Health Services
LOS ANGELES COUNTY

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

Tel: (213)240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

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

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June 12, 2012

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

Dear Supervisors:

APPROVAL OF DELEGATED AUTHORITY TO EXECUTE AN AGREEMENT WITH THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES FOR LOW INCOME HEALTH PROGRAM PAYMENTS
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval and delegation of authority to sign a superseding agreement with the California Department of Health Care Services for operation of the Low Income Health Program, which replaces the existing agreement with similar terms but compensates the County using capitation payments for services.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Delegate authority to the Director of the Department of Health Services (DHS), the Chief Executive Officer of the Ambulatory Care Network (ACN), and the Chief Operating Officer of the ACN, or their respective designees, to execute, if appropriate, on behalf of the County of Los Angeles, a superseding agreement with the California State Department of Health Care Services (DHCS) for the implementation of the Low Income Health Program (LIHP), otherwise referred to in Los Angeles County as the Healthy Way LA-Matched (HWLA) Program, so long as the final rates are within 40 percent of the rates in Exhibit 1 (attached). The agreement, which is still subject to review and approval by the Centers for Medicare and Medicaid Services (CMS), is largely similar to the existing agreement but includes payment on a capitated basis.

2. Authorize DHS to make, if appropriate, intergovernmental transfers (IGTs)

to DHCS sufficient to provide the non-federal share of the capitation payments due under the superseding LIHP agreement.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The recommended actions will allow the DHS Director, ACN Chief Executive Officer, and ACN Chief Operating Officer, or their respective designees, to sign and implement, if acceptable to DHS, an agreement with DHCS, substantially similar to Exhibit 1, which would retroactively replace the existing agreement for the LIHP before the State's June 30, 2012, deadline. The most significant change from the existing agreement is that, instead of receiving federal financial participation based on County expenditures for services, DHS will receive annual capitation payments retroactive to July 1, 2011 and through June 30, 2012. These payments are funded using IGTs for the non-federal share. The recommendations further authorize DHS to make the necessary IGTs. The advantages of receiving capitated payments are increased predictability of revenues and a more simplified claiming process. DHS has been receiving interim payments during this fiscal year. If the Department elects to change to capitation, the interim payments will be reconciled to the capitation rates.

The capitation payment rates are based on actuarially sound per enrollee rates developed by Optumas (an actuary) using the guidance provided by CMS in accordance with 42 C.F.R. Section 438.6(c), as well as the State standards in Welfare and Institutions Code Section 15910.3. CMS is now reviewing the documentation submitted by DHCS for approval. If CMS approves alternate rates, DHS will analyze the impact to determine whether they produce adequate payments for DHS.

If the Director elects to sign the superseding agreement and obtain reimbursement on the basis of capitated rates, DHS will notify your Board once the superseding agreement is executed. In the event CMS requires material reductions to the rates, DHS will not execute this agreement and will continue to obtain reimbursement on a cost basis for FY 2011-12

Delegated authority to enter into the superseding agreement is being requested at this time because the time frame in which to choose whether to stay on cost-based reimbursement or change to capitation is very limited and, pursuant to current state law, must be completed prior to June 30, 2012 in order to be effective for the current fiscal year. It is anticipated that CMS' decision on the rates will not be provided until shortly before June 30th. Accordingly, delegated authority is being requested at this time to ensure the Department has the authority to execute the superseding agreement if the rates approved by CMS are financially feasible.

Implementation of Strategic Plan Goals

The recommended action support Goal 2, Fiscal Sustainability, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

In the event the superseding agreement is executed, it will allow DHS to receive capitation payments for FY 2011-12 based on actuarially sound per enrollee rates determined in accordance with the Welfare and Institutions Code Section 15910.3 and the federal regulation at 42 C.F. R. Section 438.6(c). The non-federal share of such payments will be provided by the DHS in the form of IGTs.

DHS will exercise its authority to sign the agreement only after our analyses of CMS' approved rates indicate that such capitation payment will be financially feasible.

Once DHS elects to receive payment on a capitated basis, there is an option to submit, through a change order request, capitation rate adjustments for subsequent years. The Department anticipates requesting new actuarial analyses on an annual basis through the end of the LIHP in December 2013 to address any changes in patient demographics, utilization and costs.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Since July 1, 2011, the County has been participating in the LIHP authorized by the section 1115 (a) waiver, California Bridge to Reform Medicaid Demonstration (11-W-00193/9) pursuant to a contract signed in September, 2011. The LIHP program operated by the County is called HWLA.

Consistent with state law and the terms and conditions of the Demonstration Project, the existing agreement permits payment based on capitated rates, but allows for payment of federal financial participation based on certified public expenditures when the parties have not agreed upon capitation rates. At the time the original agreement was executed, the parties had not reached agreement on capitation rates so the payment methodology defaulted to certified public expenditures.

DHS continued to work with DHCS and an actuary and is now ready to move forward with this superseding agreement, which adds capitated rates for most covered services during FY 2011-12. Payment for services to HIV/AIDS patients, and out-of-network emergency care, as well as mental health care and care to jail patients, will continue to be based on certified public expenditures. CMS must approve the capitated rates before the superseding agreement is signed, and may insist that they be reduced. If capitation rates are added to the agreement before the end of the year, payment will be based on capitation for the entire fiscal year.

In addition to revisions related to payment based on capitated rates, the superseding agreement changes provisions on payment to primary care physicians not in Federally Qualified Health Centers, and on sanctions.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

An agreement to obtain capitated payments will further incentivize our department to improve the quality and health care outcomes of our patients while creating efficiencies in the delivery of services that will lead to savings in healthcare costs.

Respectfully submitted,

Mitchell H. Katz, M.D.

Director

MHK:hr

Enclosures

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

Exhibit 1

CONTRACT FOR LOW INCOME HEALTH PROGRAM

Department of Health Care Services Contract No. 11-15909-LA-07

Amendment A-01

Governmental Entity (Contractor): County of Los Angeles

Address: 313 N. Figueroa Street, Room 531
Los Angeles, CA 90012

This Contract is not subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

CONTRACT FOR LOW INCOME HEALTH PROGRAM

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME

Department of Health Care Services

CONTRACTOR'S NAME

County of Los Angeles

2. The term of this Agreement is:

July 1, 2011 through December 31, 2013

3. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	2 Pages
Exhibit A Attachment 1 – Organization and Administration of the LIHP	3 Pages
Exhibit A Attachment 2 – Financial Information	1 Page
Exhibit A Attachment 3 – Data System	1 Page
Exhibit A Attachment 4 – Quality Improvement System	7 Pages
Exhibit A Attachment 5 – Utilization Management	3 Pages
Exhibit A Attachment 6 – Provider Network	6 Pages
Exhibit A Attachment 7 – Provider Relations	1 Page
Exhibit A Attachment 8 – Provider Compensation Arrangements	5 Pages
Exhibit A Attachment 9 – Access and Availability	7 Pages
Exhibit A Attachment 10 – Scope of Services	6 Pages
Exhibit A Attachment 11 – Coordination of Care	1 Page
Exhibit A Attachment 12 – Enrollee Services	8 Pages
Exhibit A Attachment 13 – Enrollee Hearing and Appeals Process	10 Pages
Exhibit A Attachment 14 – Enrollment and Disenrollment	5 Pages
Exhibit A Attachment 15 –Additional MCE And HCCI Services	8 Pages
Exhibit B – Budget Detail and Payment Provisions	10 Pages
Exhibit B Attachment 1 – Maintenance of Effort	2 Pages
Exhibit C – Provisions for Federally Funded Programs	6 Pages
Exhibit D – Health Insurance Portability and Accountability Act (HIPAA)	11 Pages
Exhibit E – Definitions	13 Pages
Exhibit F – Program Terms and Conditions	22 Pages
Exhibit G – Duties of the State	3 Pages

4. Signatures

The person(s) signing this Contract on behalf of the Contractor asserts that he/she is an administrator, officer or other individual, duly authorized in a resolution by the governing board as having authority to sign on behalf of the Contractor, and is authorized and designated to enter into this Contract on behalf of the Contractor. This Contract shall be deemed duly executed and binding upon execution by both parties below.

Contractor

_____
Authorized Signatory

Dr. Mitchell H. Katz
Director Department of Health Services
Los Angeles County

_____
Date

_____
Authorized Signatory

Dr. Alexander K. Li
Chief Executive Officer, Ambulatory Care Network, Department of Health Services
Los Angeles County

_____
Date

_____
Authorized Signatory

Quentin O'Brien
Chief Operating Officer, Ambulatory Care Network, Department of Health Services
Los Angeles County

_____
Date

Department of Health Care Services

_____
Authorized Signatory

Jalynne Callori, Chief
Low Income Health Program Division
Department of Health Care Services

_____
Date

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.

The Low Income Health Program (LIHP) consists of two components – a Medicaid Coverage Expansion (MCE) program, and, an option of the Contractor, a Health Care Coverage Initiative (HCCI) program. Under these programs, Contractor shall provide, Covered Services to Enrollees in accordance with the Welfare and Institutions Code Section 15909 – 15915 (Chapter 723, Statutes of 2010, Assembly Bill 342), and the Special Terms and Conditions (STCs) of the Federal Section 1115(a) California Bridge to Reform Demonstration (Demonstration).

Contractor may receive payment in the amount of Federal Financial Participation (FFP) received by the State for qualifying expenditures incurred for Covered Services and for allowable Medicaid administrative activities under the LIHP. Federal funding for the qualifying expenditures for HCCI Enrollees is limited to the Safety Net Care Pool (SNCP) allocation, under the Demonstration. Funding for services rendered to MCE Enrollees is not subject to a cap on Federal funding.

DHCS may reimburse Contractor for Covered Services under the LIHP on a cost basis or the basis of capitated rates in, accordance with Exhibit B, Budget Detail and Payment Provisions. The non-federal share of payments under the LIHP is provided voluntarily by the Contractor, a governmental entity with which it is affiliated, or any other eligible public entity through Certified Public Expenditures (CPE), or permissible Intergovernmental Transfers (IGT), for capitated rates.

2. Service Location

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

3. Service Hours

Covered Services shall be provided 24 hours per day, seven (7) days a week when medically necessary.

Exhibit A
SCOPE OF WORK

4. Project Representatives

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

Department of Health Care Services	**County of Los Angeles**
Low Income Health Program Division Attention: Bob Baxter, Chief Low Income Health Program Division Implementation Section Telephone: (916) 552-9113 Fax: (916) 552-9139 Email: LIHPDHCS-SNFD@dhcs.ca.gov	Quentin O'Brien, Chief Operating Officer Telephone: (213) 240-8362 Fax: (213) 202-5991 Email: qobrien@dhs.lacounty.gov

B. Direct all inquiries to:

Department of Health Care Services	County of Los Angeles
Bob Baxter, Chief Low Income Health Program Division Implementation Section 1501 Capitol Avenue, Suite 71.3024 MS 4519 P.O. Box Number 997436 Sacramento, CA 95899-7436 Telephone: (916) 552-9113 Fax: (916) 552-9139 Email: LIHPDHCS-SNFD@dhcs.ca.gov	Quentin O'Brien, Chief Operating Officer 313 N. Figueroa St. Room 531 Los Angeles, CA 90012 Telephone: (213) 240-8362 Fax: (213) 202-5991 Email: qobrien@dhs.lacounty.gov

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 ADMINISTRATION OF THE LIHP

1. Legal Capacity

Contractor shall maintain the legal capacity to contract with DHCS.

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 director, officer, partner, trustee, or key employee of the Contractor.

2) Any member of the immediate family of any person designated above.

B. Contractor shall 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).

C. Contractor may not knowingly have a relationship with the any of the following:

1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.

a) For the purposes of this section, a relationship is described as follows:

i. A director, officer, or partner of the Contractor.

ii. A person with an employment, consulting or other arrangement for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with DHCS.

Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE LIHP

2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (E)(1).

3. Contract Performance

Contractor shall maintain the organization and staffing for implementing and operating the Contract. Contractor shall ensure the following:

A. The governing body is accountable for the LIHP.

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

4. Medical Decisions

Contractor, or Subcontractor on behalf of Contractors, shall ensure that medical decisions, including those by sub-contractors and rendering providers, are not unduly influenced by fiscal and administrative management. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit or discontinue Medically Necessary services to any Enrollee.

Medical decisions must:

A. Be rendered by qualified medical personnel.

B. Not be duly influenced by fiscal or administrative management considerations.

5. 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. Enrollee Covered Services and enrollment reporting systems as specified in Exhibit A, Attachment 3, Data System, and Exhibit A, Attachment 12, Enrollee Services.

Exhibit A, Attachment 1
ORGANIZATION AND ADMINISTRATION OF THE LIHP

B. An Enrollee grievance procedure, as specified in Exhibit A, Attachment 13, Enrollee Hearing and Appeals Process.

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

D. A method to verify whether Covered Services claimed by Contractor were actually furnished to Enrollee.

E. 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 LIHP funds received, as specified in Exhibit A, Attachment 2, Financial Information.

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

Exhibit A, Attachment 2
FINANCIAL INFORMATION

1. Inspection and Audit of Financial Records

Contractor must ensure that the State agency and CMS may inspect and audit any financial records of the entity or its Subcontractors. Contractor shall provide the State or Federal government access to any books, documents, papers, and records of the Contractor that are directly pertinent to this contract, for the purpose of making an audit, examination, excerpt, or transcription. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

2. Contractor's Obligations

A. 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.

B. Contractor must maintain a copy of each Subcontract entered into in support of this Contract and must, upon request by DHCS, make copies available for approval, inspection, or audit.

Exhibit A, Attachment 3
DATA SYSTEM

1. **Data Report System Capability**

A. Contractor will be responsible for the collection and reporting of all enrollment data and expenditure data with accompanying data documentation on Covered Services furnished to LIHP Enrollees through utilization data, including encounter data, or other methods approved by DHCS or necessary for DHCS's agents and their subcontractors to conduct mandated program evaluation or prepare mandated reports.

B. Contractor will have a Data Reporting System that has the capacity to collect, analyze, integrate, and report data, and comply with the technical specifications supplied by DHCS or DHCS's agents and their subcontractors. The Data Reporting System must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments.

2. **Data Submittal**

A. Contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of enrollment, expenditure data, and utilization data, including encounter data, for Covered Services for which Contractor has incurred any financial liability, whether directly or through Subcontracts or other arrangements.

B. Contractor shall require Subcontractors and non-contracting providers to provide utilization data, including encounter data, to Contractor, which allows the Contractor to meet their administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including data processing and completeness verification, and reporting systems sufficient to assure utilization data, including encounter data, is complete and accurate prior to submission to DHCS.

C. Contractor shall submit required data to DHCS or DHCS's agents and their subcontractors on a monthly/quarterly basis in the form and manner specified by DHCS or DHCS's agents and their subcontractors, and to CMS upon request.

3. **Health Insurance Portability and Accountability Act (HIPAA)**

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

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

1. General Requirement

A. Contractor shall implement an effective quality measurement and quality monitoring system. 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 LIHP Enrollee for malpractice committed by a Subcontractor.

B. CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required.

C. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

2. Practice Guidelines and Quality Improvement Projects

A. Practice Guidelines

Contractor shall adopt, implement and maintain practice guidelines for its providers, or those providers of Subcontractor, which meet the following requirements:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

2) Consider the needs of the Enrollees;

3) Are adopted in consultation with contracting health care professionals; and

4) Are reviewed and updated periodically as appropriate.

Contractor shall disseminate the guidelines to providers, and upon request, to Enrollees and Potential Enrollees.

Decisions regarding coverage of services, utilization management, and

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

Enrollee health education should be consistent with the practice guidelines.

B. Quality Improvement Projects (QIPs)

Contractor is required to conduct or participate in QIPs, which shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Enrollee satisfaction. Contractor shall report the status and results of each project to the State as requested. The performance improvement projects must involve the following:

1) Measurement of performance using objective quality indicators.

2) Implementation of system interventions to achieve improvement in quality.

3) Evaluation of the effectiveness of the interventions.

4) Planning and initiation of activities for increasing or sustaining improvement.

C. Under/Over-Utilization Monitoring

Contractor shall submit to an audit of, or report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized measures.

3. 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 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.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

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.

