, below, in which case the Phaseout Period shall apply to the six (6) month period beginning with the first day after the end of the Operations Period, as extended.

12. Service Area

The Service Area covered under this Contract includes:

[redacted] Counties

All Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and still remain in effect for others with each Service Area having its own Operations and Phaseout periods.

13. Contract Extension

DHCS will have the exclusive option to extend the term of the Contract for any Service Area during the last twelve (12) months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. DHCS may invoke up to five (5) separate extensions of up to twelve months each. The Contractor will be given at least nine (9) months prior written notice of DHCS' decision on whether or not it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the extension within five (5) working days of the receipt of the notice from DHCS.

14. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7. Termination for Cause, Contractor also agrees to the following:

A. Termination - State or Director

DHCS may terminate performance of work under this Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

1) Notification shall be given at least six (6) months prior to the effective date of termination, except in cases described below in Paragraph B. Termination for Cause.

2) If DHCS awards a new contract for one or more of the Service

Areas to another Contractor during one of the amendment periods as described above in Provision 13. Contract Extension, DHCS shall provide the Contractor written notification at least six (6) months prior to termination to allow for all Phaseout Requirements to be completed.

B. Termination for Cause

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) DHCS shall terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act (42 USC Section 1396), or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code Sections 1340 et seq.) by giving written notice to the Contractor. The termination will be effectuated consistent with the provisions of Title 22 CCR Section 53873. Notification will be given by DHCS at least 60 calendar days prior to the effective date of termination.

3) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to Paragraph B, item 3) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 18, Disputes. Termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides Contractor with at least 60 calendar days' notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days' notice is reasonable. Termination under this section does not relieve Contractor of its obligations under Provision 15. Phaseout Requirements below. Phaseout Requirements shall be performed after Contract termination.

C. Termination - Contractor

If mutual agreement between DHCS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 2005, Contractor shall retain the right to terminate the Contract, no earlier than

September 30, 2006, by giving at least six (6) months written notice to DHCS to that effect. The effective date of any termination under this section shall be September 30.

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the capitation rates determined by DHCS, or if DHCS decides to negotiate rates, failure to reach mutual agreement on rates; or (2) When a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this Contract, such that the Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At the request of DHCS, Contractor shall submit or otherwise make conveniently available to DHCS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by DHCS to evaluate Contractor's financial analysis.

DHCS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in Provision 15 below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

E. Notice to Members of Transfer of Care

At least 60 calendar days prior to the termination of the Contract, DHCS will notify Members about their medical benefits and available options.

15. Phaseout Requirements

A. DHCS shall retain the lesser of an amount equal to 10% of the last month’s Service Area Capitation Payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the Capitation Payment of the last

month of the Operations Period for each Service Area until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

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

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

90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, the Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any Subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for this Contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to DHCS all reports required in Exhibit A, Attachment 17, Reporting Requirements, for the period from the last submitted report through the expiration or termination date.

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

D. Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable items.

16. Sanctions

Contractor is subject to sanctions and civil penalties taken pursuant to Welfare and Institutions Code Section 14304 and Title 22 of the California Code of Regulations, Section 53872, however, such sanctions and civil penalties may not exceed the amounts allowable under 42 CFR, 438.704 and as stated in APL 18-003. If required by DHCS, Contractor shall ensure Subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of Members, and reporting, until DHCS determines that Contractor is again in compliance.

A. In the event DHCS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, DHCS may impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22 CCR Section 53872 as modified for purposes of this Contract. Title 22 CCR Section 53872 is so modified as follows:

   1) Subsection (b)(1) is modified by replacing “Article 2” with “Article 6”

   2) Subsection (b)(2) is modified by replacing “Article 3” with “Article 7”

B. The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of Title 22~~,~~ CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).

C. For purposes of Sanctions, good cause includes, but is not limited to, the following:

   1) Three (3) repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by DHCS.

   2) In the case of Exhibit A, Attachment 4 Quality Improvement System, the Contractor consistently fails to achieve the minimum performance levels, or receives a “Not Reported” designation on an External Accountability Set measure, after implementation of Corrective Actions.

   3) A substantial failure to provide Medically Necessary services required under this Contract or law to a Member.

   4) Non-compliance with the Contract or applicable federal and State law or regulation.

5) Contractor has accrued claims that have not or will not be recompensed.

D. Sanctions in the form of denial of payments provided for under this Contract for new Members shall be taken, when and for as long as, payment for those Members is denied by the CMS under 42 CFR Section 438.730.

E. The Director shall have the power and authority to take one or more of the following sanctions against Contractor for noncompliance:

1) Appointment of temporary management if Contractor has repeatedly failed to meet the contractual requirements or applicable Federal and State law or regulation. Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur.

2) Suspension of all new enrollment, including default enrollment, or marketing activities after the effective date of the sanction;

3) Require Contractor to temporarily suspend or terminate personnel or Subcontractors.

4) Take other appropriate action as determined necessary by DHCS.

17. Liquidated Damages

A. General

The Director shall have the authority to impose liquidated damages on Contractor for failure to comply with the terms of this Contract as well as all applicable Federal and State law or regulation. Therefore, it is agreed by the State and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result,

a) Proving such damages shall be costly, difficult, and time-consuming,

b) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements,

c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements,

d) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract,

e) DHCS may, at its discretion, offset liquidated damages from Capitation Payment owed to Contractor;

2) Imposition of liquidated damages as specified in Paragraphs B, Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, and C, Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period below shall follow the administrative processes described below.

3) Before imposing sanctions, DHCS shall provide Contractor with written notice specifying the nature of the sanctions and the Contractor requirement(s), contained in the Contract or as required by Federal and State law or regulation, not provided or performed,

4) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) working days from the date of the notice, unless, subject to the Contracting Officer's written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay and the proposed date of the submission of the requirement.

5) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, DHCS may impose liquidated damages for the amount specified in Paragraph B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, below.

6) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to DHCS' approval, within five (5) calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written

notice during the Corrective Action period, DHCS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in Paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, below.

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

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

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, below.

DHCS may impose liquidated damages of $25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in Provision 11. Term, above.

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

C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period shall at a minimum include:

1) DHCS may impose liquidated damages of $2,500 per day for each violation of Contract requirement not performed in accordance with Exhibit A, Attachment 4, Quality Improvement System, provision 10. Site Review, Paragraph D. Corrective Actions, until Contract requirement is performed or provided.

2) DHCS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with Provision 23 Third-Party Tort Liability.

3) DHCS may impose liquidated damages of $3,500 per violation of

Contract requirement not performed in accordance with Exhibit A, Attachment 6, Provider Network, Provision 9. Plan Physician Availability.

4) DHCS may impose liquidated damages not to exceed $10,000 per violation of this Contract's requirements, as well Federal and State law or regulation.

D. Conditions for Termination of Liquidated Damages

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

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from DHCS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other Contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

18. Disputes

In addition to Exhibit C, Provision 6. Disputes, Contractor also agrees to the following:

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

Filing a dispute will not preclude DHCS from recouping the value of the amount in dispute from Contractor or from offsetting this amount from subsequent Capitation Payment(s). If the amount to be recouped exceeds 25 percent of the Capitation Payment, amounts of up to 25 percent will be withheld from

successive Capitation Payment until the amount in dispute is fully recouped.

A. Disputes Resolution by Negotiation

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

B. Notification of Dispute

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

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

1) That it is a dispute pursuant to this section.

2) The date, nature, and circumstances of the conduct which is subject of the dispute.

3) The names, phone numbers, function, and activity of each Contractor, Subcontractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

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

5) The reason the Contractor is disputing the conduct.

6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.

7) The Contractor's desired remedy.