5) Contractor must ensure that corrective action(s) are taken for all deficiencies or areas for improvement identified.

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.

C. Contractor must ensure that the Subcontractor monitor performance on an ongoing basis and subject it to formal review upon the State's request.

4. Quality Measurement and Monitoring System Written Description

Contractor shall implement and maintain a written description of its quality measurement and quality monitoring system, that shall include the following:

A. Organizational commitment to the delivery of quality health care services as evidenced by Contractor's goals and objectives.

B. Organizational chart showing the key staff responsible for Quality Improvement.

C. A system for provider review of quality findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding quality study outcomes.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

D. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Enrollees regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

E. Mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Enrollees are able to obtain appointments within established standards described in Exhibit A, Attachment 6, Provider Network including DHCS approved Alternative Access Standards.

F Description of the quality of clinical care services provided, including, but not limited to, preventive services for adults between the ages of 19-64 years of age, primary care, specialty, emergency, inpatient, and ancillary care services.

5. Quality Improvement Annual Report

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

A. 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 review of quality of services rendered; the results of the External Accountability Set measures; and, outcomes/findings from QIPs, consumer satisfaction surveys and collaborative initiatives.

B. Copies of all final reports of non-governmental accrediting agencies (e.g. Joint Commission on the Accreditation of Health Care Organizations [JCAHO], National Committee on Quality Assurance [NCQA]) relevant to the Contractor's LIHP line of business, if any, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

C. An assessment of Subcontractor's performance of delegated Quality Improvement activities.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

6. Credentialing and Recredentialing

Contractor, or Subcontractor on behalf of Contractors, shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including Primary Care Physicians (PCP).

A. Standards

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have 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.

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 3, 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 NCQA. Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

D. Medi-Cal and Medicare Provider Status

The 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 the Contractor's provider network.

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

E. Contractor 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.

F. 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.

7. Medical Records

A. General Requirement

Contractor shall ensure that appropriate medical records for Enrollees, pursuant to, 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.

B. Medical Records

Contractor and its subcontractors 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).

Exhibit A, Attachment 4
QUALITY IMPROVEMENT SYSTEM

C. On-Site Medical Records

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

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

C. 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 the Contractor.

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

E. The integration of UM activities into the Quality Improvement System (QIS), described in Exhibit A, Attachment 4 Quality Improvement System, including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

2. Pre-Authorizations and Review Procedures

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

A. 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 condition and disease.

B. 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.

C. Reasons for decisions are clearly documented.

Exhibit A, Attachment 5
UTILIZATION MANAGEMENT

D. Notification to Enrollee regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 12 Enrollee Services and Exhibit A, Attachment 13, Enrollee Hearing and Appeals Process.

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

F. Prior Authorization requirements shall not be applied to Emergency Services

G. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit F, Program Terms and Conditions Provision 17 Audit.

H. 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.

3. Timeframes for Medical Authorization

A. Emergency Services: No prior authorization required, following the prudent lay person standard to determine that the presenting complaint might be an emergency.

B. Non-urgent care following an exam in the emergency room: Response to routine authorizations: fourteen (14) calendar days from receipt of the request for services in accordance with 42 CFR Section 438.210, or any future amendments thereto. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the DHCS for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

C. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee'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 Enrollee's health condition requires and not later than three (3)

Exhibit A, Attachment 5
UTILIZATION MANAGEMENT

working days after receipt of the request for services. The Contractor may extend the three (3) working days time period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

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 Enrollee 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 this attachment.

6. Compensation for Utilization Management Activities

Compensation to individuals or entities that conduct utilization management activities cannot be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

Exhibit A, Attachment 6
PROVIDER NETWORK

1. Network Capacity

A. Contractor shall maintain a provider network that meets adequacy and access requirements stipulated in STC 72.

B. Contractor must maintain a network of appropriate providers that is supported by written agreements.

C. In establishing and maintaining the network, the entity must consider the following:

a) The anticipated enrollment,
b) The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented,
c) The numbers and types (in terms of training, experience, and specialization) of provider required to furnish the contracted services,
d) The number of network providers who are not accepting new LIHP patients, and
e) The numbers of network providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by LIHP Enrollees, and whether the location provides physical access for Enrollees with disabilities.

2. Network Composition

Contractor shall ensure and monitor an appropriate provider network, including PCPs, specialists, allied professionals, and an adequate number of accessible inpatient Facilities and service sites within each Service Area.

3. Emergency Services

Contractor shall have, as a minimum, a designated emergency service Facility, providing care on a 24-hour-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.

4. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with STC 72.

Exhibit A, Attachment 6
PROVIDER NETWORK

5. Federally Qualified Health Center (FQHC) Services

Contractor shall contract with or otherwise offer services through at least one FQHC if such a health center exists in the county or geographic Service Area of the LIHP and shall reimburse FQHCs in accordance with STC 72.

6. Time and Distance Standard

Contractor shall ensure accessibility to primary health care services will be provided at a location within 60 minutes or 30 miles from each Enrollee's place of residence, unless the Contractor has a DHCS approved alternative access standard. Primary care appointments will be made available within 30 business days of request during the period of the Demonstration term through June 30, 2012, unless the Contractor has a DHCS approved alternative access standard described in Exhibit A, Attachment 9, Access and Availability, Provision 2. Primary care appointments will be made available within 20 business days during July 1, 2012 through December 31, 2013, unless the Contractor has a DHCS approved alternative access standard described in Exhibit A, Attachment 9, Access and Availability, Provision 2. Urgent primary care appointment will be provided within 48 hours (or 96 hours if prior authorization is required) of request. Specialty care access will be provided at a minimum within 30 business days of request, unless the Contractor has a DHCS approved alternative access standard described in Exhibit A, Attachment 9, Access and Availability, Provision 2.

In rural areas, Service Areas within a county with a population of 500,000 or fewer, other areas within a county that are sparsely populated, or other circumstances in which the standards are unreasonably restrictive, Contractor shall comply with the LIHP Alternative Access Standards described in Exhibit A, Attachment 9, Access and Availability, Provision 2, if established by DHCS.

7. Physician Availability

Contractor shall have a network physician available twenty-four (24) hours per day, seven (7) days per week to coordinate the transfer of care of an Enrollee whose emergency condition is stabilized, to authorize Medically Necessary Post-stabilization Care Services, and for general communication with emergency room personnel.

8. Network Provider Availability

Contractor shall ensure that network providers offer hours of operation to Enrollees that are no less than the hours of operation offered to other patients.

Exhibit A, Attachment 6
PROVIDER NETWORK

9. 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) Annually, according to DHCS instructions and timeline.

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

1) Geographic access for the Enrollees;

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

10. Ethnic and Cultural Composition

Contractor shall participate in efforts to promote culturally competent service delivery, including those with limited English proficiency and diverse cultural ethnic backgrounds.

11. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective Subcontractor's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(3),(4) 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(b)(2), and other applicable Federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract as defined in Exhibit E, Definitions, item 81. A. 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 laws and regulations governing this Contract.

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

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

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

   a) By DHCS, Department of Health and Human Services (DHHS), and Department of Justice (DOJ).

   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 five years from the close of the current fiscal year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

   e) Including all enrollment, expenditure, and utilization data, including encounter data, for a period of at least five years.

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

7) 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:

Exhibit A, Attachment 6
PROVIDER NETWORK

a) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHCS, DHHS, and DOJ.

b) Retain such books and records for a term of at least five years from the close of the current fiscal year for the last year in which the sub-subcontract is in effect and in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

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

9) Subcontractor’s agreement to timely gather, preserve and provide to DHCS, any records in the Subcontractor’s possession, in accordance with Exhibit F, Program Terms and Conditions Provision 22, Records Related to Recovery for Litigation.

10) Subcontractor’s agreement to provide interpreter services for Enrollee at all provider sites.

11) Subcontractor’s agreement to participate and cooperate in the Contractor’s Quality Improvement System.

12) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 3, Delegation of Quality Improvement Activities.

13) Subcontractor’s agreement to comply with all applicable requirements of DHCS, and LIHP.

C. 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.

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

Subcontracts with FQHCs shall also meet the Subcontract requirements of Provision 11, Subcontracts, above, and the reimbursement requirements in Exhibit A, Attachment 8, Provider Compensation Arrangements, and Provision 5, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

13. Nondiscrimination in Provider Contracts

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 Enrollee; 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 are consistent with Contractor's responsibilities to Enrollee. Contractor may 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 the 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.

Exhibit A, Attachment 7
PROVIDER RELATIONS

1. Provider Training

A. Contractor shall ensure that all providers receive training regarding LIHP in order to operate in full compliance with the Contract and all applicable Federal and State statutes and regulations. Contractor shall ensure that provider training relates to LIHP services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between Contractor, provider, Enrollee and/or other healthcare professionals.

2. 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 information that Emergency Service providers can use to contact the LIHP to notify it of Emergency Services 24 hours a day, including inpatient admissions, and to obtain authorization for Post-stabilization Care Services.

3. 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 an Enrollee'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 an Enrollee who is his or her patient: for the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the Enrollee needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

4. Compensation

See Exhibit A, Attachment 8, Provider Compensation Arrangements for specific provider compensation requirements relating to out-of-network Emergency Services and Federally Qualified Health Center services.

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

1. Compensation

Contractor may compensate providers as Contractor and provider negotiate and agree. Compensation cannot 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. 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 Enrollee; and

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

3. Identification of Responsible Payer

Contractor shall provide the information that identifies the payer responsible for reimbursement of services provided to an Enrollee enrolled in Contractor's LIHP to DHCS. 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.

4. Prohibited Claims

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

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

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

A. FQHCs Availability

If any FQHCs operate within the Service Area, Contractor shall contract with or otherwise offer services through at least one FQHC.

B. FQHC/RHC Reimbursement

Contractor shall reimburse any FQHCs and RHCs with which it contracts at the Medi-Cal per visit rate for that Facility, to ensure that no State general funds are required to be expended as a supplemental payment. Payments to FQHCs and RHCs shall not be less than Contractor would pay if the provider providing the services were not an FQHC or RHC.

6. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization Care Services for the MCE Population

A. Emergency Services: Contractor must provide coverage of Emergency Services provided in hospital emergency rooms for Emergency Medical Conditions, and/or required Post-stabilization Care Services, regardless of whether the provider that furnishes the services is within the LIHP network for the MCE population. Contractor may not deny payment for treatment obtained when an MCE Enrollee had an Emergency Medical Condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of 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 MCE Enrollee to seek Emergency Services. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding for coverage and payment.

Contractor may not limit what constitutes an Emergency Medical Condition, using the prudent layperson standard on the basis of lists of diagnoses, or symptoms or refuse to cover Emergency Services that meet such standard. Out-of-network providers must, as a condition for receiving payment for Emergency Services, notify the LIHP program within 24 hours of registering/admitting the patient into the emergency room. Contractor may pay for Emergency Services provided by out-of-network providers at

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

30 percent of the applicable regulatory fee-for-service rate under the State Plan (excluding any supplemental payments), except that, with respect to inpatient hospital services, Contractor may pay 30 percent of the applicable regional unweighted average of per diem rates paid to SPCP – contracted hospitals. The out-of-network provider must accept LIHP program payments made in accordance with this section as payment in full for services rendered, and the LIHP recipient may not be held liable for payment.

B. Post-Stabilization Care Services: Post stabilization care services are covered and paid for in accordance with provisions set forth in STC 63 (f)

Contractor may pay for Post-stabilization Care Services provided by out-of -network providers at 30 percent of the applicable regulatory fee-for-service rate under the State Plan (excluding any supplemental payments), except that, with respect to inpatient hospital services, Contractor may pay 30 percent of the applicable regional unweighted average of per diem rates paid to SPCP- contracted hospitals. The out-of-network provider must accept LIHP program payments made in accordance with this Provision as payment in full for services rendered, and the LIHP recipient may not be held liable for payment. Out-of-network providers must, as a condition for receiving payment for Post-stabilization Care Services, meet the approval protocols established by the LIHP program, which are subject to DHCS review.

Contractor is financially responsible for Post-stabilization Care Services obtained within or outside the entity that are not pre-approved by a LIHP provider or other entity representative, but administered to maintain the Enrollee's stabilized condition within 1 hour of a request for pre-approval of further Post-stabilization Care Service, or under the following conditions:

1) The organization does not respond to a request for pre-approval within 1 hour;

2) The organization cannot be contacted; or

3) The organization representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a LIHP physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a LIHP physician and the treating physician may continue with

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

care of the patient until a physician is reached, or the following criteria is met:

a. A LIHP physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;
b. A LIHP physician assumes responsibility for the Enrollee's care through transfer;
c. An organization representative and the treating physician reach an agreement concerning the Enrollee's care; or
d. The Enrollee is discharged.

Contractor may impose procedural requirements related to out-of-network providers' submission of claims and/or invoices (such as time limits) for out-of-network emergency and Post-stabilization Care Services. Such procedural requirements are subject to DHCS approval.

Contractor must limit charges to Enrollees for Post-stabilization Care Services to an amount no greater than what the Contractor would charge the Enrollee if he or she had obtained services through the contracted network.

7. Claims Processing

Contractor shall process all claims in accordance with this Provision 7, Claims Processing, unless the subcontractor and Contractor have agreed to an alternate payment schedule in the subcontract.

A. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f) and 42 C.F.R. Section 447.46.

B. Contractor shall pay 90% of all Clean Claims from subcontractors, who are in individual or group practices or who practice in shared health facilities, within 90 days of the date of receipt. 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.

8. Payment for Primary Care Services

During calendar year 2013, under contracts with primary care physicians, as defined in section 1902(a)(13)(C) of the Social Security Act Section (42 U.S.C. Section 1396a(a)(13)(C)), Contractor shall pay for covered primary care services, as defined in section 1902(jj) of the Social Security Act (42 U.S.C. Section 1396a(jj)), provided to Enrollees at a rate not less than 100% of the

Exhibit A, Attachment 8
PROVIDER COMPENSATION ARRANGEMENTS

payment rate that applies to such services and physicians under Medicare Part B, to the extent required under Social Security Act Section 1932(f).

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

1. General Requirement

Contractor shall ensure that it maintains a network of providers within the Service Area sufficient to provide Enrollees with access to services as provided in this Attachment.

2. Access Requirements

Contractor shall comply with access requirements in accordance with STC 72 and as specified below and in Exhibit A, Attachment 6 Provider Network, Provision 6 Time and Distance Standards. Contractor shall communicate, enforce, and monitor providers' compliance with these requirements. To the extent Contractor submits and DHCS approves alternative network access standard for all or for a portion of Contractor's Service Area, those alternative standards will supplant the standards contained herein.

A. Primary Care Access

Primary care appointments will be made available within 30 business days of request during the period of the Demonstration term through June 30, 2012 and within 20 business days during the Demonstration term from June 30, 2012, through December 31, 2013 unless the Contractor has a DHCS approved alternative access standard.

Urgent primary care appointments will be provided within 48 hours (96 hours if prior authorization is required) of request.

Accessibility to primary health care services will be provided a location within 60 minutes or 30 miles from each Enrollee's place of residence unless the Contractor has a DHCS approved alternative access standard.

B. Specialty care access will be provided at a minimum within 30 business days of request unless the Contractor has a DHCS approved alternate access standard.

C. Office Hours and Availability

Contractor shall ensure that network providers offer office hours for Enrollees that are no more restrictive than are available to other individuals served by those network providers.

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

To the extent Medically Necessary, Covered Services will be made available to Enrollees 24 hours per day, 7 days a week. Contractor will monitor provider compliance, and will take corrective action when noncompliance occurs.

Contractor shall establish mechanisms to ensure that providers comply with these timely access requirements. Such mechanisms shall include regular monitoring and corrective actions if there is a failure to comply.

D. Closed Provider Network

Contractor may limit Covered Services in accordance with Exhibit A, Attachment 10, Scope of Services and Exhibit A, Attachment 6, Provider Network, to those services provided through its closed provider network. Except with respect Medically Necessary Emergency Services and approved Post-stabilization Care Services for the MCE population, Contractor may exclude from Covered Services those services rendered by providers that are not in the Contractor's closed provider network

E. Second Opinions

Contractor shall provide Enrollees with access to a second opinion from a qualified health care professional within the network. If such a second opinion is not available within the network, Contractor shall arrange for Enrollee to obtain one outside the network at no cost to the Enrollee.