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

Following submission of the required notification, with supporting

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

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

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

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

   a) Countermand the earlier conduct which caused Contractor to file a dispute; or

   b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B Budget Detail and Payment Provisions, direct DHCS to comply with that Exhibit.

Or,

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

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

A copy of the decision shall be served on Contractor.

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

Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph F, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Provision 18, Disputes, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

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

If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer’s or Alternate Dispute Officer’s Decision above, the Contracting Officer’s or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to Paragraph D. shall be retroactive to the date of the Contracting Officer’s or alternative dispute resolution decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer’s or alternative dispute resolution decision or any appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 18, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

In addition to Exhibit C, Provision 4, Audit, Contractor also agrees to the following:

Pursuant to 42 CFR 438. 3(h), DHCS, CMS, the DHHS Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any of Contractor's, or its Subcontractors, records or documents and may, at any time, inspect the premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted. The right to audit under this Section exists for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

The Contractor will maintain such records and documents necessary to disclose how the Contractor discharged its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which the Contractor administered its daily business, and the cost thereof.

A. Records and Documents

These records and documents will include, but are not limited to, all physical books or records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHCS; financial records; all medical records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, Contractor and all of its Subcontractors shall maintain all of these records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later

C. Additional Recordkeeping Requirements

1) In accordance with 42 CFR 438.3(u), Contractor shall retain the following information for no less than 10 years:

a) Member Grievance and Appeal records as required in 42 CFR 438.416;

b) Base data as defined in 42 CFR 438.5(c);

c) MLR reports as required in 42 CFR 438.8(k); and

d) Data, information, and documentation specified in 42 CFR 438.604, 606, 608, and 610.

2) Contractor shall also require Subcontractors to be compliant, as applicable, with 42 CFR 438.3(u).

20. Inspection Rights

In addition to Exhibit D(F), Provision 2, Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall allow the DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, the DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' EQRO contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Contractor and Subcontractors pertaining to these services at any time, pursuant to 42 CFR 438.3(h).

Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor at any time.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of the Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all

aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, Subcontractor, and Provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the Subcontractor(s).

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 4, Confidentiality of Information, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its Subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical records in accordance with applicable law, (3) will not

disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et seq., Section 14100.2, W & I Code, and regulations adopted thereunder, and (4) will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Contractor by DHCS for this purpose.

22. Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a contract amendment.

23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor retains all monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

D. Cost Avoidance

1) If Contractor reimburses the Provider on a FFS basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for

services provided to Members with OHC codes A or N.

E. Post-Payment Recovery

1) If Contractor reimburses the Provider on a FFS basis, Contractor shall pay the Provider's claim and then seek to recover the cost of the claim by billing the liable third parties:

a) For services provided to Members with OHC code A;

b) For services defined by DHCS as prenatal or preventive pediatric services; or

c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.

2) In instances where Contractor does not reimburse the Provider on a FFS basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Reporting Requirements

1) Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. Reports shall be made available upon DHCS request.

2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within ten (10) calendar days of discovery in automated format as prescribed by DHCS. This information shall be sent to the California Department of Health Care Services, Third Party Liability Branch, Other Coverage Unit,

P.O. Box 997422, Sacramento, CA 95899-7422.

3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity

24. Third-Party Tort Liability

Contractor shall identify and notify DHCS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes Subcontractor and Out-of-Network Provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted Providers or Out-of-Network Providers for similar services.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14 digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Contractor name.

6) Provider name (if different from Contractor).

7) Dates of service.

8) Diagnosis code and description of illness/injury.

9) Procedure code and/or description of services rendered.

10) Amount billed by a Subcontractor or Out-of-Network Provider to Contractor (if applicable).

11) Amount paid by other health insurance to Contractor or Subcontractor (if applicable).

12) Amounts and dates of claims paid by Contractor to Subcontractor or Out-of-Network Provider (if applicable).

13) Date of denial and reasons for denial of claims (if applicable).

14) Date of death (if applicable).

C. Contractor shall identify to DHCS' Third Party Liability Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to the Third Party Liability Branch with the information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to the California Department of Health Care Services, Third Party Liability Branch, Recovery Section, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.

25. Records Related To Recovery for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its Subcontractors' possession, relating to threatened or pending litigation by or against DHCS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or

against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors related to this Contract or Subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment Provisions, DHCS agrees to pay Contractor for complying with Paragraph A, Records, above, as follows:

1) DHCS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with Paragraph A. Any third party assisting Contractor with compliance with Paragraph A above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with Paragraph A, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by DHCS.

2) If Contractor uses existing personnel and resources to comply with Paragraph A, DHCS shall reimburse Contractor as specified below. Contractor shall maintain and provide to DHCS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by DHCS.

a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph A.

b) Costs for copies of all documentation submitted to DHCS pursuant to Paragraph A, subject to a maximum reimbursement of ten (10) cents per copied page.

3) Contractor shall submit to DHCS all information needed by DHCS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

26. Fraud and Abuse Reporting

A. For purposes of this Exhibit, the following definitions apply:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2 and as further defined in W. & I. Code Section 14043.1(a).)

Conviction or **Convicted** means that a judgment of conviction has been entered by a federal, State, or local court, regardless of whether an appeal from that judgment is pending (42 CFR 455.2). This definition also includes the definition of the term "convicted" in W & I Code Section 14043.1(f)**.**

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law (42 CFR 455.2; W. & I. Code Section 14043.1(i).)

Waste means the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit.

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

1) Contractor and its Subcontractor, to the extent that its Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain procedures that are designed to detect and prevent Fraud, Waste, and Abuse. The procedures must include a compliance program, as set forth in 42 CFR 438.608(a), that at a minimum includes all of the following elements:

a) Written policies and procedures that articulate a commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements.

b) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract, and who reports directly to the

Chief Executive Officer and the Board of Directors.

c) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the compliance program and compliance with the requirements under this Contract.

d) A system for training and educating the Compliance Officer, senior management, and employees on federal and State standards and requirements of this Contract.

e) Effective lines of communication between the Compliance Officer and employees.

f) Enforcement of standards through well-publicized disciplinary guidelines.

g) Establishment and implementation of a system with dedicated staff for: routine internal monitoring and auditing of compliance risks; promptly responding to compliance issues as they are raised; investigation of potential compliance problems as identified in the course of self-evaluation and audits; correction of such problems promptly and thoroughly, or coordination of suspected criminal acts with law enforcement agencies to reduce the potential for recurrence; and ongoing compliance with the requirements under this Contract.

2) Prompt reporting to DHCS of all Overpayments identified or recovered, specifying which Overpayments are due to potential fraud.

3) Prompt notification to DHCS when Contractor receives information about changes in a Member’s circumstances that may affect the Member’s eligibility including the following:

a) Changes in the Member’s residence;

b) Changes in the Member’s income; and

c) The death of a Member.

4) Prompt notification to DHCS when Contractor receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the Medi-Cal managed care program, including the termination of their Provider agreement with Contractor.

5) Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members, and the application of this verification processes on a regular basis.

6) When Contractor makes or receives annual payments under this Contract of at least $5,000,000, provide written policies for all of its employees, and for any Subcontractor or agent, that provides detailed information about the False Claims Act and other federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

7) Fraud and Abuse Reporting

Prompt referral of any potential Fraud, Waste, or Abuse that Contractor identifies to the DHCS Audits and Investigations Intake Unit. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity.

Fraud reports submitted to DHCS must, at a minimum, include:

a) Number of complaints of fraud and abuse submitted that warranted preliminary investigation.

b) For each complaint which warranted a preliminary investigations, supply:
   i. Name and/or SSN or CIN;

   ii. Source of complaint;

   iii. Type of Provider (if applicable);

   iv. Nature of complaint;

   v. Approximate dollars involved; and

   vi. Legal and administrative disposition of the case.

The report shall be submitted on a Confidential Medi-Cal Complaint Report (MC 609) that can be sent to DHCS in one of three ways:

a) Email at PIUCases@DHCS.ca.gov;

b) E-fax at (916) 440-5287; or

c) U.S. Mail at:

Department of Health Care Services
Audits & Investigations Division
Attention: Chief, Intake Unit
1500 Capitol Avenue
MS 2500
Sacramento, CA 95814

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: police report, health plan's documentation (background information, investigation report, interviews, and any additional investigative information), Member information (patient history chart, Patient profile, Claims detail report), Provider enrollment data, Confirmation of services, list items or services furnished by the Provider, Pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

8) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.608(a)(8) and 438.610. Additionally, Contractor is prohibited from employing, paying, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). Contractor is deemed to have knowledge of any providers on these lists. Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 State working days of removing a suspended, excluded, or terminated provider from its Provider Network and confirm that the provider is no longer receiving payments in connection with the Medicaid program. A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three ways:

a) Email at PIUCases@DHCS.ca.gov;

b) E-fax at (916) 440-5287; or

c) U.S. Mail at:

Department of Health Care Services
Managed Care Operations Division
Attention: Chief, Program Integrity Unit
MS 4417
P.O. Box 997413
Sacramento, CA 95899-7413

C. Federal False Claim Act Compliance

Contractor shall comply with 42 USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this Provision, which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

27. Equal Opportunity Employer

Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

28. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not discriminate against Members or Eligible Beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract, discriminations on the grounds of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56 include, but are not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, of the participants to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, except where medically indicated. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member’s health.

C. Discrimination Complaints

Contractor agrees that copies of all Grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, ~~or~~ physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, will be forwarded to DHCS for review and appropriate action.

29. Federal Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act.

30. Disabled Veteran Business Enterprises (DVBE)

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.

31. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

32. Federal False Claims Act Compliance

Effective January 1, 2007, Contractor shall comply with 42USC Section 1396a(a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this Contract. Upon request by DHCS, Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor’s applicable written policies and procedures and any relevant employee handbook excerpts.

33. Disclosures

In accordance with 42 CFR 438.608(c), Contractor and any Subcontractors shall:

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

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

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

34. Treatment of Recoveries

A. Per 42 CFR 438.608(d)(1) relating to the treatment of recoveries made by Contractor of Overpayments to Providers, Contractor shall comply with guidelines issued by DHCS pertaining to:

1) The retention policies for the treatment of recoveries of all Overpayments from Contractor to a Provider, including for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse.

2) The process, timeframes, and documentation required for reporting the recovery of all Overpayments.

3) The process, timeframes, and documentation required to pay recoveries of Overpayments to DHCS when Contractor is not permitted to retain some or all of the recoveries of Overpayments.

4) This Provision does not apply to any amount of a recovery to be retained under the False Claims Act cases or through other investigations.

B. Contractor shall require and have a mechanism in place for a Network Provider to report to Contractor when it has received an Overpayment, to return the Overpayment to Contractor within 60 calendar days after the date the Overpayment was identified, and to notify Contractor in writing of the reason for the Overpayment, per 42 CFR 438.608(d)(2).

C. Contractor shall annually report to DHCS their recoveries of Overpayments per 42 CFR 438.608(d)(3).

D. In accordance with 42 CFR 438.608(d)(4), DHCS shall use the results of the information and documentation collected in Paragraph A.1) of this Provision, and the report in Paragraph C of this Provision, for setting actuarially sound capitation rates for Contractor consistent with the requirements in 42 CFR 438.4.

E. Contractor shall also comply with these requirements as directed in APL17-003.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

Exhibit E, Attachment 3
DUTIES OF THE STATE

1. Payment for Services

DHCS shall pay the appropriate Capitation Payment set forth in Exhibit B, Budget Detail and Payment Provisions, Provision 4. Capitation Rates to the Contractor for each eligible Member under this Contract, and ensure that such payments are based on actuarially sound capitation rates as defined in 42 CFR 438.4 and developed in accordance with standards specified in 42 CFR 438.5. Payments will be made monthly for the duration of this Contract. Any adjustments for Federally Qualified Health Centers will be made in accordance with W & I Code 14087.325.

2. Medical Reviews

DHCS shall conduct medical reviews in accordance with W & I Code 14456. DHCS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of DHCS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by DHCS in order to eliminate duplication of auditing efforts.

3. Enrollment Processing by DHCS

A. General

The parties to this Contract agree that the primary purpose of DHCS' Medi-Cal Managed Care System is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal FFS system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, and the lack of a current valid address for some beneficiaries. The parties desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of this entire Provision 3, below. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

B. Enrollment Processing Definitions

For purposes of this entire Provision 3. Enrollment Processing by DHCS, the following definitions shall apply:

Exhibit E, Attachment 3
DUTIES OF THE STATE

1) Fully Converted County means a county in which the following circumstances exist, except for those Medi-Cal beneficiaries covered by Title 22 CCR Section 53887:

   a) Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a) may no longer choose to receive Covered Services on a FFS basis; and

   b) All new Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a) must now choose a managed care plan or they will be assigned to a managed care plan; and

   c) All Eligible Beneficiaries listed in the Medi-Cal Eligibility Data System (MEDS) as meeting the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a) on the last date that both a. and b. above occur:

      i. Have been notified of the requirement to choose a managed care plan and informed that if they fail to choose a plan they will be assigned to a managed care plan; and

      ii. Those beneficiaries still eligible for Medi-Cal and enrollment into a managed care plan at the time their plan enrollment is processed in MEDS have been enrolled into a managed care plan.

2) Mandatory Plan Beneficiary means:

   a) A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a), both at the time her/his plan enrollment is processed by the DHCS Enrollment Contractor and by MEDS; or

   b) An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory enrollment criteria contained in Title 22 CCR Section 53845(a); or

   c) An Eligible Beneficiary meeting the criteria of Title 22 CCR Section 53845(b), and who subsequently meets the criteria

of Title 22 CCR Section 53845(a).

3) Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:

a) is eligible to receive Covered Services on a FFS basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, zip code or county code changes; or

b) becomes eligible for enrollment in a managed care plan on a retroactive basis.

C. DHCS Enrollment Obligations

1) DHCS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new Members, DHCS or its enrollment contractor shall enroll or assign Eligible Beneficiaries in Contractor's plan when selected by the Eligible Beneficiary or when the Eligible Beneficiary fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, DHCS will ensure that in a Fully Converted County a Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 calendar days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in Title 22 CCR Section 53845(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate changes and aid code changes, have been executed. DHCS will use due diligence in making any changes to MEDS and to this Contract. DHCS will provide Contractor a list of Members on a monthly basis.

2) DHCS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in Title 22 CCR Section 53845(a) to plans in accordance with Title 22 CCR Section 53884.

3) Notwithstanding any other provision in this Contract, Sub-Paragraphs 1) and 2) above shall not apply to:

a) Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management Plan and such plan's contract with DHCS expires, terminates, or is assigned or transferred to Contractor;

b) Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;

c) Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract;

d) Eligible Beneficiaries meeting the criteria of Title 22 CCR Section 53845(b), who subsequently meet the criteria of Title 22 CCR Section 53845(a) due solely to DHCS designating a prior voluntary aid code as a new mandatory aid code;

e) Eligible Beneficiaries residing in an excluded zip code area within a county that is not a fully converted county; or

f) Eligible Beneficiaries without a current valid deliverable address or with an address designated as a county post office box for homeless beneficiaries.

D. Disputes Concerning DHCS Enrollment Obligations

1) Contractor shall notify DHCS of DHCS' noncompliance with this Provision 3. Enrollment Processing pursuant to the requirements and procedures contained in Exhibit E, Attachment 2, Provision 18, Disputes.