F. Direct Access to Woman's Health Specialist

Contractor shall provide female Enrollees 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 shall be in addition to the Enrollee's designated source of primary care, if that source is not a women's health specialist.

G. Documentation and Assurances

Contractor shall submit documentation to the State demonstrating that it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Enrollees in the Service Area, and that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the Service Area.

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

This documentation shall be submitted at the time of contracting, and at any time Contactor undergoes a significant change that would affect adequate capacity and services (including changes in Contractor's Covered Services, geographic Service Area, or significant changes to Contractor's eligibility income standards).

3. Primary Care and Coordination of Services

Contractor shall implement procedures to deliver primary care to and coordinate health care services for Enrollees. These procedures must:

A. Ensure that the Enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Enrollee.

B. Coordinate the services the Contractor furnishes to the Enrollee with the services the Enrollee receives from any other MCO, or PIHP.

C. Share with other MCOs, or PIHPs, serving the Enrollee with special health care needs the results of its identification and assessment of that Enrollee's needs to prevent duplication of those activities.

D. Ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

4. Medical Home

Contractor shall assign each Enrollee to a Medical Home, which may be a single provider, Facility, or health care team that maintains the Enrollee's medical information and coordinates Enrollee's health care services. The Medical Homes shall meet the requirements of Welfare and Institutions Code Section 15910.2(b)(2).

5. Emergency Services

Contractor shall ensure that an Enrollee with an Emergency Medical 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 Services without prior authorization pursuant to STC 63.

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

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

C. Contractor shall ensure that a network physician is available 24 hours a day to authorize Medically Necessary Post-stabilization Care Services and coordinate the transfer of stabilized Enrollees in an emergency department, if necessary.

6. Services for Individuals with Special Needs

A. Contractor shall implement mechanisms to assess Enrollees identified by the State as having special health care needs, in order to identify any special conditions of the Enrollee that require a course of treatment or regular care monitoring. The assessment mechanism will use appropriate health care professionals.

B. Enrollees identified by the assessment mechanism to need a course of treatment or regular care monitoring shall be allowed to directly access a specialist (such as through a Standing Referral or an approved number of visits), as appropriate for the Enrollee's condition and identified needs.

7. Changes in Availability or Location of Covered Services

Contractor shall report any substantial change in the availability or location of services to be provided under this Contract its quarterly progress report to DHCS or DHCS's agents.

8. Access for Disabled Enrollees

Contractor shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access to Covered Services for the disabled.

9. Civil Rights Act of 1964

Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 USC Section 2000d, 45 CFR 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 Enrollees or potential Enrollees through provision of high quality interpreter and linguistic services.

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

10. Cultural and Linguistic Requirements

Contractor shall ensure that services are delivered in a culturally competent manner. Contractor shall have policies that describe how Contractor's provider network supports the ethnic, cultural, and linguistic needs of its Enrollees.

Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Contractor shall participate in related actions implemented by DHCS.

11. Linguistic Services

A. Contractor must notify its Enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

B. Contractor shall make its written information available in the prevalent non-English languages in its particular Service Area.

C. Contractor shall provide, at minimum, the following linguistic services at no cost to Enrollees:

1) Oral Interpreter services shall be provided in all languages spoken by Enrollees and not limited to those that speak the threshold or concentration standards languages.

2) Fully translated written informing materials, including but not limited to the Enrollee Services Guide, information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or Limited English Proficiency (LEP) Enrollees that speak the identified threshold or concentration standard languages.

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

4) Telecommunications Device for the Deaf (TDD).

TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general

D. Contractor shall provide translated materials to either the community potentially served by the LIHP or the LIHP's Enrollee population that meets the definition of Necessary second language described in Exhibit C, Provisions For Federally Funded Programs, Provision 5.

12. Coverage of Out-of-Network Emergency Services for the MCE population

The LIHP must cover Emergency Services for the MCE population provided in hospital emergency rooms for Emergency Medical Conditions, and/or required Post-stabilization Care Services, regardless of whether the provider that furnishes the services is within the LIHP network.

A. Payment

Contractor may pay for Emergency Services, Post-stabilization Care Services, and all other Covered Services provided by out-of-network providers at 30 percent of the applicable regulatory fee-for-service rate under the State plan (less any supplemental payments), except that, with respect to inpatient hospital services, Contractor may pay 30 percent of the applicable regional un-weighted average of per diem rates paid to SPCP-contracted hospitals. The out-of-network provider must accept LIHP program payments as payment in full for the services rendered, and the LIHP recipient may not be held liable for payment.

B. Out-of-network providers

Providers must, as a condition for receiving payment for Emergency Services, notify the LIHP program within 24 hours of admitting the patient into the emergency room, and, with respect to Post-stabilization Care Services, meet the approval protocols established by the LIHP program.

C. Funding of Out-of-Network Emergency Services.

In addition to the funding mechanisms described in paragraph 39 of the STCs [CPE and IGT], the State may fund the non-federal share of LIHP program payments for out-of-network Emergency Services with provider fee revenues that comply with section 1903(w).

Exhibit A, Attachment 9
ACCESS AND AVAILABILITY

D. LIHP Materials

LIHPs will include in program materials information about Enrollees' ability to receive emergency and/or Post-stabilization Care Services in out-of-network hospitals as well as their right to not be liable for payment for these services. LIHP programs will ensure that Enrollee identification cards indicate to emergency service providers that the LIHP program should be contacted for reimbursement and approval for Post-stabilization Care Services.

13. Continue Service During Insolvency

Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge, during Contractor insolvency.

Exhibit A, Attachment 10
SCOPE OF SERVICES

1. Covered Services

Contractor shall provide or arrange for all Medically Necessary Covered Services for Enrollees. Covered Services are those core services set forth in the California Bridge to Reform Demonstration and described below, and other add-on services described in Exhibit A, Attachment 15, Additional MCE and HCCI Services.

If Contractor's network is unable to provide Medically Necessary Covered Services, Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the entity is unable to provide them.

The out-of-network provider must coordinate with Contractor with respect to payment. The entity must ensure that cost to the Enrollee is no greater than it would be if these services were furnished within the network.

All services provided under the Contract must be allowable under Section 1905(a) of the Social Security Act.

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

2. Medically Necessary Services

For purposes of this Contract, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered.

The Contractor must address in its definition of Medically Necessary Covered Services the extent to which it is responsible for covering services related to the prevention, diagnosis, and treatment of health impairments the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.

3. Core Services

Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not

Exhibit A, Attachment 10
SCOPE OF SERVICES

arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 CFR 440.230).

A. Intake Assessment

Contractor shall require the Enrollee's Medical Home to provide an intake assessment of each new Enrollee's general health status.

B. MCE Core Benefits

Contractor shall provide the following MCE core benefits to MCE Enrollees to the extent available under the California State Plan:

1. Medical equipment and supplies;
2. Emergency Care Services (including transportation);
3. Acute Inpatient Hospital Services;
4. Laboratory Services;
5. Mental health benefits as described in I of this Provision either through the LIHP or through a carved-out delivery system that is separate from the LIHP;
6. Prior-authorized Non-Emergency Medical Transportation (when Medically Necessary, required for obtaining medical care and provided for the lowest cost mode available);
7. Outpatient Hospital Services;
8. Physical Therapy;
9. Physician services (including specialty care);
10. Podiatry;
11. Prescription and limited non-prescription medications;
12. Prosthetic and orthotic appliances and devices; and
13. Radiology.

C. HCCI Core Benefits

Contractor shall provide the following HCCI core benefits to HCCI Enrollees to the extent available under the California State Plan:

1. Medical equipment and supplies;
2. Emergency Care Services;
3. Acute Inpatient Hospital Services;
4. Laboratory Services;
5. Outpatient Hospital Services;
6. Physical Therapy;
7 Physician services(including specialty care);

Exhibit A, Attachment 10
SCOPE OF SERVICES

8. Prescription and limited non-prescription medications;
9 Prosthetic and orthotic appliances and devices; and
10. Radiology.

D. Excluded or Non Covered Benefits

The following services are excluded from the MCE and HCCI core benefits:

1. Organ Transplants;
2. Bariatric surgery; and
3. Infertility related services

E. Additional MCE and HCCI Services

Contractor will include additional benefits and limits to the additional benefits, in the LIHP, allowable under Section 1905(a) of the Social Security Act, as described in Exhibit A, Attachment 15, Additional MCE and HCCI Services.

F. Limited Service Populations

Individuals determined eligible for the LIHP by the State or the Contractor pursuant to California Welfare and Institutions Code Section 14053.7, for enrollment in the Contractor's LIHP, shall be limited to acute inpatient hospital services.

G. Denial of Services

Except for those Medically Necessary Emergency Services for MCE Enrollees described in STC 63(f) and Exhibit A, Attachment 9, Access and Availability, the LIHP may exclude from the core benefits, those services listed above in B. and C., and E. of this Provision that are rendered by providers that are not in the Contractor's provider network.

H. Cost Sharing

The LIHP must comply with Medicaid cost-sharing requirements for MCE and HCCI populations as required by STC 70. All Enrollees must be limited to a 5 percent aggregate cost sharing limit per family. The LIHPs with existing MCE and HCCI programs must be in compliance with all Medicaid cost-sharing requirements for MCE populations that are set forth in statute, regulations and policies.

Exhibit A, Attachment 10
SCOPE OF SERVICES

I. Mental Health Services for MCE Enrollees

1) Contractor shall cover mental health services, for MCE Enrollees, as described in STC 64 and 65, and may provide mental health services through a delivery system separate from the LIHP and authorized under a separate agreement. Mental health services shall be covered to the extent listed below.

2) Contractor shall cover the following services:

a) Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health Facility.

b) Psychiatric pharmaceuticals.

c) Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment Contractor may elect to extend treatment if it is determined to be Medically Necessary.

d) Contractor may, provide benefits that extend beyond those listed above. Nothing in this section shall prohibit Contractor from providing add-on mental health benefits, including Medically Necessary benefits that are beyond the day or visit limitations set forth above. Add-on mental health benefits will be provided to the extent they are described in Exhibit A, Attachment 15, Additional MCE and HCCI Services.

Contractor will provide mental health benefits to individuals who have been diagnosed by a MCE participating provider acting within the provider's scope of practice with a mental health diagnosis specified in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

a) The Enrollee must also have at least one of the following impairments as a result of the diagnosed mental disorder:

i. A significant impairment in an important area of life functioning

ii. A probability of significant deterioration in an important area of life functioning.

Exhibit A, Attachment 10
SCOPE OF SERVICES

b) The intervention recommended by the enrolled provider, within the scope of his or her practice, must be reasonable calculated to:

i. Significantly diminish that impairment; or

ii. Prevent significant deterioration in an important area of life functioning.

c) In addition to the criteria listed above, for an inpatient admission for treatment of a diagnosed mental disorder, the impairment, symptoms or must meet one of the following criteria:

i. Represent a current danger to self, others or property;

ii. Prevent the Enrollee from providing for, or utilizing food, shelter or clothing.

iii. Present a severe risk to Enrollee's health and safety;

iv. Require further psychiatric evaluation or medication treatment that cannot be provided on an outpatient basis.

J. 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.

K. Pharmaceutical Services and Provision of Prescribed Drugs

1) Contractor must provide a comprehensive prescription drug benefit that utilizes generic and/or brand name drugs representing at least one drug from all classes of drugs. This comprehensive prescription drug benefit must provide a prior authorization review process for any medically necessary drug and Contractor may seamlessly continue care with other governmental drug programs in the provision of comprehensive prescription drug benefit.

Contractor shall cover and ensure the provision of all prescribed drugs, within its formulary and limits, 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 the California State Board of Pharmacy Laws and Regulations. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Enrollee Services Guide.

At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Enrollee can reasonably be expected to have the prescription filled.

2) If Contractor intends to use a formulary, Contractor shall submit to DHCS a complete formulary prior to the beginning of operations.

3) The Contractor shall implement and maintain a process to ensure that its formulary is reviewed and updated.

4. Service Verification

Contractor must have a method to verify whether services were actually furnished to Enrollees.

Exhibit A, Attachment 11
COORDINATION OF CARE

1. Coordination of Care

Contractor will delegate to the Enrollee's Medical Homes those requirements for care coordination, pursuant to Welfare and Institutions Code 15910.2(b), including:

A. A primary health care contact who facilitates the Enrollee's access to preventive, primary, specialty, mental health, or chronic illness treatment, as appropriate.

B. An intake assessment of each new Enrollee's general health status.

C. Referrals to qualified professionals, community resources, or other agencies as needed.

D. Care coordination for the Enrollee across the service delivery system, as agreed to between the Medical Home and the Contractor. This may include facilitating communication among Enrollee's health care providers, including appropriate outreach to mental health providers.

E. Care management, case management, and transitions among levels of care, if needed and as agreed to between the Medical Home and the LIHP project.

Contractor shall maintain procedures for monitoring the coordination of care provided to Enrollees, including but not limited to all Medically Necessary services delivered both within and outside the Contractor's provider network.

2. Immunization Registry Reporting

Contractor shall ensure that Enrollee-specific immunization information is periodically reported to an immunization registry(ies) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Enrollee's initial health assessment 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.

Exhibit A, Attachment 12
ENROLLEE SERVICES

1. Enrollees Rights and Responsibilities

A. Enrollee Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Enrollee's rights and responsibilities and shall communicate these to its Enrollees, providers, and, upon request, potential Enrollees.

1) Contractor's written policies regarding Enrollee rights shall include the following:
   a) To be treated with respect, giving due consideration to the Enrollee's right to privacy and the need to maintain confidentiality of the Enrollee's medical information.
   b) To be provided with information about the organization and its services.
   c) Enrollee's right to choose his or her health professional to the extent possible and appropriate, and at a minimum shall have a choice of at least two Primary Care Providers 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 formulate Advance Directives.
   g) To request a State fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
   h) To disenroll upon request.
   i) To be notified of his or her disenrollment rights, at a minimum, annually.
   j) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
   k) To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.
   l) To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR Sections164.524 and 164.526.
   m) To receive written Enrollee informing materials in alternative formats that take into account special needs of individuals who are visually limited or of limited reading proficiency.

Exhibit A, Attachment 12
ENROLLEE SERVICES

n) Freedom to exercise these rights without adversely affecting how he or she is treated by the Contractor, providers, or the State.

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

B. Enrollees' Right to Confidentiality

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

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential medical information to unauthorized persons
2) Contractor shall counsel Enrollees on their right to confidentiality and Contractor shall obtain Enrollee's authorization prior to release of confidential information, unless such authorization is not required pursuant to California law or HIPAA.

C. Enrollees' 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 438.6(i).

2. Written Enrollee Information

A. Contractor shall provide all new LIHP Enrollees with written Enrollee information as specified in Welfare and Institutions Code Section 15910.2(b)(8) and 42 CFR 438.210. Compliance may be met through distribution of the Enrollee Services Guide.

B. Contractor shall ensure that all written Enrollee information is provided to Enrollees in a manner and format that may be readily understood.

1) Written Enrollee-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9 Access and Availability, Provision 11, Linguistic Services.

Exhibit A, Attachment 12
ENROLLEE SERVICES

2) Written Enrollee informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.

3) Contractor must comply with the information requirements of 42 CFR. 438.10 to ensure that, before enrolling, the eligible individual receives from the LIHP the accurate oral and written information he or she needs to make an informed decision on whether to enroll.

4) Contractor must ensure that any marketing information, including plans and materials, is accurate and does not mislead, confuse, or defraud the recipients or the State agency.

5) Marketing materials cannot contain any assertion or statement (whether written or oral) that the provider is endorsed by CMS, the Federal or State government or similar entity.

C. Contractor shall provide each Enrollee, or family unit, information on the following:

1) The Contractor name, address, telephone number and Service Area.

2) A description of the LIHP MCE and HCCI Covered Services including health education, interpretive services provided at service sites, "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services.

3) Procedures for accessing Covered Services including that Covered Services shall be obtained through the LIHP network of providers unless otherwise allowed under this Contract.

4) Any restriction on the Enrollee’s freedom of choice among network providers.

5) Cost sharing, if any

6) A description of the Enrollee identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Enrollees to obtain services.