2) DHCS shall have 120 calendar days from the date of DHCS' receipt of Contractor's notice (the "cure period") to cure any noncompliance with this Provision 3. Enrollment Processing, identified in Contractor's notice, without incurring any financial liability to the Contractor. For purposes of this section, DHCS shall be deemed to have cured any noncompliance with this Provision 3. Enrollment Processing, identified in Contractor's notice if within the cure period any of the following occurs:

a) Mandatory Plan Beneficiaries receive an effective date of plan enrollment that is within the cure period, or

b) DHCS corrects enrollment that failed to comply with this Provision 3. Enrollment Processing, by redirecting enrollment from one Contractor to another within the cure period in order to comply with this Provision 3. Enrollment Processing, or

c) Within the cure period, DHCS changes the distribution of beneficiary Assignment (subject to the requirements of Title

22 CCR Section 53845), to the maximum extent new beneficiaries are available to be assigned, to make up the number of incorrectly assigned beneficiaries as soon as possible.

3) If it is necessary to redirect enrollment or change the distribution of beneficiary Assignment due to noncompliance with this Provision 3. Enrollment Processing, and such change varies from the requirements of Title 22 CCR Section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with Sections 53884(b)(5) or (b)(6) after correcting a noncompliance with this Provision 3, Enrollment Processing.

4) Notwithstanding Exhibit E, Attachment 2, Provision 1, Governing Law or any other provision of this Contract, if DHCS fails to cure a noncompliance with this Provision 3, Enrollment Processing, within the cure period, DHCS will be financially liable for such noncompliance as follows:

DHCS will be financially liable for Contractor's demonstrated actual reasonable losses as a result of the noncompliance, beginning with DHCS' first failure to comply with its enrollment obligation set forth herein. DHCS' financial liability shall not exceed 15 percent of Contractor's monthly Capitation Payment calculated as if noncompliance with this Provision 3. Enrollment Processing did not occur, for each month in which DHCS has not cured noncompliance pursuant to Paragraph D. Sub-Paragraph 2) above, beginning with DHCS' first failure to comply with its enrollment obligation set forth herein.

5) Notwithstanding Paragraph D. Sub-Paragraph 4) above, DHCS shall not be financially liable to Contractor for any noncompliance with Provision 3. Enrollment Processing, in an affected county (on a county-by-county basis) if Contractor's loss of Mandatory Plan Beneficiaries, in a month in which any noncompliance occurs, is less than five percent of Contractor's total Members in that affected county in the month in which the noncompliance occurs. The parties acknowledge that the above-referenced five-percent threshold shall apply on a county-by-county basis, not in the aggregate.

4. Disenrollment Processing

DHCS shall review and process requests for disenrollment and notify the Contractor and the Member of its decision.

Exhibit E, Attachment 3
DUTIES OF THE STATE

5. DHCS Approval Process

A. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor pursuant to Exhibit E, Attachment 2, Provision 8, Obtaining DHCS Approval.

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to Exhibit E, Attachment 2, Provision 8, Obtaining DHCS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Paragraph shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to DHCS approval in accordance with Exhibit A, Attachment 6, Provision 13, Subcontracts, Paragraph C. regarding Departmental Approval – Non-Federally Qualified HMOs, and Paragraph D. regarding Departmental Approval – Federally Qualified HMOs.

6. Program Information

DHCS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 calendar days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, DHCS shall notify Contractor within 30 calendar days, in writing, of the reason for the delay and when Contractor may expect the information.

7. Catastrophic Coverage Limitation

DHCS shall limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

DHCS shall agree that there will be no risk limitation and that Contractor will have full financial liability to provide Medically Necessary Covered Services to Members.

Exhibit E, Attachment 3
DUTIES OF THE STATE

9. Notice of Termination of Contract

DHCS shall notify Members of their health care benefits and options available upon termination or expiration of this Contract.

10. Program Integrity

DHCS shall monitor during the Contract term on program integrity standards, in accordance with 42 CFR 438.602, and shall conduct the following:

A. Monitoring of Contractor, Subcontractors, and Network Providers for compliance as applicable with 42 CFR 438.604, 438.606, 438.608, 438.610, 438.230, and 438.808.

B. Review of the ownership and control disclosures submitted by Contractor and any Subcontractors as required in 438.608(c).

C. Confirm the identity and determine the exclusion status of Contractor, any Subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of this Contract, through routine checks of federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it must promptly notify Contractor and take action consistent with 42 CFR 438.610(c).

D. Periodically, but no less frequently than once every three (3) years, conduct, or contract for the conduct of, an independent audit of the Encounter Data and financial data submitted by, or on behalf of, Contractor.

E. Receive and investigate information from whistleblowers relating to the integrity of Contractor, Subcontractors, or Network Providers receiving federal funds.

F. Post on its web site as required in 42 CFR 438.602(g), the following documents and reports:

1) This Contract.

2) The data required in 42 CFR 438.604(a)(5).

3) The name and title of individuals included in 42 CFR 438.604(a)(6).

4) The results of any audits under Section E of this Provision.

G. Implement conflict of interest safeguards described in 42 CFR 438.58 and comply with the requirements described in this Provision.

H. Mental Health Parity

1) Monitor Contractor's compliance with mental health parity requirements in 42 CFR 438.900 et seq.

2) Ensure that Contractor, Subcontractors, and any contracted entities are not applying any financial or treatment limitations to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to medical/surgical benefits in the same classification.

The print out of this page should be discarded. The electronic version of this document page had “hidden” text with instructions to the user. Click on the “Show/Hide” or “¶” button to see the hidden text.

DO NOT DELETE THIS PAGE ELECTRONICALLY – It is coded to be “hidden” and the

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I. Recitals

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

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

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

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act.

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

II. Definitions

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

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

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

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

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

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

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

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

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

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

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

1. ***Specific Use and Disclosure Provisions***. Except as otherwise indicated in this Addendum, Business Associate may:

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

B. Prohibited Uses and Disclosures

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

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

C. Responsibilities of Business Associate

Business Associate agrees:

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

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

3. ***Security.*** To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

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

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

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

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

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

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

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

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the

requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

   a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or
   b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

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

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

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

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

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

H. ***Internal Practices****.* To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. ***Documentation of Disclosures****.* To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009.

Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

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

   a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and
   b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2. ***Investigation and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the

extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. ***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve the determination of whether a breach occurred and individual notifications are required, and the corrective action plan.

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

5. ***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

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

DHCS Program Contract Manager
DHCS Privacy Officer
DHCS Information Security Officer

See the Scope of Work exhibit for Program Contract Manager information
Privacy Officer
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413

Toll Free: (866) 866-0602
Telephone: (916) 445-4646
Email: privacyofficer@dhcs.ca.gov
Fax: (916) 440-7680

Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413

Email: iso@dhcs.ca.gov
Fax: (916) 440-5537

Telephone: ITSD Service Desk
(916) 440-7000 or
(800) 579-0874

K. *Termination of Agreement.* In accordance with Section 13404(b) of the

HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

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

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

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

IV. Obligations of DHCS

DHCS agrees to:

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

B. ***Permission by Individuals for Use and Disclosure of PHI***. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate’s permitted or required uses and disclosures.

C. ***Notification of Restrictions***. Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate’s use or disclosure of PHI.

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

V. Audits, Inspection and Enforcement

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

1. Failure to detect or

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

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

VI. Termination

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

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

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

C. ***Judicial or Administrative Proceedings****.* Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

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

VII. Miscellaneous Provisions

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

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

Exhibit G
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

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

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

C. ***Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

D. ***No Third-Party Beneficiaries.*** Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

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

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

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

H. ***No Waiver of Obligations***. No change, waiver or discharge of any liability or

obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit G, Attachment A

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I. Personnel Controls

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

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

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

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

II. Technical Security Controls

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

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

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

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

E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

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

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

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

H. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be wiped using the Gutmann or US Department of Defense (DOD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the DHCS Information Security Office.