Exhibit A, Attachment 12
ENROLLEE SERVICES

Compliance with the above requirements may be met by distribution of an Enrollee Services Guide.

7) Compliance with the following may be met through distribution of a provider directory:

The name, provider number, address and telephone number of each Service Location (e.g., locations of hospitals, PCPs, specialists, psychologists, pharmacies, and FQHCs. In the case of a medical group/foundation or IPA, the medical group/foundation or IPA name, provider number, address and telephone number shall appear for each physician provider, if any, which non-English languages are spoken, and identification of providers that are not accepting new patients

D. In addition, Enrollees must be provided with information about the following:

1. Procedures for selecting a PCP or requesting a change in PCP, and allowable times at which an Enrollee may make such a request.

2. 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 Enrollees' right to interpretive services, at no cost, to assist in receiving after hours services as required in Exhibit A, Attachment 9 Access and Availability, Provision 11, Linguistic Services.

3. Definition of what constitutes an Emergency Medical Condition, emergency health care and Post-stabilization Care Services, as defined in Exhibit E, Definitions, and that prior authorization is not required to receive Emergency Services. Include the use of 911 for obtaining Emergency Services.

4. Procedures for obtaining emergency health care from specified providers or from out-of-network providers, including outside Contractor's Service Area.

5. Process for referral to specialists in sufficient detail so Enrollee can understand how the process works, including timeframes.

Exhibit A, Attachment 12
ENROLLEE SERVICES

6. Procedures for obtaining any transportation services to service sites that are offered by Contractor and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

7. Procedures for filing a grievance or appeal with Contractor is stipulated in Exhibit A, Attachment 13, Enrollee Hearing and Appeals Process.

8. The causes for which a Enrollee shall be disenrolled and not continue to receive services under this Contract as stipulated in Exhibit A, Attachment 14, Enrollment and Disenrollment, Provision 2, Disenrollment.

9. Procedures for disenrollment, including an explanation of the Enrollee's right to disenroll without cause at any time.

10. Information on the Enrollee's right to the 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 as stipulated in Exhibit A, Attachment 13, Enrollee Hearing and Appeals Process.

11. Information on the availability of, and procedures for obtaining, services at FQHCs.

12. Procedures for providing female Enrollees 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 Enrollee’s designated source of primary care if that source is not a woman’s health specialist.

13. A statement as to whether the Contractor uses a Physician Incentive Plan pursuant to 42 CFR 438.6

14. A notice as to whether the Contractor uses a drug formulary.

15. Policies and procedures regarding an Enrollees’ right to formulate Advance Directives. This information shall include the Enrollee’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.

16. Instructions on how an Enrollee can view online, or request a copy of, Contractor's non-proprietary clinical and administrative policies and procedures.

17. Notice to Enrollees of their right to request and obtain information pertaining to cultural and linguistic services, procedures for obtaining benefits, Enrollee rights and protections, post stabilization care services rules, information on grievance and fair hearing procedures, any restrictions on Enrollee's freedom of choice among providers, obtaining out of network services must be sent at least once a year.

18. Notice of any significant change in Enrollee's rights must be provided at least 30 days before the intended effective date of change.

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

E. Enrollee Identification Card

Contractor shall provide an identification card to each Enrollee, which identifies the Enrollee and authorizes the provision of Covered Services to the Enrollee. The card shall specify that Emergency Services rendered to the MCE Enrollee by non-contracting providers are reimbursable by the Contractor, if notified within 24 hours of emergency room admittance, and if Post-stabilization Care Services meets approved protocols set forth by the Contractor.

3. Notification of Changes in Access to Covered Services

A. Contractor shall ensure Enrollees are notified in writing of any significant changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR Section 438.10(f)(4), at least 30 calendar days prior to the effective date of such changes.

B. Pursuant to 42 CFR 438.10(f)(5) Contractor shall make a good faith effort to give written notice of termination of a contracted provider within 15 days

after receipt or issuance of the termination notice to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

4. Primary Care Provider Selection

A. Contractor shall implement and maintain procedures to ensure that each new Enrollee has an appropriate and available Primary Care Physician.

1) Contractor shall provide each new Enrollee an opportunity to select a Primary Care Physician from among at least two Primary Care Physicians upon enrollment.

2) Contractor may allow Enrollees 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 Enrollee may select his or her health professional to the extent possible.

4) Contractor shall ensure that Enrollees are allowed to change a Primary Care Physician, once every twelve (12) months following the initial enrollment

B. Contractor shall disclose to affected Enrollees any reasons for which their selection or change in Primary Care Physician could not be made.

C. Contractor shall ensure that Enrollees 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.

5. Primary Care Provider Assignment

A. If the Enrollee does not select a PCP upon enrollment, Contractor shall assign that Enrollee to a PCP and notify the Enrollee and the assigned PCP.

Exhibit A, Attachment 12
ENROLLEE SERVICES

6. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Enrollees of a decision to deny, defer, or modify requests for prior authorization, in accordance with Exhibit A, Attachment 13, Enrollee Hearing and Appeals Process.

7. Protection Against Liability- Subcontractors and Referrals

A. Subcontractors and referral providers may not bill Enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers).

8. Limited Services Populations

Notwithstanding any other provisions of this Contract, the provisions of this Exhibit A, Attachment 12, Enrollee Services, shall not apply with respect to the Limited Service Populations described in Exhibit A, Attachment 10, Scope of Services, Section 3.F.

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

1. Definitions

A. An “action” is:

1) A denial, termination or reduction of eligibility for MCE or HCCI.

2) A denial or limited authorization of a requested LIHP service, including the type or level of service.

3) A reduction, suspension, or termination of a previously authorized service.

4) A failure to provide LIHP services in a timely manner pursuant to the STCs of the California Bridge to Reform Demonstration for the LIHP.

5) A failure of the LIHP or the State to act within the timeframes for grievances and appeals as outlined herein.

B. A “grievance” is an expression of dissatisfaction about any matter other than an action, as “action” is defined above.

C. An “appeal” is defined as a request for review of an action, as defined in A., above.

2. Processes required - each LIHP must have in place:

A. A process for internal resolution of LIHP applicants and Enrollee grievances and appeals of actions; and

B. A process for LIHP applicants and Enrollee appeal of actions to a State fair hearing.

3. Internal grievance and appeal process and coordination with the State fair hearing process.

A. For those individuals whose LIHP eligibility is determined by the State, the State assumes the responsibility and accountability for the resolution process. For those individuals whose LIHP eligibility is determined by the county, the State delegates to the county responsibility for the resolution process.

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

B. Exhaustion of the internal appeal process will be required of a LIHP applicant or Enrollee prior to filing a request for a State fair hearing to appeal an action. (42 CFR 438.402.)

C. Grievances will not be appealable to a State fair hearing.

4. Matters outside the scope of the grievance and appeal process, including the right to a State fair hearing.

A. The sole issue is one of Federal or State law or policy, LIHP protocols approved under the Demonstration STCs (42 CFR 431.230(1).)

B. The establishment of and any adjustments to the upper income limit made by the LIHP, in accord with STC 58(b).

C. The establishment by a LIHP of enrollment cap of HCCI, and if as the result of such cap the HCCI is completely closed, establishment of enrollment caps for MCE. (STC 58(c).)

D. The establishment by a LIHP of wait lists as a result of enrollment caps created in accord with STC 58(c). (STC 58(d).)

E. The requirement that a LIHP make a timely eligibility determination is waived with respect to individuals' eligibility for a capped program while those individuals are placed on a county wait list for that program. The County's determination to place individuals on a wait list, rather than enrolling them in the capped program directly, is not subject to appeal. Nothing in this Provision shall preclude those individuals from appealing the County's determination of eligibility for other programs.

5. Grievance and Appeals Process

A. Notice of Grievance and Appeal Rights

1) LIHP applications will inform applicants of their right to file an internal grievance or appeal and the procedures for exercising this right, as well as the right to appeal an action as identified herein to a State fair hearing upon exhaustion of the internal process. Such information shall be made available in languages in addition to English as outlined in 42 CFR 438.10(c).

2) Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all Enrollees at the same time that a Notice

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

of Action is issued (as generally required in B., below, and in B.2 and B.3., specifically.

3) Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all providers within the LIHP network at the time they enter into a contract, or when the LIHP begins, whichever is earlier.

B. Notice of Action

1) Format - the notice of action will be in writing, and available in languages in addition to English as outlined in 42 CFR 438.10(c).

2) Notice to Applicants – notice will be provided upon completion of an eligibility determination.

3) Timing of Notice for Enrollees – a notice of action will be mailed to Enrollee at least 10 calendar days before the date of the action. Exceptions to such notice will follow 42 CFR 431.213.

a) Notices regarding standard authorization of service that deny or limit services will be provided as expeditiously as the Enrollee's health condition requires and within 14 calendar days following receipt of the request for service. (42 CFR. 438.210(d)(1).) The timeframe may be extended for up to 14 additional calendar days if the Enrollee or provider requests the extension, and the LIHP justifies (to the State agency upon request) a need for additional information and how the extension is in the Enrollee's interest. Failure to timely reach authorization decisions constitute a denial and an adverse action, and notice must be provided on the date the timeframe expires. (42 CFR 438.404(c)(5).)

b) When a LIHP determines (for a request from the Enrollee) or the provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that following the standard timeframe in (a), above, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the LIHP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the Enrollee's health condition requires and no later than 3 working days. The 3 working days time period may be extended by up to 14 calendar days if the Enrollee requests an extension or if the LIHP justifies (to the State agency upon request) a need for

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

additional information and how the extension is in the Enrollee's interest.

c) The requirement for advance notice may be shortened to 5 calendar days in case of probable fraud by Enrollees where the agency has facts indicating probable fraud and those facts have been verified, if possible, through secondary sources. (42 CFR 431.214.)

4) Content of Notice - the intended action; the reasons for the action (including statutory and regulatory references, if applicable); the effective date of the action; the program requirements that support the action; the Enrollee's right to file an appeal; the procedures for exercising these rights; the circumstances under which expedited resolution is available and how to request it, and the circumstances under which benefits are continued and how to request it. (42 CFR 438.404.)

C. The Internal Grievance and Appeal Requirements

1) For both grievances and appeals:

a) The LIHP will provide any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability. *(*42 CFR 438.406.) for all stages of the grievance and appeal processes, at no cost to applicants or LIHP recipients.

b) LIHP applicants Enrollees must file an internal grievance within 60 calendar days of the incident giving rise to the grievance, and must file an appeal of action within 60 calendar days of the date of the notice of action.

c) The LIHP will acknowledge receipt in writing of each grievance and appeal.

d) The decision maker must not be involved in any previous level of review or decision making.

e) The decision maker in the following cases must be a health care professional with the appropriate clinical expertise in treating the Enrollee's condition or disease:

i. An appeal of a denial based on lack of Medical Necessity.

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

ii. A grievance regarding denial of expedited resolution of an appeal.

iii. Grievance or appeal that involves clinical issues.

2) Requirements for appeals of actions

a) Oral inquiries seeking to appeal an action will be treated as an appeal and confirmed in writing by the LIHP or the State unless the applicant, Enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.

b) Applicants, Enrollees and their representatives will have the opportunity, before and during the appeals process:

i. To examine the LIHP's position statement related to the reason services are delayed, denied or withdrawn by the LIHP or the State, the Enrollee's case file, including medical records, and any other documents under consideration in the appeal, and

ii; To confront and cross-examine adverse witnesses.

c) LIHP applicants and Enrollees and their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses, in person, in writing, or by telephone if requested by the individual.

d) In regard to the option for LIHP applicants and Enrollees and their representatives to present evidence via the telephone, hearings can be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings conducted in this manner must meet the following criteria:

i. Telephonic hearings may be requested by the individual, at any stage of the appeals process, free of charge,

ii. The individual must receive a written notice that a hearing can be conducted by telephone or video conference in lieu of an in-person hearing. Such notice must contain information about the process for an individual to review the records, submit evidence, and receive reimbursement for costs in accordance with (iii) through (vii) of this section C.2.d.

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

iii. LIHP applicants and Enrollees and their representatives must have the opportunity, before and during the appeals process, to examine the LIHP's position statement, the LIHP recipient's case file, including medical records, and any other documents under consideration in the appeal.

iv. LIHP applicants and Enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal.

v. The record must be kept open for 15 calendar days to permit the LIHP applicants and Enrollees and their representatives to submit evidence and any other documents for consideration in the appeal after the hearing has concluded.

vi. LIHP applicants and Enrollees and their representatives must be able to obtain reimbursement of LIHP recipient's costs in order to attend an in-person hearing. i.e. transportation.

vii. Changes in Process

a. At any point prior to or during a telephone or video conference hearing, at the request of either party or the decision maker, an in-person hearing can be ordered.

b. If an individual has an in person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.

D. Timeframe for Resolution of Appeals and Grievances

1) Standard disposition of grievances – Oral or written notice must be mailed within 60 calendar days of receipt of the grievance.

2) Standard resolution of appeals – LIHP must mail written notice within 45 calendar days of receipt of the appeal.

3) Expedited resolution of appeals – LIHP must mail written notice within 3 working days of receipt of the appeal. In addition, reasonable efforts to provide oral notice will be made.

4) Timeframes on the above may be extended by up to 14 calendar days if either the Enrollee requests it, or the LIHP can show (to the satisfaction of the State

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

DHCS upon its request) that there is a need for additional information and how the delay is in the Enrollee's interest.

5) Written notice of the reason for the delay under (4.), above, must be provided, unless requested by the Enrollee.

6) If a request for expedited resolution of an appeal is denied, the appeal must be treated under the standard resolution timeframe. In addition, reasonable efforts to give prompt oral notice of the denial must be made, and follow up with written notice within 2 calendar days must be provided.

E. Content of Notice of Appeals Resolution

1) Written notice of the resolution must include:

a. The results of the resolution process and the date it was completed.

b. Be available in languages in addition to English as outlined in 42. CFR 438.10(c)

c. For appeals not resolved wholly in favor of the Enrollee:

i. The right to request a State fair hearing and how to do so and the date by which the request of a State fair hearing must be made to be considered timely;

ii. If applicable, the right to request to receive benefits while the hearing is pending, and how to make the request; and

iii. That the Enrollee may be held liable for the cost of those benefits if the hearing decision upholds the LIHPs action.

F. State Fair Hearing

1) A State fair hearing may be requested within 90 calendar days of the date of the Notice of Resolution of the internal appeal of an action.

2) The State will take final administrative action in accord with 42 CFR 431.244(f)(1), or 431.244(f)(2), if applicable.

3) The LIHP will be a party to the State fair hearing.

G. Continuation of benefits during an appeal of action or a State fair hearing

1) The Enrollee's benefits must be continued if:

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

a) An Enrollee's eligibility is terminated or reduced;

b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c) The services were ordered by an authorized provider;

d) The original period covered by the original authorization has not expired;

e) The Enrollee or provider (on behalf of the Enrollee) timely files an appeal; and

f) The Enrollee requests extension of benefits.

2) "Timely filing" as used in this section means filing on or before the later of either:

a. Ten (10) calendar days from the mailing of the notice of action

b. The intended effective date of the proposed action.

c. In the case of a State fair hearing, 10 calendar days from the date of the internal appeal decision.

3) Benefits that are continued under this section shall be continued until:

a) The Enrollee withdraws the appeal;

b) Ten (10) calendar days pass after the mailing of a notice resolving the Internal appeal adverse to the Enrollee, unless the Enrollee requests a State fair hearing with continuation of benefits within 10 calendar days of the issuance of the internal appeal decision;

c) A State fair hearing decision adverse to the LIHP recipients is issued,

d) As ordered by the Administrative Law Judge at the State fair hearing, in limited permissible circumstances, such as 431.230(a)(1); or

e) The time period or service limits of a previously authorized service has been met.

4) If the final resolution of the internal appeal or the State fair hearing is adverse to the Enrollee, the LIHP may recover the cost of the services furnished to the Enrollee while the appeal is pending, to the extent they were furnished solely because of the requirements of this section of the procedures.

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

5) If services were not furnished pending the internal appeal or the State fair hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the LIHP must provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires.

6) If the Enrollee received disputed services while the internal appeal or the State fair hearing was pending, and the resolution reverses a denial of services, the LIHP must cover such services.