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

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

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

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

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

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

III. Audit Controls

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

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

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

IV. Business Continuity / Disaster Recovery Controls

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

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

V. Paper Document Controls

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

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

C. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

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

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

BOARD LETTER FACT SHEET

Agenda Review Date: November 17, 2021
Board Meeting Date: November 30, 2021
Sup. Dist. / SPA No.: All SupervisorialDistricts

DRAFT

BOS Approval

DEPARTMENT: ***Mental Health***

SUBJECT: Request approval to amend the Sole Source Consultant Contract with the Steinberg Institute to increase the total contract amount and to extend the term for continued support to Los Angeles County.

I. PUBLIC BENEFIT (precise description, mandated or non-mandated)

A non-mandated consultation program that will strengthen the County's public mental health system by increasing efficiency in the delivery of community based services and consumer access.

II. RECOMMENDED ACTIONS (summarized)

Approve and authorize the Director of Mental Health (Director) to execute an amendment to the Contract with the Steinberg Institute to increase the Total Contract Amount (TCA) and to extend the term through fiscal year (FY) 2022-23. The TCA increase for FY 2021-22 is $275,000, and the TCA for FY 2022-23 (extension period) is $350,000.

Delegate authority to the Director to execute future amendments to: extend the term; provide administrative non-material changes; add additional/related services; modify or replace an existing Statement of Work and/or reflect federal, State, and County regulatory and/or policy changes, provided that: the County's total payment will not exceed an increase of more than 10 percent of the TCA; and to also terminate in accordance with the Contract's termination provisions.

III. COST AND FUNDING SOURCES

Cost: $275,000 (Increase in Total Contract Amount for FY 2021-22)

Funding: Mental Health Services Act and 2011 Sale Tax Realignment revenues

IV. BACKGROUND (critical and/or insightful)

As a strong partner and advocate for the County, the Steinberg Institute has championed that quality mental health care is not only a critical public policy, but also a civil rights issue. In fact, the Steinberg Institute facilitated the process to help the County to reform the mental health civil commitment system and strengthen the continuum of mental health care through initiatives such as the Mental Health Services Act and Mental Health Civil Commitment Reform. Efforts by the Steinberg Institute has targeted County's mental health system by (1) giving a voice to consumers or peers living with mental illness; (2) fighting for more resources and effective treatments; (3) building a more robust system of oversight and public/private partnerships that promises to improve research and bridge gaps in services.

V. POTENTIAL ISSUE(S)

n/a

VI. DEPARTMENT & COUNTY COUNSEL CONTACTS

Angel Baker, Division Chief of Program Development, Abaker@dmh.lacounty.gov, (213) 949-8843
Emily Issa, County Counsel, EIssa@counsel.lacounty.gov, (213) 974-1827

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

November 30, 2021

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 TO EXTEND THE SOLE SOURCE CONSULTANT CONTRACT WITH STEINBERG INSTITUTE TO CONTINUE TO SUPPORT LOS ANGELES COUNTY WITH INITIATIVES INVOLVING THE MENTAL HEALTH SERVICES ACT AND MENTAL HEALTH CIVIL COMMITMENT REFORM

(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval to amend the Sole Source Consultant Contract with the Steinberg Institute to increase the total contract amount and extend the term through June 30, 2023 for continued support to Los Angeles County with initiatives involving the Mental Health Services Act and Mental Health Civil Commitment Reform.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve and authorize the Director of Mental Health (Director), or designee, to prepare, sign, and execute an amendment (Attachment I) to the Contract with the Steinberg Institute to increase the Total Contract Amount (TCA) and extend the term through fiscal year (FY) 2022-23. The TCA increase for FY 2021-22 is $275,000, and the TCA for FY 2022-23 (extension period) is $350,000, fully funded by 2011 Realignment funds and Mental Health Services Act (MHSA) revenue.

2. Delegate authority to the Director, or designee, to prepare, sign, and execute future amendments to the Contract in Recommendation 1, including amendments that extend the term for up to two additional years, provide administrative non-material changes; provide or add additional/related services; modify or replace an existing Statement of Work; and/or reflect federal, State, or County regulatory and/or policy changes, provided that: the County's total payment will not exceed an increase of more than 10 percent of the TCA, and the amendments are subject to County Counsel's review and approval as to form, with notification to the Board and Chief Executive Office (CEO).

3. Delegate authority to the Director, or designee, to terminate the Contract described in Recommendation 1 in accordance with the termination provisions, including Termination for Convenience. The Director, or designee, will notify the Board and CEO, in writing, of such termination action.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The Steinberg Institute has been an invaluable partner assisting the Department of Mental Health (DMH) with enhancing system reform efforts which are intended to strengthen the mental health system, increase efficiency, and offer greater access to care to the largest number of residents throughout the County. As a powerful and effective advocate and problem solver for mental health care in California, the Steinberg Institute is uniquely qualified, with its sound working relationships with the State Legislature and Executive departments.

Approval of Recommendation 1 will allow DMH to increase the TCA and extend the term of the current Sole Source Consultant Contract with Steinberg Institute for the continued support to the County with initiatives involving the MHSA and Mental Health Civil Commitment Reform.

Approval of Recommendation 2 will allow DMH to make future amendments the Contract to extend the term, incorporate necessary changes, and/or modify the TCA.

Approval of Recommendation 3 will allow DMH to terminate the Contract in accordance with the Contract's termination provisions.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended actions are consistent with the County's Strategic Plan Goal I, Make Investments that Transform Lives, specifically Strategy I.1 — Increase Our Focus on Prevention Initiatives, and Strategy I.2 — Enhance Our Delivery of Comprehensive Interventions.

FISCAL IMPACT/FINANCING

For FY 2021-22, the increase to the TCA is $275,000, and is fully funded by MHSA and 2011 Sales Tax Realignment revenues. Sufficient funding is available in DMH's approved budget for FY 2021-22.

Funding for future fiscal years will be requested through DMH's annual budget request process. There is no increase in net County costs associated with the recommended actions.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

More than two million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California. In response to inadequate funding for mental health services, Darrell Steinberg co-authored Proposition 63, also called the Mental Health Services Act (MHSA). The MHSA includes a whatever-it-takes approach to support and provide services for people with severe mental illness.

In 2015, the Steinberg Institute was established as a first-of-its-kind statewide non-profit organization. It is dedicated to raising the profile of quality mental health care as a critical public policy and civil rights issue. The Steinberg Institute serves as a strong partner for the County in reforming the mental health civil commitment process and strengthening the continuum of mental health care, with an emphasis on community based mental health services, including supportive housing for those with serious mental illness who are homeless.

The partnership between the Steinberg Institute and DMH has been a dynamic and highly effective one. As such, the Steinberg Institute and DMH continue to work together with State partners on legislative, reform, and budgeting issues as they relate to the MHSA. The result of this work facilitated the prioritization of mental health reform in 2020, especially in the face of the COVID-19 pandemic, sending several bills to the Governor for his signature, which DMH and the Steinberg Institute worked on together. Specifically,

Assembly Bill 3242 was signed and authorizes a Lanterman-Petris-Short examination, assessment, or evaluation to be conducted using telehealth or other audio-visual technology, and signed Senate Bill 803 establishes a statewide and county-based peer support specialist certification program. As such, California now joins the 48 other states who already offer this program. The Steinberg Institute and DMH will continue to collaborate with our State partners to address issues related to prevention and early intervention, early psychosis identification, peer certification, mental health parity, the Lanterman-Petris-Short Act, and homelessness.