6. LIHP Monitoring Reporting

DHCS expects the Contractor to maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process. To demonstrate the efficacy of the LIHPs grievance and appeals process, the Contractor will provide to DHCS the following data on a quarterly basis:

A. Time period(s) covered

B. Average number of LIHP recipients in the time period

C. Total number of appeal and the total number of grievance cases received by the LIHP and the State in the period;

D. Rate of appeals and the rate of grievances per 1000 LIHP

E. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of:

1) Number and percent decided fully in favor of the LIHP recipient;

2) Number and percent decided partially in favor of the Enrollee;

3) Number and percent not decided in favor of the Enrollee;

4) Number and percent withdrawn by the Enrollee; and

5) Number and percent of cases resolved through the fair hearing process, using telephonic procedures;

a) Number and percent decided in fully favor of the Enrollee using telephonic procedures;

Exhibit A, Attachment 13
ENROLLEE HEARING AND APPEALS PROCESS

b) Number and percent decided partially in favor of the Enrollee using telephonic procedures;

c) Number and percent not decided in favor of the Enrollee using telephonic procedures; and

d) Number and percent withdrawn by the Enrollee using telephonic procedures.

F. Issues involved in all cases.

G. Time it takes to resolve the cases (upper and lower limits, median/mean)

1) Number and percent of these cases involving expedited processing; and

H. Quality Improvement activities related to issues identified through the County's LIHP.

Exhibit A, Attachment 14
ENROLLMENT AND DISENROLLMENT

1. Enrollment

Contractor shall enroll applicants in the MCE and/or HCCI programs in accordance with the eligibility criteria set forth in the STCs. Enrollment in the LIHP is voluntary.

Contractor must ensure that eligibility determinations for the MCE and HCCI populations are made by individuals who are employed under merit system principles by the State or local governments, including local health departments. These employees will refer any applicant who may be eligible for either Medi-Cal or the Children's Health Insurance Program (CHIP) to the State or local government social services office for an eligibility determination.

A. Eligibility

For both the MCE and HCCI programs, eligible individuals may not be otherwise eligible for Medi-Cal or CHIP, must be non-pregnant, and must meet income eligibility standards identified below and pursuant to the STCs and Exhibit E, Provision 42.

The Contractor shall (except for limited service populations pursuant to Exhibit A, Scope of Work, Attachment 10, Scope of Services, Provision 3(F)) perform the initial eligibility determination as to whether an applicant meets the eligibility standards for the MCE or HCCI programs, using applicable methodologies or procedures in effect in the Contractor's county(s) under this Demonstration, and may determine an individual eligible subject to a wait list.

B. Enrollment - General

Contractor has developed income eligibility standards which can be increased with a written fourteen day notice to DHCS pursuant to Exhibit F, Provision 9 and the methodologies and procedures for making eligibility determinations and enrolling eligible individuals in the MCE and/or HCCI program as applicable. Contractor has established the upper income limit for eligibility for the MCE program at 133 percent of the Federal Poverty Level (FPL), and for the HCCI program at 200 percent of the FPL.

LIHP Potential Enrollees residing within the Contractor's Service Area may be enrolled at any time during the term of this Contract. LIHP Potential Enrollees shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, gender, marital status, sexual orientation, health status, or

Exhibit A, Attachment 14
ENROLLMENT AND DISENROLLMENT

disability, subject to the eligibility criteria in the STCs. MCE applicants may be enrolled prior to HCCI applicants and have priority.

C. Adjustments to Income Eligibility

In the event that funding will not be sufficient to continue to enroll applicants under the upper income limit for eligibility that had been established for LIHP applicants under this Contract, Contractor may reduce the upper income limit for new applicants.

If Contractor operates a HCCI program, Contractor may not reduce the upper income limits for MCE applicants unless Contractor has ceased enrolling HCCI applicants.

Prior to implementing any reduction in the upper income limit, the Contractor must submit a 120-day written notice to the State describing the nature of the adjustment to the income limit, the proposed start date of the adjustment(s), and the LIHP's actual and projected enrollment.

D. Enrollment Caps

In cases where a Contractor determines, based on advance budget projections that it cannot continue to enroll applicants without exceeding the funding available for the LIHP, the Contractor may establish enrollment caps for the HCCI program. If, notwithstanding enrollment caps that totally close new enrollment in the HCCI program, the Contractor estimates that it will still exceed available funding, the Contractor can establish enrollment caps for the MCE population.

If the Contractor has established enrollment caps in accordance with this Provision, it may employ wait lists for enrollment into an HCCI and/or MCE program, as a method of managing individual applicant enrollment. Contractor is not required to determine an applicant's eligibility prior to placing the individual on a wait list.

1) If the Contractor employs a wait list for enrollment into an HCCI and/or MCE program, it must ensure outreach is conducted for those individuals on a wait list, for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are still seeking coverage. Outreach materials will remind individuals they can apply for Medi-Cal and CHIP programs at any time.

Exhibit A, Attachment 14
ENROLLMENT AND DISENROLLMENT

E. Coverage

MCE Enrollee coverage shall begin at 12:01 a.m. on the first day of the calendar month in which the application is received and eligibility requirements are met. For those who do not meet the eligibility requirements during the month of application, the beginning date of coverage shall be the first day of the first month in which the above criteria are met. The term of enrollment shall continue indefinitely unless this Contract expires, is terminated, or the Enrollee is disenrolled under the conditions described in Provision 2, Disenrollment.

Existing MCE and Existing HCCI Enrollee are entitled to continued eligibility for LIHP coverage, even though they may not meet the income eligibility requirements established in Provision 1 if they continue to meet the income eligibility standard in effect at the time of their enrollment.

Retroactive eligibility will not be extended prior to the date of application to the LIHP population.

2. Disenrollment

Contractor shall process an Enrollee disenrollment under the following conditions, and shall report quarterly the reason for which disenrollment occurred

A. Disenrollment of an MCE Enrollee is mandatory when:

1) In accordance with Medicaid law and policy; such reasons include: Enrollee has been determined to be unable to provide documentation of citizenship; Enrollee does not provide or no longer meets program eligibility requirements; Enrollee exceeds income limits allowed for the program; Enrollee voluntarily disenrolls from the program; Enrollee is institutionalized in an Institutions for Mental Diseases (IMD); Enrollee attains the age of 65; Enrollee is no longer living; or

2) If Enrollee no longer resides in the county participating in the MCE program.

Exhibit A, Attachment 14
ENROLLMENT AND DISENROLLMENT

B. Disenrollment of an HCCI Enrollee is mandatory when:

1) Enrollee has been determined to be unable to provide documentation of citizenship;

2) Enrollee does not provide or no longer meets program eligibility requirements

3) Enrollee exceeds income limits allowed for the program;

4) Enrollee voluntarily disenrolls from the program

5) Enrollee no longer resides in the county participating in the HCCI program;

6) Enrollee becomes incarcerated or is institutionalized in an IMD;

7) Enrollee attains the age of 65;

8) Enrollees no longer living; or

9) Enrollee obtains other health coverage.

C. Enrollee may voluntarily disenroll without cause at any time by submitting an oral or written request for disenrollment to the LIHP.

D. Disenrollment shall become effective promptly upon receipt by Contractor of all documentation necessary to process the disenrollment. The effective date of an approved disenrollment must be no later than the first day of the second month following the disenrollment request. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Enrollee.

Exhibit A, Attachment 14
ENROLLMENT AND DISENROLLMENT

3. Eligibility Redeterminations

Contractor must redetermine the eligibility of Enrollee in a MCE or HCCI program at least once every twelve (12) months.

A. These eligibility redeterminations cannot use income eligibility standards more restrictive during the period of redetermination than those “in effect” during the period of the MCE or HCCI recipient’s initial eligibility determination.

B. Each redetermination must include a reassessment of the recipient’s eligibility for Medi-Cal and the CHIP. If upon redetermination a recipient is determined ineligible the recipient shall be disenrolled in according with Provision 2, Disenrollment, and referred to the county Medi-Cal office, if appropriate.

4. Change in Health Status

Contractor may not request disenrollment because of a change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the LIHP seriously impairs the entity's ability to furnish services to either this particular Enrollee or other Enrollees).

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Contractor will include the following additional benefits to its core benefits for the MCE and HCCI components of the LIHP as follows:

Covered Health Care Services	**MCE**	**HCCI**
Adult Immunizations	Limited based on Medical Necessity	Limited based on medical necessity
Ambulatory Surgery Center Services	Limited based on Medical Necessity; prior authorization required.	Limited based on medical necessity; prior authorization required.
Audiology	Covered as core hospital outpatient department or physician service benefits when provided by in-network provider; subject to the same limits as those benefits.	Covered as hospital outpatient department or physician service benefits when provided by in-network provider; subject to the same limits as those benefits.
Bariatric Surgery	Not Offered	Not Offered
Case Management	Limited based on Medical Necessity, and must be provided by in-network provider.	Limited based on medical necessity and must be provided by in-network provider.
Dental	Not Offered	Not Offered
Dental Emergency	Not Offered	Not Offered
Durable Medical Equipment	Not Offered	Not Offered
Health Education	Limited to programs related to disease prevention or to a disease specific topic; if disease specific, patient must have disease; further limited to services provided by in-network provider.	Limited to programs related to disease prevention or to a disease specific topic; if disease specific, patient must have disease; further limited to services provided by in-network provider.
Hemodialysis	Not Offered	Not Offered
Home Health Care	No Offered	Not Offered
Hospice	Not Offered	Not Offered
Incontinence Supplies	Not Offered	Not Offered
Non-Physician Medical Practitioner Services	Limited to medically necessary care rendered by credentialed, in-network practitioners.	Limited to medically necessary care rendered by credentialed, in-network practitioners.
Occupational Therapy	Covered as core hospital outpatient	Covered as hospital outpatient department

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Covered Health Care Services	**MCE**	**HCCI**
	department or physician service benefits when provided by in-network provider; also subject to same limits as those benefits.	or physician service benefits when provided by in-network provider; also subject to same limits as those benefits.
Optometry	Limited to retinal exams or reading retinal scans when the patient receiving the exam or scan either has signs or symptoms of retinal disease or damage, or is at high risk for such disease or damage. Refractometry not covered.	Limited to retinal exams or reading retinal scans when the patient receiving the exam or scan either has signs or symptoms of retinal disease or damage, or is at high risk for such disease or damage. Refractometry not covered.
Organ Transplants	Not Offered	Not Offered
Podiatry	Covered as part of the physician service benefit when provided by a credentialed, in-network provider; also subject to the same limits as that benefit.	Covered as part of the physician service benefit when provided by a credentialed in-network provider; also subject to the same limits as that benefit.
Prior-authorized Non-Emergency Medical Transportation (when medically necessary, required for obtaining medical care and provided for the lowest cost mode available)	*Core Benefit*	Covered to the same extent and subject to same limits as for MCE population
Restorative Care Living Arrangements	Not Offered	Not Offered
Short Term Rehabilitation Services	Not Offered	Not Offered
Skilled Nursing	Not Offered	Not Offered
Specialty Outpatient	Not Offered	Not Offered
Speech Therapy	Covered as core hospital outpatient department or physician service benefits when provided by an in-network provider; also subject to the same limits as those	Covered as hospital outpatient department or physician service benefits when provided by an in-network provider; also subject to the same limits as those benefits.

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Covered Health Care Services	**MCE**	**HCCI**
	benefits.	
Subacute Care	Not Offered	Not Offered
Telemedicine	Covered when provided by an in-network provider with the technical capability to provide the telemedicine service.	Covered when provided by an in-network provider with the technical capability to provide the telemedicine service .
Transportation to Emergency Care Services	*Core Benefit*	Limited to situations where transport by ordinary means is medically contraindicated and the transportation is required to provide covered emergency care. Claims must be accompanied by justification.

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

All mental health services will be provided through a carve-out pursuant to Exhibit A, Attachment 10, Scope of Services, Provision 3.B.5, and STC 65.c.

Covered Mental Health Services	**MCE**	**HCCI**
Acute Inpatient Hospital Services: Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.	*Core Benefit*	Limited to medically necessary services where medical necessity is confirmed through a retrospective billing approval.
Acute Inpatient Hospital Services >10 days	Limited to medically necessary services where medical necessity is confirmed through a retrospective billing approval.	Limited to medically necessary services where medical necessity is confirmed through a retrospective billing approval.
Case Management	Limited to medically necessary services. Case consultation services provided to tier 2 clients may be subject to prior authorization and visit limits.	Limited to medically necessary services. Case consultation services provided to tier 2 clients may be subject to prior authorization and visit limits.
Case Management for frequent ED users	Not Offered	Not Offered
Crisis Hotline	Limited to services provided by an in-network provider	Limited to services provided by an in-network provider
Crisis Intervention	Limited to medically necessary services provided by an in-network provider and no more than 8 hours per 24 hour period, pursuant to 9 CCR § 1840.366	Limited to medically necessary services provided by an in-network provider and no more than 8 hours per 24 hour period pursuant to 9 CCR § 1840.366
Crisis Residential Treatment	Limited to medically necessary services provided by an in-network provider	Limited to medically necessary services provided by an in-network provider
Crisis Stabilization	Limited to medically necessary services provided by an in-network provider and no more than 20 hours per 24 hour period, pursuant to 9 CCR § 1840.368	Limited to medically necessary services provided by an in-network provider and no more than 20 hours per 24 hour period, pursuant to 9 CCR § 1840.368
Day Rehabilitation	Not Offered	Not Offered

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Covered Mental Health Services	**MCE**	**HCCI**
Day Treatment Intensive	Not Offered	Not Offered
Dual Diagnosis Treatment	Limited to medically necessary services provided by an in-network provider.	Limited to medically necessary services provided by an in-network provider.
Family/Collateral Therapy	Limited to medically necessary services provided by an in-network provider. Services provided to tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limits.	Covered: limited to medically necessary services provided by an in-network provider. Services provided to tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limits.
Group Therapy	Limited to medically necessary services provided by an in-network provider.	Limited to medically necessary services provided by an in-network provider.
Hospital Administrative Day	Limited to medically necessary services where medical necessity is confirmed through a retrospective approval.	Limited to medically necessary services where medical necessity is confirmed through a retrospective approval.
Individual Therapy	Limited to medically necessary services provided by an in-network provider. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limit.	Limited to medically necessary services provided by an in-network provider. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limit.
Information and Referral Services	Limited to services provided by an in-network provider.	Limited to services provided by an in-network provider
Laboratory studies related to psychiatric diagnosis and treatment	Limited to medically necessary services.	Limited to medically necessary services.
Medication Assisted Treatment	Not Offered	Not Offered
Medication Support	Limited to medically necessary services provided by an in-network provider and to no more than 4 hours per 24 hour period pursuant to 9 CCR § 1840.372.	Limited to medically necessary services provided by an in-network provider and to no more than 4 hours per 24 hour period pursuant to 9 CCR § 1840.372.
Mental Health Assessment	Covered where necessary to determine if client meets coverage criteria for mental	Covered where necessary to determine if client meets coverage criteria for mental

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Covered Mental Health Services	**MCE**	**HCCI**
	health services, or to determine the scope of services that are medically necessary.	health services or to determine the scope of services that are medically necessary.
Mental Health Rehabilitation Centers	Not Offered	Not Offered
Outpatient Encounters: Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. Contractor may elect to extend treatment if it is determined to be medically necessary.	*Core Benefit*	Limited to medically necessary services provided by an in-network provider. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred.
Outpatient Encounters >12 days	Limited to medically necessary services provided by an in-network provider. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limit.	Limited to medically necessary services. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limit.
Peer Support	Limited to medically necessary services provided by an in-network provider	Limited to medically necessary services provided by an in-network provider
Plan Development	Not Offered	Not Offered
Prevention Services	Limited to medically necessary services provided by an in-network provider. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregated visit limit.	Limited to medically necessary services provided by an in-network provider. Services provided to Tier 2 clients may be subject to prior authorization after a threshold number of visits has occurred and may be subject to aggregate visit limit.
Psychiatric Pharmaceuticals	*Core Benefit*	Limited to medically necessary services provided by an in-network provider
Self-Help Services	Limited to services supervised or facilitated	Limited to services supervised or facilitated