On June 4, 2021, DMH notified your Board of its intent to execute a Sole Source Contract extension with Steinberg Institute for the continued provision of support to Los Angeles County with initiatives involving the MHSA and Mental Health Civil Commitment Reform (Attachment II) and, DMH considers this request approved, as we did not hear otherwise. The required Sole Source Checklist (Attachment III) approved by the CEO is also attached.

As mandated by your Board, the Steinberg Institute's performance will continue to be evaluated by DMH on an annual basis to ensure compliance with all Contract terms and performance standards.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

These actions will enable DMH to enhance system reform efforts which are intended to strengthen the mental health system, increase efficiency, and offer greater access to care to the largest number of residents throughout the County.

Respectfully submitted,

JONATHAN E. SHERIN, M.D., Ph.D.
Director

JES:GCP:SK
RLR:MP:atm

Attachments

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

CONTRACT NO. MH050186

AMENDMENT NO. 02

THIS AMENDMENT is made and entered into this 30th day of November, 2021, by and between the COUNTY OF LOS ANGELES (hereafter "County"), and Steinberg Institute (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "Department of Mental Health Consultant Services Contract", dated March 5, 2019, and further identified as County Contract No. MH050186, and any amendments thereto (hereafter collectively "Contract"); and

WHEREAS, on December 7, 2021, the County Board of Supervisors delegated authority to the Director of Mental Health, or designee, to execute an amendment to the Contract to extend the term for one year, modify the existing Statement of Work (SOW), and add $275,000 to the Contract for fiscal year (FY) 2021-22 and $350,000 for FY 2022-23; and

WHEREAS, said Contract provides that changes may be made in the form of a written amendment which is formally approved and executed by the parties; and

WHEREAS, County and Contractor intend to amend the Contract to extend the term and revise Exhibit A, SOW, and Exhibit B Fee Schedule (FS); and

WHEREAS, as a result of the above changes, the Total Contract Amount (TCA) will increase; and

WHEREAS, Contractor warrants that it continues to possess the competence, expertise, and personnel necessary to provide services consistent with the requirements of the Contract.

NOW, THEREFORE, County and Contractor agree as follows:

1. This Amendment is effective upon execution.
2. The term of the Contract is extended through June 30, 2023.
3. For FY 2021-22, the TCA is increased by $275,000 from $825,000 to $1,100,000.
4. For FY 2022-23, the TCA is increase by $350,000 from $1,100,000 to $1,450,000.
5. Exhibit A-1, Statement of Work, shall be deleted in its entirety and replaced with Exhibit A-2, Statement of Work, attached hereto and incorporated by reference. For FY 2021-22, all references in the Contract to Exhibit A-1, Statement of Work, shall be deleted and replaced with "Exhibit A-2, Statement of Work."
6. Exhibit B-1, Fee Schedule, shall be deleted in its entirety, and replaced with Exhibit B-2, Fee Schedule, attached hereto and incorporated by reference. All references in the Contract to Exhibit B-1, Fee Schedule, shall be deleted and replace with "Exhibit B-2, Fee Schedule."
7. Except as provided in this Amendment, all other terms and conditions of the Contract shall remain in full force and effect.

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be subscribed by the County's Director of Mental Health or his designee, and Contractor has caused this Amendment to be subscribed on its behalf by its duly authorized officer, on the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Jonathan E. Sherin, M.D., Ph.D.
Director of Mental Health

Steinberg Institute
CONTRACTOR

By _____

Name Maggie Merritt

Title Executive Director
(AFFIX CORPORATE SEAL HERE)

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL

By: Emily D. Issa
Deputy County Counsel

STATEMENT OF WORK

1.0 SCOPE OF WORK

Steinberg Institute will consult on an as needed basis with the Department of Mental Health (DMH) to support Los Angeles County (LAC) with initiatives involving the Mental Health Services Act and mental health civil commitment reform. Steinberg Institute will work with the DMH to enhance system reform efforts which are intended to strengthen the mental health system, increase efficiency, and offer greater access to care to the largest number of residents throughout the County.

2.0 BACKGROUND

The LAC DMH is the largest county mental health department in the country. DMH directly operates 75 mental health clinics and more than 100 co-located sites and provides mental health services to over 250,000 residents of Los Angeles County annually. In addition, DMH contracts with over 1,000 unique contractors, including non-governmental agencies and individual practitioners who provide a spectrum of mental health services to residents of all ages throughout the County.

More than 2 million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California. Thirty years ago, the State of California (State) cut back on its services in state hospitals for people with severe mental illnesses, without providing adequate funding for mental health services in the community. To address this issue, voters approved Proposition 63 in 2004. Proposition 63, also called the Mental Health Services Act (MHSA), was enacted into law on January 1, 2005. It places a 1% tax on personal income above $1 million; since that time, it has generated approximately $15 billion. Proposition 63 emphasizes transformation of the mental health system while improving the quality of life for Californians with mental illness

In 2004, Darrell Steinberg co-authored Proposition 63, the MHSA. The MHSA includes a "whatever-it-takes" approach to support and services for people with severe mental illness. In 2015, Mr. Steinberg established a first-of-its-kind statewide non-profit organization, the Steinberg Institute. It is dedicated to raising the profile of quality mental health care as a critical public policy and civil rights issue. The Steinberg Institute focuses on building public leadership for targeted improvements in California's systems of mental and behavioral health. The Steinberg Institute gives clear and potent voice to people living with mental illness, fighting for more resources, better treatments, and an integrated system of care. Their efforts have resulted in billions of additional dollars for mental health

services, a more robust system of oversight, and public/private partnerships that promise improved research and treatments. They protect the precious resource embodied by the MHSA by ensuring that the State communicates a clear strategy for spending MHSA dollars, and that the services funded are data-driven and effective. The Steinberg Institute works at bridging divides, bringing together thought leaders from provider agencies, advocacy groups, research organizations, private industry, State and local agencies, and the Legislature — all with the aim of changing the status quo through strategic alliances and creative exchange. They work to incorporate nontraditional partnerships and inspire leadership on issues of mental health. Their goal is the creation of a more effective and equitable system of care.

As a powerful and effective advocate and problem solver for mental health care in California, with decades long history of championing policy issues affecting brain health, the Steinberg Institute is uniquely qualified, with its sound working relationships with the State Legislature and Executive departments, to assist the County with the development of a different type of mental health system that prioritizes service delivery to the largest number of residents countywide.

3.0 CHANGES TO THE CONTRACT

3.1 All changes must be made in accordance with sub-paragraph 8.1 Amendments of the Contract.

4.0 QUALITY CONTROL

The Contractor shall establish and utilize a comprehensive Quality Control Plan to assure the County a consistently high level of service throughout the term of the Contract. The Plan shall be submitted to the County Contract Project Monitor for review. The plan shall include, but may not be limited to the following:

4.1 Method of monitoring to ensure that Contract requirements are being met;

4.2 A record of all inspections conducted by the Contractor, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

5.0 QUALITY ASSURANCE PLAN

The County will evaluate the Contractor's performance under this Contract using the quality assurance procedures as defined in this Contract, Paragraph 8,

Standard Terms and Conditions, Paragraph 8.15, County's Quality Assurance Plan.

5.1 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Contract at any time during normal business hours. However, these personnel may not unreasonably interfere with the Contractor's performance.

6.0 RESPONSIBILITIES

The County's and the Contractor's responsibilities are as follows:

COUNTY

6.1 Personnel

The County will administer the Contract according to the Contract, Paragraph 6.0, Administration of Contract - County. Specific duties will include:

6.1.1 Monitoring the Contractor's performance in the daily operation of this Contract.

6.1.2 Providing direction to the Contractor in areas relating to policy, information and procedural requirements.

6.1.3 Preparing Amendments in accordance with the Contract, Paragraph 8. Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

CONTRACTOR

6.2 Project Manager

6.2.1 Contractor shall provide a full-time Project Manager or designated alternate. County must have access to the Project Manager during business hours. Contractor shall provide a telephone number where the Project Manager may be reached on an 8 (eight) hour per day basis.

6.2.2 Project Manager shall act as a central point of contact with the County.

6.2.3 Project Manager shall have 20 (twenty) years of experience.

6.2.4 Project Manager/alternate shall have full authority to act for Contractor on all matters relating to the daily operation of the Contract. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

6.3 Personnel

6.3.1 Contractor shall assign a sufficient number of employees to perform the required work. At least one employee on site shall be authorized to act for Contractor in every detail.

6.4 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Contractor. Contractor shall use materials and equipment that are safe for the environment and safe for use by the employee.

6.5 Contractor's Office

Contractor shall maintain an office with a telephone in the company's name where Contractor conducts business. The office shall be staffed during the hours of 8 a.m. to 5 p.m., Monday through Friday, by at least one employee who can respond to inquiries and complaints which may be received about the Contractor's performance of the Contract. When the office is closed, an answering service shall be provided to receive calls. **The Contractor shall answer calls received by the answering service within** 24 (twenty-four) hours **of receipt of the call.**

7.0 SPECIFIC WORK REQUIREMENTS

7.1 Steinberg Institute shall focus its specific work requirements as defined herein, on select DMH's Priorities as framed in the Department’s Strategic Plan for individuals suffering from Severe and Persistent Mental Illness (SPMI) with or without co-morbid addiction by: (1) Expanding resources for California’s mental health system; (2) Increasing the flexibility of funding to optimize impact at the population level; (3) Securing dedicated housing; (4)

Facilitating alternative crisis response and justice reform initiatives; and (5) Engineering and re-engineering client engagement tools.

7.1.1 Expanding resources for California's mental health system by advocating for:

7.1.1.1 Opportunities to increase the allocation of 1991 and 2011 Realignment Funding with a particular focus on addressing the lack of acute and subacute bed capacity to divert clients from the streets and jails where treatment cannot be delivered properly; and

7.1.1.2 Dedicated one-time and ongoing funding from the State budget to support mission critical efforts that are not adequately funded at the current time including the build out of specialized engagement services (i.e. HOME Pilot), specialized housing (i.e. Board and Care) and specialized intensive services (i.e. FSP) dedicated to clients experiencing homelessness (SMPI-EH); and

7.1.1.3 Optimization of magnitude and processes for drawdown of federal match (FFP) through Medi-Cal.

7.1.2 Increasing the flexibility of funding to optimize impact at the population level by advocating for:

7.1.2.1 An MHSA "Refresh" whereby the different funding buckets are collapsed into one bucket that can be used to deliver resources that address access challenges, treatment inadequacies and social determinants of health and wellbeing as deemed necessary by local/county governments and their communities, including but not limited to:

7.1.2.1.1 Opportunities (i.e. employment, housing subsidies)
7.1.2.1.2 Services (FSP, MAT, acute, subacute, residential treatment)
7.1.2.1.3 Infrastructure, including housing (emergency, interim, permanent), treatment facilities (acute, subacute, residential), and additional infrastructural support such as IT upgrades

7.1.2.2 Identification of population outcomes that serve as the primary form of accountability and benchmarks that must be achieved for ongoing access to funds, including but not limited to:

7.1.2.2.1 Prevention of college student disenrollment due to onset of psychotic illness
7.1.2.2.2 Decrease in number of mental health crises that lead to incarceration or justice involvement otherwise
7.1.2.2.3 Increase in the number of clients suffering from SPMI-EH moved from the streets into stable housing

7.1.3 Securing dedicated housing by advocating for:

7.1.3.1 Inclusion of Board and Care for SPMI and SPMI-EH in all state housing investments both one-time for infrastructure and ongoing for subsidy
7.1.3.2 Exploration of newly liberated habitable space (from the COVID-19 Pandemic) as potential inventory for clients suffering from SPMI-EH
7.1.3.3 Use of No Place Like Home funds as housing subsidy and to expand housing inventory through investment in modification and improvement of existing infrastructure

7.1.4 Facilitating alternative crisis response and justice reform initiatives by advocating for:

7.1.4.1 Statewide 988 implementation and related efforts to realize a “Care First, Jails Last” system and culture in California
7.1.4.2 Increase in Medi-Cal reimbursement of CSU/MHUCC services from 24 hours to 72 hours
7.1.4.3 Statewide investment in one-time costs to increase capacity for CSU/MHUCC’s, CRTP’s and Peer Respite facilities

7.1.5 Engineering and re-engineering client engagement tools by advocating for:

7.1.5.1 Guaranteed resource allocation to include real time access to housing, FSP and treatment beds for any client subjected to engagement tools

7.1.5.2 Requirement that any client subjected to engagement tools first receive relentless engagement efforts with guaranteed resources as above

7.1.5.3 New statute that allows for the use of a Psychiatric Advanced Directive

7.1.5.4 Modification of Laura's Law to decrease its administrative burden and exclusionary criteria and increases its authority to provide treatment (i.e. involuntary medication)

7.1.5.5 A new standard to replace current LPS law based on the requirement of Living Safely in the Community

7.2 Steinberg Institute shall provide at DMH's request and upon approval by DMH, specialized mental health policy research, analysis, advisement, technical assistance, facilitation, and consultation.

7.2.1 STEINBERG INSTITUTE shall facilitate meetings and education sessions between LACDMH, other California counties, and legislators and their staff to encourage learning and sharing of knowledge and ideas that further the goals of DMH.

7.2.2 STEINBERG INSTITUTE shall facilitate stakeholder group processes as requested by DMH to articulate Departmental priorities to stakeholder groups.

7.2.3 STEINBERG INSTITUTE shall serve as a source of expertise on key trends and activities in the mental health arena, and advise DMH on opportunities to inform debate.

7.2.4 STEINBERG INSTITUTE shall evaluate regulatory obstacles to mental health reform, and identify and assess potential activities to address such obstacles.

7.2.5 STEINBERG INSTITUTE shall act as a steward for the $2.2 billion that comes into California annually via the MHSA by providing the LAC with, including but not limited to, the following support:

7.2.5.1 Provide briefings, analyses, and strategic recommendations on potential legislation and/or regulations.

7.2.5.2 Write pieces for publication in local media and respond to any media requests as related to MHSA.

7.2.5.3 Work with DMH to develop educational materials.

7.2.5.4 Arrange meetings with key thought leaders and decision makers regarding MHSA scope and implementation.

7.2.5.5 Work to ensure the full implementation of the "No Place Like Home Program (Proposition 2)" by analyzing current roadblocks and following up with policy changes.

7.2.5.6 Provide monthly reports at a minimum or as needed during the legislative session.

7.2.6 STEINBERG INSTITUTE shall provide an annual report to DMH at the end of the legislative session summarizing the services that were rendered during the period of performance and how it furthered the parties' collaboration objectives.

7.2.7 STEINBERG INSTITUTE shall identify grant opportunities and additional funding sources and provide consultation, analysis, and strategic advice to DMH on these issues.

8.0 GREEN INITIATIVES

8.1 Contractor shall use reasonable efforts to initiate "green" practices for environmental and energy conservation benefits.

8.2 Contractor shall notify County's Project Manager of Contractor's new green initiatives prior to the contract commencement.