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Covered Mental Health Services	**MCE**	**HCCI**
	by an in-network provider	by an in-network provider
Social Rehabilitation	Not Offered	Not Offered
Therapeutic Behavioral Services	Not Offered	Not Offered
Transitional Residential Services	Not Offered	Not Offered
Treatment Placement	Not Offered	Not Offered

Exhibit A, Attachment 15
ADDITIONAL MCE AND HCCI SERVICES

Covered Substance Use Services	**MCE**	**HCCI**
Assessment	Not Offered	Not Offered
Behavioral Health Integration	Not Offered	Not Offered
Case Management	Not Offered	Not Offered
Collateral Services	Not Offered	Not Offered
Day Care Rehabilitation	Not Offered	Not Offered
Detoxification	Not Offered	Not Offered
Group Counseling	Not Offered	Not Offered
Individual Counseling	Not Offered	Not Offered
Medication Assisted Treatment	Not Offered	Not Offered
Narcotic Replacement Therapy (methadone)	Not Offered	Not Offered
Outpatient	Not Offered	Not Offered
Residential Acute Stabilization	Not Offered	Not Offered
Residential Perinatal Treatment	Not Offered	Not Offered
Residential Treatment Including Detoxification	Not Offered	Not Offered
Screening and Intervention	Not Offered	Not Offered
Sober Living Environment	Not Offered	Not Offered
Treatment Placement	Not Offered	Not Offered

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

Budget Detail and Payment Provisions

1. Contract Contingent Upon Funding
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Payment of 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. Recovery of Capitation Payments
11. Maintenance of Effort
12. HCCI Allocation
13. Excluded Providers

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

1. Contract Contingent Upon Funding

A. This Contract shall be implemented only to the extent that the Contractor, a governmental entity with which it is affiliated, or any other eligible public entity voluntarily provides the non-federal share of expenditures under this the Contract. The contributions of the non-federal share specified herein are voluntary contributions to the non-federal share of Medicaid expenditures for purposes of Section 5001(g)(2) of the American Recovery and Reinvestment Act of 2009 (Public Law No. 111-5) and Section 10201(c)(6) of the Patient Protection and Affordable Care Act (Public Law No. 111-148). The voluntary contributions may be comprised of Certified Public Expenditures (CPEs) incurred by the LIHP and other public entities of under the Low-Income Health Program component of California's Bridge to Reform Section 1115 Medicaid Demonstration, and intergovernmental transfers made by eligible public entities to DHCS for payments to Contractor for services provided or arranged by Contractor. Contractor may decide to stop providing funds for the non-federal share of such expenditures under this Contract in accordance with the provisions in Exhibit F, Program Terms and Conditions.

B. It is mutually agreed that the performance by the State and Contractor for the period of the Contract is dependent upon the availability of both the Federal and non-federal share of funding for expenditures under this Contract. Should Contractor elect not to voluntarily provide the non-federal share for expenditures made under this Contract, or should Federal Financial Participation no longer be available for expenditures made under this Contract,, 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.

2. Amounts Payable

A. Except as provided in paragraph B, payment to the LIHP shall be based on actuarially sound per Enrollee rates determined in accordance with this Exhibit B and Welfare and Institutions Code Section 15910.3, the non-federal share of which shall be provided by the Contractor, a governmental entity with which it is affiliated, or any other eligible public entity that voluntarily agrees to participate in funding the LIHP.

B. The LIHP shall be entitled to the Federal Financial Participation received by the State which is based on CPE of the LIHP, a governmental entity

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

with which it is affiliated, or any other eligible public entity that voluntarily agrees to participate in funding the LIHP for the following services:

1. Mental Health Services described in Exhibit A, Scope of Work, Attachment 10 Scope of Services and Attachment 15 Additional MCE and HCCI Services, that are not considered in the determination of the capitation rates.

2. Substance Use Services described in Exhibit A, Attachment 15 Additional MCE and HCCI Services.

3. Allowable Medicaid Administrative Expenditures incurred by the Contractor on behalf of the State as specified in Exhibit E, Definitions, Item 45, that are not considered in the determination of the capitation rate.

4. Services provided to the Limited Service Populations as specified in Exhibit A, Scope of Work, Attachment 10 Scope of Services and Attachment G, Supplement 1, Section III, H of the STCs, that are not considered in the determination of the capitation rate.

5. Services rendered from the effective date of the Contract until the effective date of the actuarially sound capitation rates that are agreed to by DHCS and Contractor and approved by CMS. If the Contractor and DHCS do not agree to capitation rates, payment will continue to be based on CPEs for the term of the Contract.

6. The following services when provided to Enrollees who meet the requirement in the definition of eligible individuals in Part B of the Ryan White Care Act, section 2616(b)(1) of the Public Health Service Act (42 U.S.C.300ff-26(b)(1)):
    a) The core medical services defined for the Ryan White Care Act in section 2612(b)(3) (42 U.S.C. 300ff-22(b)(3)), to the extent they are Covered Services.
    b) Medical transportation services, to the extent they are Covered Services.

7. Emergency Services and related Post-stabilization Care services provided by out-of-network providers, as described in Exhibit A, Attachment 9, Access and Availability, Provision 12, Coverage of Out-of-Network Emergency Services for the MCE Population.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

C. Certified Public Expenditures under this Contract shall be reported by Contractor and the related Federal Financial Participation paid to Contractor by the State in accordance with the claiming protocols approved by CMS under the STCs for the Demonstration. Such payments shall include any interim payments authorized under the STCs and related documents approved by CMS.

D, Services listed in Provision 2. B above shall be treated as carve out services pursuant to Attachment G, Supplement 2, of the STCs.

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 Enrollee, 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. Payment of Capitation Rates

A. DHCS shall make payments to Contractor on a quarterly basis at the rate specified in Exhibit B, Budget Detail and Payment Provisions, Provision 4 for each Enrollee in the LIHP, excluding Limited Service Populations, as reported by the LIHP in accordance with instructions issued by DHCS. The rates paid do not compensate Contractor for services identified in Exhibit B, Budget Detail and Payment Provisions, Provision 2.B. Capitation payments will be made at the beginning of the quarter for each month in the quarter beginning with the effective date of the capitation rates agreed to by Contractor and DHCS, unless otherwise provided in this Agreement. Contractor's CPE claims for costs excluded by Exhibit B, Budget Detail and Payment Provisions, Provision 2.B.6 will be reconciled to ensure that the CPE claims do not duplicate capitation payments for any service.

B. The capitation payment shall be a per Enrollee per month rate in the amount specified below:

LIHP Enrollees (for the period 7/01/11 through 6/30/12)

Group	Rate
MCE	451.14
HCCI	353.30
Mental Health Services	N/A

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

C. The capitation rates shall be the rates proposed by the report submitted by the LIHP pursuant to Welfare & Institutions Code 15910.3 and reviewed and approved by the State.

DHCS shall make payments only to the extent that DHCS has received Intergovernmental Transfers from the Contractor, a governmental entity with which it is affiliated, or any other eligible public entity that voluntarily agrees to participate in funding the LIHP in an amount adequate to fund the non-federal share of the rates, as authorized in State Law. Such amount shall reflect all relevant Federal law and policies with regard to the calculation of the federal share, as authorized in State and federal law including, but not limited to, increased FFP available pursuant to Social Security Act Section 1905(dd) (42 U.S.C. Section 1396d(dd)) or Social Security Act Section 1945 (42 U.S.C. Section 1396w-4).

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 Enrollee for all Covered Services required by such Enrollee and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. DHCS is not responsible for payments for losses incurred by Contractor.

6. Determination Of Rates

A. Contractor shall submit to DHCS the actuarially sound capitation rates per Enrollee to be paid under this Contract, listed in this Exhibit B, Budget Detail and Payment Provisions, Provision 4.b. and any updates or re-determinations of those rates, in accordance with Federal Medicaid principles and the provisions of Welfare and Institutions Code Section 15910.3. Rates shall be reflected in Exhibit B, Budget Detail and Payment Provisions.

B. DHCS shall review the proposed capitation rates submitted by Contractor and approve the Contractor's capitation rates annually beginning with Demonstration Year 7 if those rates comply with W & I Code Section 15910.3. The capitation rates shall be approved prior to the beginning of the Demonstration Year. However, for Demonstration Year 7, Contractor shall be paid on a cost-basis using CPEs on an interim basis only until the capitation rate is determined. Upon final approval, the capitation rate for Demonstration Year 7 will be paid retroactive to July 1, 2011 and

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

reconciled to the interim payments received by Contractor based on CPEs for the interim period.

D. Once the actuarially sound capitation rates are established, the Contractor may submit capitation rates for subsequent years based on appropriate increases or decreases to that rate. Any changes to the capitation rate shall be effectuated through a change order to this Contract in accordance with the provisions of Exhibit F, Program Terms and Conditions, Provision 3, Amendment Process and Provision 4, Change Requirements, subject to the following provisions:

1) The 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 a 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 then in effect. Those continued payments shall constitute interim payment only. Upon final approval of the change order providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the 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) Final reconciliation, recoupment of any overpayment, and payment of any underpayment shall be implemented in accordance with Attachment G, Supplement 2, Section III,D.

E. If mutual agreement between DHCS and Contractor cannot be attained on capitation rates, Contractor shall retain the right to terminate the Contract, or to elect to be reimbursed under this Contract on a cost basis.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

7. Redetermination Of Rates - Obligation Changes

The capitation rates may be adjusted during the rate year to reflect changes in federal or state law or regulation that change the cost of fulfilling the obligations of the Contractor. Contractor shall submit revised rates to DHCS to review for compliance according to Provision 6.B above. DHCS shall promptly respond to requests by Contractor for a rate redetermination. 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 approved by DHCS after consultation with Contractor.

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.

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. Any reinsurance shall comply with 42 CFR Section 438.6.

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 Enrollees, 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.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

10. 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, after consultation with Contractor, that an Enrollee has either been improperly enrolled in Contractor's LIHP, or should have been disenrolled with an effective date in a prior month, DHCS may recover the FFP of the capitation payments made to Contractor for the Enrollee 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 Enrollees during the month(s) in question may be paid by the Contractor, if the Enrollee is determined eligible for the LIHP.

Upon request by Contractor, DHCS may allow Contractor to retain the capitation payments made for Enrollees that are eligible to enroll in Contractor's LIHP, but should have been retroactively disenrolled. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Enrollee, until the Enrollee is disenrolled on a non-retroactive basis pursuant to Exhibit A, Scope of Work, Attachment 14, Enrollment and Disenrollment, Provision 2, Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory Federal Medicaid requirements, the Federal DHHS may disallow FFP for payments made by DHCS to Contractor. DHCS may recover the FFP amounts disallowed by DHHS through 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 after consultation with Contractor that any other erroneous or improper payment not mentioned above has been made to Contractor, DHCS may recover the FFP amount of the erroneous or improper payments through 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. At least thirty

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

(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.

11. Maintenance of Effort

Contractor must demonstrate that the annual amount of non-federal funds expended by Contractor for Covered Services provided to Enrollees in effect under the prior demonstration as HCCI programs will be maintained or increased above the State Fiscal Year (SFY) 2006-07 level and for any new LIHP will be maintained or increased above the SFY 2009-10 level in the absence of the Demonstration, which are identified in Exhibit B, Budget Detail and Payment Provisions, Attachment 1, entitled Maintenance-of-Effort, as the Maintenance-of-Effort requirement (MOE). For purposes of determining compliance with this Section, such annual amount of non-federal funds expended by Contractor shall be determined using data and accounting methods consistent with those used in Exhibit B, Budget Detail and Payment Provisions, Attachment 1, Maintenance of Effort, and shall be submitted to DHCS annually for review. If the Contractor cannot meet the MOE requirement, CMS may reduce Federal funding for LIHP expenditures by the amount of the deficiency. DHCS may recover the FFP paid to the Contractor for LIHP expenditures for the amount of the deficiency.

12. HCCI Allocation

A. An Allocation of HCCI funding shall be available for Covered Services to HCCI Enrollees only if the Contractor operates an MCE program. The allocation requires CMS approval and if CMS denies approval of the allocation for any reason, the allocation amount may be modified by agreement of the parties with CMS approval to reflect adjustments required by CMS.

B. The maximum amount of FFP allocated to Contractor for Covered Services rendered to HCCI Enrollees annually will be:

$9,153,000 for the Extension Period, and Demonstration Year 6,

$146,000 for Demonstration Year 7,

$10,120,000 for Demonstration Year 8,

$6,050,000 for Demonstration Year 9 (July 1, 2013 through December 31, 2013).

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

C. The Allocation for each Demonstration Year is considered an annual allotment for Covered Services rendered during the Demonstration Year to HCCI Enrollees. Claims may be made and payments may be received for Covered Services rendered in prior Program Years, subject to the two-year time limit on filing of claims pursuant to Section 1320-b of Title 42 of the United States Code.

D. Payments for Covered Services to MCE Enrollees and Payments for allowable Medicaid Administrative Expenditures for MCE and HCCI Enrollees as applicable, incurred by the Contractor as specified in Exhibit A, Attachment 10, Scope of Services, and Exhibit E, Definitions that are not subject to an allotment or a maximum payment limit.

13. Excluded Providers

FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services.

Exhibit B, Attachment 1
MAINTENANCE OF EFFORT

This Exhibit assists Contractor and DHCS in assuring compliance with the maintenance-of-effort (MOE) requirement applicable to the LIHP.

1. Identify the total amount of non-federal funds expended for health care services during State Fiscal Year (SFY) 2006-07 that was not reimbursed by any other payor, using Medicare cost principles.

Total non-federal funds expenditures should include expenditures that:

- Provide health care services (such as hospital, clinic, physician, mental health, or other such services) other than for individuals that are not eligible for LIHP.
- Are from any payment source (e.g., county general purpose funds, State realignment funds, borrowed funds, and carryover funds from prior years).

Total non-federal funds expenditures should not include expenditures that are:

- Made from grants from a particular source which are specifically targeted for a particular purpose or program.
- For capital investments in health care Facilities.
- For all public health functions.

The intent is to identify expenditures for health care services that are similar to those to be made as part of the LIHP.

Total non-federal funds expenditures for SFY 2006-07.
$990,268,742

* Contractor must provide a worksheet showing the budget or expenditure accounts and expenditure amounts used to determine the amount reported.

2. Identify any extraordinary and non-recurring expenditures incurred for health care services during SFY 2006-07.

The intent is to identify truly unusual expenditures for health care services that are not expected to be repeated. Examples include expenditures to respond to a health epidemic, or expenditures from substantial special funds. Contractor shall discuss with DHCS any expenditure identified under this section and DHCS will make the final determination whether the expenditure will be excluded from the baseline.

Exhibit B, Attachment 1
MAINTENANCE OF EFFORT

Total amount of extraordinary and non-recurring expenditures during SFY 2006-07:
$209,626,000

*Contractor must provide a list of the extraordinary and non-recurring expenditures.

3. Baseline expenditures for health care services for SFY 2006-07 (Section 1. minus Section 2.): $780,642,742

4. Determine the portion of SFY 2006-07 expenditures reported in Section 3. for health care services provided to individuals who would have been eligible for the LIHP. (This step will not be necessary if costs related to ineligible groups were excluded in Section 1.)

DHCS does not specify any particular methodology for determining this amount. However, Contractor must provide documentation demonstrating the methodology used to arrive at this amount.

5. MOE requirement: $641,766,397

Contractor's MOE requirement will be reduced by the amount of any reduction in the State's level of contribution of realignment funds to the Contractor's health account for SFYs 2011-12, 2012-13 and 2013-14. However, Federal funding for the LIHP may be reduced as a result of a reduction in Contractor's MOE requirement.

Exhibit C
PROVISIONS FOR FEDERALLY FUNDED PROGRAMS

1. Fair Employment Practices

   A. In the performance of this Contract, the Contractor must not discriminate against any employee or applicant for employment because of race, color, religion, ancestry, sex, age, national origin, physical handicap, mental condition, sexual orientation, or marital status. The Contractor must take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, color, religion, ancestry, sex, age, national origin, mental condition, physical handicap, marital status, or sexual orientation. Such action must include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising, layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor must post in conspicuous places, available to employees and applicants for employment, notices to be provided by the State setting forth the provisions of this Fair Employment Practices Provision.