9.0 QUESTIONS

All programmatic questions should be directed to:

Jonathan E. Sherin, M.D., Ph.D.
Director
County of Los Angeles — Department of Mental Health
510 S. Vermont Avenue, 22nd Floor I Los Angeles, CA 90020
Phone: (213) 738-4601
Email: JSherin@dmh.lacounty.gov

All invoice questions should be directed to:

Angel Baker
Division Chief, Program Development, MH
County of Los Angeles – Department of Mental Health
Office of Administrative Operations – Special Programs
510 S. Vermont Ave., 22nd Floor | Los Angeles, CA 90020
Phone: (213) 351-1918
Email: ABaker@dmh.lacounty.gov

10. INVOICE SUBMITTALS

All invoices with relevant supporting documentation should be submitted to:

Provider Reimbursement Section (PRS)
County of Los Angeles — Department of Mental Health
510 S. Vermont Avenue, 15th Floor
Los Angeles, CA 90020

EXHIBIT B-2

STEINBERG INSTITUTE
CONSULTANT SERVICES CONTRACT

FEE SCHEDULE

Steinberg Institute shall submit monthly invoices for actual costs incurred for deliverables provided under the SOW and based on the Fee Schedule. Steinberg Institute shall submit all relevant supporting documentation along with monthly invoices and maintain copies of all other documents which will be made available to DMH at any time for audit purposes. Total compensation for all services furnished shall not exceed the total contract amount (TCA) of ONE MILLION FOUR HUNDRED FIFTY THOUSAND DOLLARS ($1,450,000) for the contract term commencing on March 5, 2019 through June 30, 2023.

Each payment will be made only upon approval by the designated DMH program representative following review and determination that Steinberg Institute has satisfactorily performed tasks in each respective deliverable as stated in the SOW.

Overhead shall be included at the rate of 15% of invoiced expenses.

All programmatic questions should be directed to:

Jonathan E. Sherin, M.D., Ph.D.
Director
County of Los Angeles – Department of Mental Health
510 S. Vermont Avenue, 22nd Floor | Los Angeles, CA 90020
Phone: (213) 738-4601
Email: JSherin@dmh.lacounty.gov

All invoice questions should be directed to:

Angel Baker
Division Chief, Program Development, MH
County of Los Angeles – Department of Mental Health
Office of Administrative Operations – Special Programs
510 S. Vermont Ave., 22nd Floor | Los Angeles, CA 90020
Phone: (213) 351-1918
Email: ABaker@dmh.lacounty.gov

All invoices with relevant supporting documentation should be submitted to:

Provider Reimbursement Section (PRS)
County of Los Angeles – Department of Mental Health
510 S. Vermont Avenue, 15th Floor
Los Angeles, CA 90020

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

Curley L. Bonds, M.D.
Chief Medical Officer

Lisa H. Wong, Psy.D.
Senior Deputy Director

June 4, 2021

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **NOTICE OF INTENT TO AMEND THE SOLE SOURCE CONTRACT WITH STEINBERG INSTITUTE TO SUPPORT LOS ANGELES COUNTY WITH INITIATIVES INVOLVING THE MENTAL HEALTH SERVICES ACT AND MENTAL HEALTH CIVIL COMMITMENT REFORM**

In accordance with the Los Angeles County Board of Supervisors' (Board) Policy No. 5.100 (Sole Source Contracts), the Department of Mental Health (DMH) is notifying your Board of our Department's intent to increase the Total Contract Amount and extend the term of the current sole source contract with the Steinberg Institute for consultant services, to support DMH with initiatives involving the Mental Health Services Act (MHSA) and mental health civil commitment reform.

DMH will request that your Board authorize the extension of the current sole source contract effective July 1, 2022 through June 30, 2023, with an option to extend it an additional fiscal year, if necessary; and increase the Total Contract amount by $275,000 for Fiscal Year (FY) 2021-22 and $350,000 for FY 2022-23. The contract will be funded by 2011 Realignment Revenues and MHSA revenue.

JUSTIFICATION

The Steinberg Institute was established as a first-of-its-kind statewide non-profit organization. It is dedicated to raising the profile of quality mental health care as a critical public policy and civil rights issue. The Institute serves as a strong partner for the County

in reforming the mental health civil commitment process and strengthening the continuum of mental health care, with an emphasis on community based mental health services, including supportive housing for those with serious mental illness who are homeless.

The Steinberg Institute will continue to focus on building public leadership for targeted improvements in California's systems of mental and behavioral health by giving a clear and potent voice to people living with mental illness, fighting for more resources, better treatments, and an integrated system of care. Efforts by the Steinberg Institute have resulted in billions of additional dollars for mental health services, a more robust system of oversight, and public/private partnerships that promise improved research and treatments. Additionally, the Steinberg Institute works at bridging divides, bringing together thoughtful leaders from provider agencies, advocacy groups, research organizations, private industry, State and local agencies, and the Legislature. They also work to incorporate nontraditional partnerships and inspire leadership on issues of mental health with the goal of creating a more effective and equitable system of care.

As a powerful and effective advocate and problem solver for mental health care in California, with decades long history of championing policy issues affecting brain health, the Steinberg Institute is uniquely qualified, with its sound working relationships with the State Legislature and Executive departments, to assist the County with the development of a different type of mental health system that prioritizes service delivery to the largest number of residents countywide.

NOTIFICATION TIMELINE

Pursuant to Board Policy No. 5.100 (Sole Source Contracts), DMH is required to notify your Board at least six months prior to the expiration of an existing contract when departments intend to extend the term of the current contract beyond its original term and/or increase the total contract amount and do not have the delegated authority to do so. If requested by a Board office or the Chief Executive Office, DMH will place this item on the Health and Mental Health Services Cluster Agenda.

Unless otherwise instructed by your Board office within four weeks of this notice, DMH will commence negotiations and will present your Board a letter for approval to extend the sole source contract with the Steinberg Institute after this six month notification period.

If you have any questions or concerns, please contact me at (213) 738-4601, or your staff may contact Stella Krikorian, Division Manager, Contracts Development and Administration Division, at (213) 738-4023.

JES:GCP:SK
RLR:MP:atm

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

SOLE SOURCE CHECKLIST

Department Name: Mental Health

☐ New Sole Source Contract

☑ Sole Source Amendment to Existing Contract
Date Existing Contract First Approved: March 5, 2019

Check (✓)	JUSTIFICATION FOR SOLE SOURCE CONTRACTS **Identify applicable justification and provide documentation for each checked item.**
☑	➢ Only one bona fide source (monopoly) for the service exists; performance and price competition are not available. A monopoly is an "*Exclusive control of the supply of any service in a given market. If more than one source in a given market exists, a monopoly does not exist* ."
☐	➢ Compliance with applicable statutory and/or regulatory provisions.
☐	➢ Compliance with State and/or federal programmatic requirements.
☐	➢ Services provided by other public or County-related entities.
☐	➢ Services are needed to address an emergent or related time-sensitive need.
☐	➢ The service provider(s) is required under the provisions of a grant or regulatory requirement.
☐	➢ Additional services are needed to complete an ongoing task and it would be prohibitively costly in time and money to seek a new service provider.
☐	➢ Services are needed during the time period required to complete a solicitation for replacement services; provided services are needed for no more than 12 months from the expiration of an existing contract which has no available option periods.
☐	➢ Maintenance and support services are needed for an existing solution/system during the time to complete a solicitation for a new replacement solution/ system; provided the services are needed for no more than 24 months from the expiration of an existing maintenance and support contract which has no available option periods.
☐	➢ Maintenance service agreements exist on equipment which must be serviced by the original equipment manufacturer or an authorized service representative.
☐	➢ It is more cost-effective to obtain services by exercising an option under an existing contract.
☐	➢ It is in the best economic interest of the County (e.g., significant costs to replace an existing system or infrastructure, administrative cost savings and excessive learning curve for a new service provider, etc.) In such cases, departments must demonstrate due diligence in qualifying the cost-savings or cost-avoidance associated with the best economic interest of the County.

Chief Executive Office

Date