   B. The Contractor must permit access to his records of employment, employment advertisements, application forms, and other pertinent data and records by the State Fair Employment and Housing Commission, or any other agency of the State of California designated by the State, for the purposes of investigation to ascertain compliance with the Fair Employment Practices Provision of this Contract.

   C. Remedies for Unlawful Employment Practice:

      (1) The State may determine an unlawful practice under the Fair Employment Practices Provision of this Contract to have occurred upon receipt of a final judgment having that effect from a court in an action to which Contractor was a party, or upon receipt of a written notice from the Fair Employment and Housing Commission that it has investigated and determined that the Contractor has violated the provisions of the Fair Employment and Housing Act and has issued an order, under Government Code Section 12970, which has become final.

      (2) For unlawful practices under this Fair Employment Practices Provision, the State must have the right to terminate this Contract after a determination pursuant to (C) (1) of this section has been made.

Exhibit C
PROVISIONS FOR FEDERALLY FUNDED PROGRAMS

d) Contractor agrees to comply with Title 2, Division 3, Part 2.8 (Government Code Sections 12900 et seq.), and any amendments thereto, and any regulation adopted pursuant to that part.

2. Nondiscrimination in Services, Benefits and Facilities

A. The Contractor must not discriminate in the provision of services because of race, color, religion, national origin, sex, age, mental or physical handicap or sexual orientation as provided by State and Federal law.

B. For the purposes of this Contract, distinctions on the grounds of race, color, religion, national origin, age or mental or physical handicap or sexual orientation include but are not limited to the following: denying an Enrollee any service or benefit which is different, or is provided in a different manner or at a different time from that provided other Enrollees under this Contract; subjecting a Enrollee to segregation or separate treatment in any matter related to his receipt of any service; restricting a Enrollee in any way in the enjoyment, advantage or privilege enjoyed by others receiving any service or benefit; treating a Enrollee differently from others in determining whether the Enrollee satisfied any admission, eligibility, other requirement or condition which individuals must meet in order to be provided any benefit; the assignment of times or places for the provision of services on the basis of the race, color, religion, national origin, age, mental or physical handicap or sexual orientation of the Enrollee to be served.

C. The Contractor must take affirmative action to ensure that services to intended Enrollee are provided without regard to race, color, religion, national origin, sex, age, mental or physical disability, or sexual orientation.

3. Clean Air and Water

(This Paragraph is applicable only if the Contract exceeds $100,000, or the Federal Contracting Officer or State has determined that orders under an indefinite quantity contract in any one year will exceed $100,000, or a Facility to be used has been the subject of a conviction under the Clean Air Act (42 U.S.C. 1857c-8[c] [1]) or the Federal Water Pollution Control Act (33 U.S.C. 1319[c]) and is listed by EPA, or the contract is not otherwise exempt.)

A. The Contractor agrees as follows:

1) To comply with all the requirements of Section 114 of the Clean Air Act, as amended (42 U.S.C. 1857, et seq., as

Exhibit C
PROVISIONS FOR FEDERALLY FUNDED PROGRAMS

amended by Pub.L., 91-604) and Section 308 of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq., as amended by Pub.L., 92-500), respectively relating to inspection monitoring, entry, reports, and information, as well as other requirements specified in Section 114 and Section 308 of the Air Act and the Water Act, respectively, and all regulations and guidelines issued there under before the award of this Contract.

2) No obligation required by this Contract will be performed in a facility listed on the Environmental Protection Agency List of Violating Facilities on the date when this contract was executed unless and until the EPA eliminates the name of such facility or facilities from such listing.

3) To use its best efforts to comply with clean air standards and clean water standards at the facility in which the services are being performed.

4) To insert the substance of the provisions of this Paragraph into any written delegation.

B. The terms used in this Paragraph have the following meanings:

1) The term "Air Act" means the Clean Air Act, as amended (42 U.S.C. 1857 et seq., as amended by Pub.L., 91-604).

2) The terms "Water Act" means Federal Water Pollution Control Act, as amended (33 U.S.C. 1251 et seq., as amended by Pub.L., 92-500).

3) The term "clean air standards" means any enforceable rules, regulations, guidelines, standards, limitations, orders, controls, prohibitions, or other which are contained in, issued under, or otherwise adopted pursuant to the Air Act or Executive Order 11738, an approved implementation procedure or plan under section 110(d) of the Clean Air Act (42 U.S.C. 1857c-5[d]), an approved implementation procedure or plan under section 111(c) or section 111(d), or an approved implementation procedure under section 112(d) of the Air Act (42 U.S.C. 1857c-7[d]).

4) The terms "clean water standards" means any enforceable limitation, control, condition, prohibition, standard, or other

Exhibit C
PROVISIONS FOR FEDERALLY FUNDED PROGRAMS

requirement which is promulgated pursuant to the Water Act or contained in a permit issued to a discharger by the Environmental Protection Agency or by a State under an approved program, as authorized by Section 402 of the Water Act (33 U.S.C. 1317).

5) The term "compliance" means compliance with clean air or water standards. Compliance must also mean compliance with a schedule or plan ordered or approved by a court of competent jurisdiction, the Environmental Protection Agency or an air or water pollution control agency in accordance with the requirements of the Air Act or Water Act and regulations issued pursuant thereto.

6) For the purposes of this Provision, the term "facility" means any building, plant, installation, structure, mine, vessel or other floating craft, location, or site of operations, owned, leased, or supervised by a Contractor. Where a location or site of operations contains or includes more than one building, plant, installation, or structure, the entire location or site must be deemed to be a facility except where the Director, Office of Federal Activities, Environmental Protection Agency, determines that independent facilities are collected in one geographical area.

4. Utilization of Small Business Concerns

A. It is the policy of the Federal Government and the State as declared by the Congress and the State Legislature that a fair proportion of the purchases and contracts for supplies and services for the State be placed with small business concerns.

B. The Contractor must accomplish the maximum amount of delegation to, and purchase of goods or services from, small business concerns that the Contractor finds to be consistent with the efficient performance of this Contract.

5. Provision of Bilingual Services

A. When the community potentially served by the Contractor consists of non-English or limited-English speaking persons, the Contractor must take all steps necessary to develop and maintain an appropriate capability for communicating in any necessary second language, including, but not limited to the employment of, or contracting for, in public contact positions of persons qualified in the necessary second languages in a number sufficient to ensure full and effective communication between the

Exhibit C
PROVISIONS FOR FEDERALLY FUNDED PROGRAMS

non-English and limited-English speaking applicants for, and Enrollees of, the Facility's services and the Facility's employees.

Contractor may comply with this Paragraph by providing sufficient qualified translators to provide translation in any necessary second language for any patient, caller or applicant for service, within ten minutes of need for translation. Contractor must maintain immediate translation capability in the emergency room when five percent of the emergency room patients or applicants for emergency room services are non-English or limited-English speaking persons.

Contractor must provide immediate translation to non-English or limited-English speaking patients whose condition is such that failure to immediately translate would risk serious impairment. Contractor must post notices in prominent places in the Facility of the availability of translation in the necessary second languages.

B. As used in this Paragraph:

1) "Non-English or limited-English speaking persons" refers to persons whose primary language is a language other than English;

2) "Necessary second language" refers to a language, other than English, which is the primary language of at least five percent (5%) of either the community potentially served by the contracting Facility or of the Facility's patient population;

3) "Community potentially served by the contracting Facility" refers to the geographic area from which the Facility derives eighty percent (80%) of its patient population; and

4) "Qualified translator" is a person fluent in English and in the necessary second language, familiar with medical terminology, and who can accurately speak, read, write and readily interpret in the necessary second language.

6. Federal Contract Funds

A. It is mutually understood between the parties that this Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Contract were executed after the determination was made.

Exhibit C
PROVISIONS FOR FEDERALLY FUNDED PROGRAMS

B. This Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Contract. In addition this Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Contract in any manner.

C. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Contract shall be amended to reflect any reduction in funds.

D. DHCS has the option to invalidate or cancel the Contract with thirty (30) calendar days advance written notice or to amend the Contract to reflect any reduction in funds.

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. Recitals

A. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental 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; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI shall have the meaning given to such term under HIPAA and HIPAA regulations, as the same may be amended from time to time.

B. DHCS desires to protect the privacy and provide for the security of PHI disclosed, created or received on behalf of DHCS pursuant to this Contract.

IN THE USE OR DISCLOSURE OF INFORMATION PURSUANT TO THIS CONTRACT, THE PARTIES AGREE AS FOLLOWS:

1.2 Definitions

Capitalized terms used herein without definition shall have the meanings ascribed to them in the HIPAA Regulations or the Health Information for Economic and Clinical Health Act (HITECH Act), as applicable.

2. Permitted Uses and Disclosures.

A. *Permitted Uses and Disclosures.* Except as otherwise required by law, Contractor may use or disclose PHI pertaining to Enrollees only to perform functions, activities or services specified in this Contract provided that such use or disclosure is for purposes directly connected with the administration of the MCE or HCCI programs. Those activities which are for purposes directly connected with the administration of the MCE or HCCI programs include, but are not limited to: establishing eligibility and enrollment of applicants, collecting ,and reporting data required by CMS and DHCS, and conducting the LIHP evaluation required by CMS and DHCS providing services for Enrollees; conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the MCE or HCCI programs; and conducting or assisting a legislative investigation or audit related to the administration of the MCE or HCCI programs. Notwithstanding this Exhibit D, the Contractor, as a Covered Entity, may permissibly use or disclose PHI for treatment, payment, and health care operations, and as otherwise permitted or required under HIPAA or the HITECH Act.

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

B. *Specific Use and Disclosure Provisions.* Except as otherwise indicated in this Contract, Contractor may:

1) *Use and disclose for management and administration.* Use and disclose PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided that disclosures are required by law, or the Contractor 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 Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

2) *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 Contractor on behalf of DHCS with PHI received by the Contractor in its capacity as the Contractor of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

C. *Prohibition of External Disclosures of Lists of Enrollees.* A Contractor must provide DHCS's Contracting Officer with a list of external entities, including persons, organizations, and agencies, other than those within its treatment network and other than DHCS, to which it discloses lists of LIHP Enrollee names and addresses. This list must be provided within thirty (30) calendar days of the execution of this Contract and annually thereafter.

3. Responsibilities of Contractor

Contractor agrees:

A. *Divulging LIHP Status.* Not to divulge the LIHP status of a Contractor's Enrollees without DHCS' prior approval except for treatment, payment and operations, or as required by law.

B. *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 or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Contract. Contractor shall maintain a comprehensive written information

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. Contractor will provide DHCS with information concerning such safeguards as DHCS may reasonably request.

C. *Security.* To take any and all appropriate steps necessary to ensure the continuous security of all computerized data systems containing PHI, and provide data security procedures for the use of DHCS at the end of the contract period. These steps shall include, at a minimum:

1) Complying with all of the data system security safeguards listed in this Contract.

2) 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 Contract;

3) General Security Controls

a) Confidentiality Statement. All persons that will be working with DHCS PHI must sign a confidentiality statement supplied by the Contractor. The statement must include 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. The statement must be renewed annually.

b) Background check. Before a member of the Contractor's workforce may access DHCS PHI, Contractor must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data.

c) Workstation/Laptop encryption. All workstations and laptops that process and/or store DHCS PHI must be encrypted with a DHCS approved solution or a solution using a vendor product specified on the California Strategic Sourced Initiative (CSSI) located at the following link: www.pd.dgs.ca.gov/masters/EncryptionSoftware.html. The encryption solution must be full disc unless approved by the DHCS Information Security Office.

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

d) Only the minimum necessary amount of DHCS PHI may be downloaded to a laptop or hard drive when absolutely necessary for business purposes.

e) Removable media devices. All electronic files that contain DHCS PHI must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.) with a DHCS approved solution or a solution using a vendor product specified on the CSSI.

f) Email security. All emails that include DHCS PHI must be sent in an encrypted method using a DHCS approved solution or a solution using a vendor product specified on the CSSI.

g) Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

h) Patch Management. All workstations, laptops and other systems that process and/or store DHCS data must have security patches applied and up-to-date.

i) User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI. Passwords are not to be shared. Must be at least eight (8) characters. Must be a non-dictionary word. Must not be stored in readable format on the computer. Must be changed every sixty (60) days. Must be changed if revealed or compromised. Must be composed of characters from at least three (3) of the following four (4) groups from the standard keyboard:

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

j) Data Destruction. All DHCS data must be destroyed using Department of Defense standard methods for data destruction when the DHCS data is no longer needed.

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

k) Remote Access. Any remote access to DHCS PHI must be executed over an encrypted method approved by DHCS or using a vendor product specified on the CSSI. All remote access must be limited to minimum necessary and least privilege principles.

4) System Security Controls

a) System Timeout. The system must provide an automatic timeout after no more than twenty (20) minutes of inactivity.

b) Warning Banners. All systems containing DHCS PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. User must be directed to log off the system if they do not agree with these requirements.

c) System Logging. The system must log success and failures of user authentication at all layers. The system must log all system administrator/developer access and changes if the system is processing and/or storing PHI. The system must log all user transactions at the database layer if processing and/or storing DHCS PHI.

d) Access Controls. The system must use role based access controls for all user authentication, enforcing the principle of least privilege.

e) Transmission Encryption. All data transmissions must be encrypted end-to-end using a DHCS approved solution or a solution using a vendor product specified on the CSSI, when transmitting DHCS PHI.

f) Host Based Intrusion Detection. All systems that are accessible via the Internet or store DHCS PHI must actively use a comprehensive third-party real-time host based intrusion detection and prevention program.

5) Audit Controls

a) System Security Review. All systems processing and/or storing DHCS PHI must have at least an annual system

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

security review. Reviews must include administrative and technical vulnerability scanning tools.

b) Log Reviews. All systems processing and/or storing DHCS PHI must have a routine procedure in place to review system logs for unauthorized access. Logs must be maintained for six (6) years after the occurrence.

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

6) 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 in the event of an emergency.

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

7) Paper Document Controls

a) Supervision of Data. Contractor must have a policy that:

i. DHCS PHI 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.

ii. DHCS PHI 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.

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

b) Escorting Visitors. Visitors to areas where DHCS PHI is contained shall be escorted and DHCS PHI shall be kept out of sight while visitors are in the area unless they are authorized to view the PHI.

c) Confidential Destruction. DHCS PHI must be disposed of through confidential means, such as shredding and pulverizing.

d) Removal of Data. DHCS PHI must not be removed from the premises of the Contractor except for routine business purposes or with the express written permission of DHCS.

e) Faxing. Faxes containing DHCS PHI 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.

f) Mailing. DHCS PHI shall only be mailed using secure methods. Large volume mailings of DHCS PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted.

D. *Contractor's Agents.* To ensure that any agents, including Subcontractors but excluding providers of treatment services, to whom Contractor provides PHI received from or created or received by Contractor on behalf of DHCS, agree to the same restrictions and conditions that apply to Contractor with respect to such PHI; and to incorporate, when applicable, the relevant provisions of this Contract into each Subcontract or subaward to such agents or Subcontractors.

E. *Availability of Information to Enrollees.* To provide access to Enrollees (upon reasonable notice and during Contractor's normal business hours) to their PHI in a Designated Record Set in accordance with 45 CFR 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical and billing records about Enrollees; enrollment, payment, , and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about Enrollees eligibility on behalf of DHCS.

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

F. *Amendment of Information.* To make available PHI for amendment, upon Enrollee's request, and to incorporate any amendments to PHI in accordance with 45 CFR 164.526.

G. *Internal Practices.* To make Contractor's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Contractor on behalf of DHCS, available to DHCS in a time and manner designated by DHCS, for purposes of determining compliance with the provisions of this Contract.

H. *Documentation and Accounting of Disclosures.* To document and make available to DHCS and to a Enrollee such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Enrollee for an accounting of disclosures of PHI, in accordance with 45 CFR 164.528.

I. *Notification of Breach.* During the term of this Agreement:

1) *Discovery of Breach.* To notify DHCS immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or within twenty-four (24) hours by e-mail or fax of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Contract, or potential loss of confidential data affecting this Contract. Notification shall be provided to the DHCS LIHP Contracting Officer, 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, notification shall be provided by calling the DHCS ITSD Help Desk. Contractor 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 of Breach.* To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within seventy-two (72) hours of the discovery,

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

to notify the DHCS LIHP Contracting Officer, the DHCS Privacy Officer, and the DHCS Information Security Officer of:

a) What data elements were involved and the extent of the data involved in the breach,

b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data,

c) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,

d) A description of the probable causes of the improper use or disclosure; and

e) Whether Civil Code sections 1798.29 or 1798.82 or any other Federal or State laws requiring individual notifications of breaches are triggered.

3) *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 Contract.

DHCS LIHP Contracting Officer	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See Paragraph 4 of Exhibit A (Scope of Work) DHCS LIHP Contracting Officer Information	Privacy Officer c/o Office of Legal Services Department of Health Care Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Telephone: (916) 440-7750 Email: privacyofficer@dhcs.ca.gov	DHCS Information Security Officer Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Help Desk 916-440-7000 or 800-579-0874

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

J. *Notice of Privacy Practices.* To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, the HITECH Act, applicable State and Federal laws and regulations, and Provision 2.A., Permitted Uses and Disclosures of this Exhibit D. Such NPP's must include the DHCS Privacy Officer contact information included in part H. above of this Contract as an alternative means for LIHP Enrollee to lodge privacy complaints. All NPP's created or modified after August 1, 2003, must be submitted to Contractor's DHCS contract manager for review.

K. *Termination*. Upon termination of this Agreement for any reason, Contractor shall either return or destroy all PHI related to the functions or services performed under this Attachment G and as requested by Covered Entity, that Contractor or its agents or Subcontractors still maintain in any form, and shall retain no copies of such PHI. If Covered Entity requests that Contractor return PHI, such PHI shall be returned in a mutually agreed upon format and timeframe. If Contractor reasonably determines that return or destruction is not feasible, Contractor shall continue to extend the protections of this Agreement to such PHI, and limit further uses and disclosures of such PHI to those purposes that make the return or destruction of such PHI not feasible, If Contractor is asked to destroy the PHI, Contractor shall destroy PHI in a manner that renders the PHI unusable, unreadable or indecipherable to unauthorized individuals as specified in the HITECH Act.

4. Miscellaneous Provisions

A. *Amendment.* The parties acknowledge that Federal and State laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Contract 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 HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS's request, Contractor agrees to promptly enter into negotiations with DHCS concerning an amendment to this Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA regulations or other applicable laws. DHCS may terminate this Contract upon thirty (30) calendar days written notice in the event (i) Contractor does not promptly enter into negotiations to amend this Contract when requested by DHCS pursuant to this Section or (ii) Contractor does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to

Exhibit D
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

satisfy the standards and requirements of HIPAA, the HIPAA regulations, and applicable laws.

B. *Assistance in Litigation or Administrative Proceedings.* Contractor shall make itself and its employees, and use all due diligence to make any Subcontractors or agents assisting Contractor in the performance of its obligations under this Contract, 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. The HITECH Act or other laws relating to security and privacy, except where Contractor or its Subcontractor, employee or agent is a named adverse party.

Exhibit E
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:

1. **Action means:**
   A. A denial, termination or reduction of eligibility for Medicaid Coverage Expansion (MCE) or Health Care Coverage Initiative (HCCI).

   B. A denial or limited authorization of a requested LIHP service, including the type or level of service.

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

   D. A failure to provide LIHP services in a timely manner, pursuant to the Special Terms and Conditions of the California Bridge to Reform Demonstration for the LIHP.

   E. A failure of the LIHP or the State to act within the timeframes for grievances and appeals as outlined herein.

2. **Administrative Costs** means only those costs that arise out of the operation of the Low Income Health Program (LIHP) including 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 LIHP, and excluding any allowable Medicaid Administrative Expenditures recognized under Attachment J of the STCs of the California Bridge to Reform Demonstration.

3. **Advance Directives** means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

4. **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.

5. **AIDS Beneficiary** means an Enrollee 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.

6. **Appeal** means a request for review of an action, as defined in this Exhibit.

Exhibit E
DEFINITIONS

7. **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 Enrollees 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.

8. **Certified Public Expenditure, or CPE**, means expenditures that a governmental entity certifies it has incurred in furnishing health care services to eligible Enrollees, which may be used as a mechanism for providing the non-federal share of the allowable Federal payments under the LIHP, in accordance with 42 CFR. § 433.51.

9. **Clean Claim** means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Contractor's claims system. Clean claim does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

10. **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

11. **Contract** means this written agreement between DHCS and the Contractor.

12. **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 Enrollees.

13. **Corrective Actions** means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.

14. **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.

15. **Covered Services** means those core services described in Exhibit A, Scope of Work, Attachment 10, Scope of Services and any add-on services contained in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services. Covered Services do not include:

Exhibit E
DEFINITIONS

A. Services for major organ transplants, bariatric surgery, and infertility services as specified in Exhibit A, Scope of Work, Attachment 10, Scope of Services.

B. Long-term care services unless approved by CMS as an additional service, as specified in Exhibit A, Scope of Work Attachment 10, Scope of Services.

C. Home and Community Based Services (HCBS)

D. California Children Services (CCS.

E. Alcohol and substance abuse treatment services and outpatient heroin detoxification unless approved by CMS as an additional service, as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services.

F. Vision services, including Fabrication of optical lenses unless approved by CMS as an additional service, as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services.

G. Directly observed therapy for treatment of tuberculosis

H. Dental services unless approved by CMS as an additional service, as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services.

I. Acupuncture services as specified in Title 22 CCR Section 51308.5, unless approved by CMS as an additional service as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services.

J. Chiropractic services as specified in Title 22 CCR Section 51308, unless approved by CMS as an additional service as specified in Exhibit A, Scope of Work, Attachment 15,Additional MCE and HCCI Services.

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 an Enrollee 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

Exhibit E
DEFINITIONS

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 alpha-fetoprotein-testing program administered by the Genetic Disease Branch of California Department of Public Health.

O. Adult Day Health Care.

P. Pediatric Day Health Care.

Q. Personal Care Services.

R. Family Planning Services, unless approved by CMS as an additional service as specified in Exhibit A, Scope of Work, Attachment 15,Additional MCE and HCCI Services.

S. State Supported Services unless approved by CMS as an additional service as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services .

T. Targeted case management services as specified in Title 22 CCR Sections 51185 and 51351,unless approved by CMS as an additional service as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services.

U. Childhood lead poisoning case management provided by county health departments.

V. Optional benefits as set forth in Welfare and Institutions Code Section 14131.10, as implemented by the Medi-Cal Fee-For-Service program, unless approved by CMS as an additional service as specified in Exhibit A, Scope of Work, Attachment 15, Additional MCE and HCCI Services.

16. **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

17. **Demonstration, or California Bridge to Reform Demonstration:** The Demonstration Project approved by DHHS on November 1, 2010, which authorizes and makes Federal Financial Participation available for LIHPs.

Exhibit E
DEFINITIONS

18. **Demonstration Year (DY)** means the period of time associated with each operational year of the Demonstration, during which the LIHPs are operational. The periods are:

    A. DY 6 November 1, 2010 through June 30, 2011
    B. DY 7 July 1, 2011 through June 30, 2012
    C. DY 8 July 1,2012 through June 30, 2013
    D. DY 9 July 1 2013 through June 30, 2014

19. **Department of Health and Human Services (DHHS)** means the Federal agency responsible for management of the LIHP program.

20. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Medicaid Program in California.

21. **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.

22. **Director** means the Director of the California Department of Health Care Services.

23. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, 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 in serious jeopardy.
    B. Serious impairment to bodily function.
    C. Serious dysfunction of any bodily organ or part.

24. **Emergency Services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish those services under Title XIX and that are needed to evaluate or stabilize an Emergency Medical Condition.

25. **Encounter** means any single medically related service rendered by (a) medical provider(s) to an Enrollee enrolled in the LIHP during the date of service. It

Exhibit E
DEFINITIONS

includes, but is not limited to, all services for which the Contractor incurred any financial liability.

26. **Enrollee** means any Eligible individual who has enrolled in the Contractor's LIHP.

27. **Enrollee Services Guide m**eans written informational materials provided to Enrollee as specified in 42 CFR 438.210

28. **Enrollment** means the process by which an Eligible Individual becomes an Enrollee of the Contractor's LIHP.

29. **Facility** means any premise that is:

    A. Owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this Contract, or

    B. Maintained by a provider to provide services on behalf of the Contractor.

30. **Federal Financial Participation** means Federal share of expenditures allowed under the California Bridge to Reform Demonstration.

31. **Federal Poverty Level (FPL)** refers to the poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the Code of Federal Regulations. The poverty guidelines are used as an eligibility criterion for participation in the LIHP.

32. **Federally Qualified Health Center (FQHC)** means an entity defined in Section 1905(l)(2)(B) of the Social Security Act (42 USC Section 1396d(l)(2)(B)).

33. **Fee-For-Service (FFS)** means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Enrollee.

34. **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.

35. **Grievance** means an expression of dissatisfaction about any matter other than an action, as “action” is defined in this Exhibit.

36. **Healthcare Effectiveness Data and Information Set (HEDIS®)** means the set of standardized performance measures sponsored and maintained by the

Exhibit E
DEFINITIONS

National Committee for Quality Assurance.

37. **Hearing,** as required of the LIHP pursuant to Exhibit A, Attachment 13, Enrollee Hearing and Appeals Process, means a meeting process, which is not an evidentiary hearing, under which an individual is provided a reasonable opportunity by the LIHP to present evidence and allegations of fact or law, and cross examine witnesses, in person or in writing, or by telephone. The evidentiary hearing that is required by 42 CFR 431 Part E shall be provided under the State fair hearing process, as described in Exhibit A, Scope of Work, Attachment 13, Enrollee Hearing and Appeals Process.

38. **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.

39. **Intergovernmental Transfer, or IGT**, means funds that are transferred from a public agency to the State for use as the non-federal share of expenditures that are eligible for Federal Financial Participation, as authorized by 42 CFR Section 433.51.

40. **Joint Commission on the Accreditation of Health Care Organizations (Joint Commission or 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.

41. **LIHP, or Low Income Health Program,** means a county-based elective program that consists of two components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI), operated under the California Bridge to Reform Demonstration.

Exhibit E
DEFINITIONS

42. **LIHP Enrollee** means any person enrolled in LIHP who is not eligible for Medi-Cal or CHIP, must meet county residency requirements, immigration status, be non-pregnant, and must meet income eligibility standards for family incomes between 0 and 200 percent of the Federal Poverty Level (FPL) that are determined by the Contractor. This includes existing Enrollees who were enrolled in the "Medi-Cal Hospital/Uninsured Care Demonstration, in their county of residence on November 1, 2010. Existing Enrollees are entitled to continued eligibility even though they may not meet the current income eligibility standards imposed by the Contract under the LIHP.

    1) HCCI Enrollee must be between 19 and 64 years of age, meet county residency requirements and have family incomes above 133 through 200 percent of the FPL based on Contractors HCCI income eligibility standards, must not have third party coverage, and is pending documentation of citizenship consistent with 1902(a)(46)(B) of the Act or otherwise have satisfactory immigration status.

    2) MCE Enrollee must be between 19 and 64 years of age who meet county residency requirements and have family incomes at or below 133 percent of the FPL based on Contractors MCE income eligibility standards, may have third party coverage, and is pending documentation of citizenship consistent with 1902(a)(46)(B) of the Act or otherwise have satisfactory immigration status.

43. **Marketing** means any communication from an MCO or PIHP to a LIHP recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's, or PIHP's LIHP product, or either to not enroll in, or to disenroll from, another MCO's, or PIHP's LIHP product.

44. **Managed Care Organization or MCO** means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR 438, and that is –

    1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489; or

    2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

        (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and

Exhibit E
DEFINITIONS

(ii) Meets the solvency standards of 42 CFR 438.116.

45. **Medicaid Administrative Expenditures** means allowable costs incurred by Contractor in performing administrative activities related to the Demonstration on behalf of the State that are recognized under Attachment J of the STCs.

46. **Medical Records** means written documentary evidence of treatments rendered to LIHP Enrollees.

47. **Medical Home** means a single provider, Facility, or health care team that maintains an individual's medical information, and coordinates health care services for enrolled individuals. Medical Homes must meet the standards contained in Welfare and Institutions Code Section 15910.2(b).

48. **Medically Necessary** or **Medical Necessity** means reasonable and necessary services in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. The Contractor must address in its description of Medically Necessary Covered Services the extent to which it is responsible for covering services related to the prevention, diagnosis, and treatment of health impairments, the ability to achieve age-appropriate growth and development and the ability to attain, maintain, or regain functional capacity.

49. **NCQA Licensed Audit Organization** is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

50. **Non-Emergency Medical Transportation** means ambulance, litter van and wheelchair van medical transportation services when the Enrollee's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR Sections 51323, 51231.1, and 51231.2, rendered by licensed providers.

51. **Non-Medical Transportation** means transportation of Enrollees to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Enrollees by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

Exhibit E
DEFINITIONS

52. **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.

53. **Nurse** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

54. **Other Healthcare Coverage Sources** (OHCS) means the responsibility of an individual or entity, other than Contractor or the Enrollee, for the payment of the reasonable value of all or part of the healthcare benefits provided to an Enrollee. 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.

55. **Outpatient Care** means treatment provided to an Enrollee who is not confined in a health care Facility.

56. **Physician** means a person duly licensed as a physician by the Medical Board of California.

57. **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 Enrollees under this Contract.

58. **Pre-Paid Inpatient Health Plan or PIHP** means an entity that:

    1) Provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;

    2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and

    3) Does not have a comprehensive risk contract.

59. **Policy Letter** means a document that has been dated, numbered, and issued by DHCS, Low Income Health Program 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.

Exhibit E
DEFINITIONS

60. **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.

61. **Post-Stabilization Care Services** means Covered Services related to an Emergency Medical Condition that, subject to approval in accordance to Contractor's protocols, are provided after an Enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition.

62. **Potential Enrollee** means any person who is not currently an Enrollee but meets county residency requirements, immigration status, is not eligible for Medicaid or CHIP, is not pregnant, is within the following populations and may voluntarily elect to enroll in LIHP:

    A. HCCI Enrollee must be between 19 and 64 years of age, meet county residency requirements and have family incomes above 133 through 200 percent of the FPL based on Contractors LIHP income eligibility standards, must not have third party coverage, and is pending documentation of citizenship consistent 1902(a)(46)(B) of the Act, or otherwise have satisfactory immigration status.

    B. MCE Enrollee must be between 19 and 64 years of age who meet county residency requirements and have family incomes at or below 133 percent of the FPL based on Contractors LIHP income eligibility standards, may have third party coverage, is pending documentation of citizenship consistent 1902(a)(46)(B) of the Act, or otherwise have satisfactory immigration status..

63. **Preventive Care** means health care designed to prevent disease and/or its consequences.

64. **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, and mid-level practitioners. This type of care emphasizes caring for the Enrollee's general health needs as opposed to specialists focusing on specific needs.

65. **Primary Care Physician (PCP)** means a physician responsible for supervising, coordinating, and providing initial and primary care to patients who may serve as the Medical Home for Enrollees. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

66. **Primary Care Provider** means a person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating

Exhibit E
DEFINITIONS

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.

67. **Prior Authorization** means a formal process requiring a health care to obtain advance approval to provide specific services or procedures.

68. **Quality Improvement (QI)** means the result of an effective Quality Improvement System.

69. **Quality Improvement Projects (QIPs**) means studies used for Quality Improvement purposes.

70. **Quality Improvement System (QIS)** means the systematic activities to monitor and evaluate the medical care delivered to Enrollees 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.

71. **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.

72. **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.

73. **Rural Health Clinic (RHC)** means an entity defined in Title Section 1905(l)(1) of the Social Security Act (42 USC Section 1396d(l)(1)).

74. **Safety Net Care Pool (SNCP)** means Federal funding provided under paragraph 35 of the STCs of the California Bridge to Reform Demonstration.

75. **Service Area** means the geographic area that the Contractor is approved to operate in under the terms of this Contract.

76. **Service Authorization Request** means an Enrollee's request for the provision of a Covered Service.

77. **Service Location** means any location at which an Enrollee obtains any Covered Service provided by the Contractor under the terms of this Contract.

Exhibit E
DEFINITIONS

78. **Special Terms and Conditions (STCs):** The Special Terms and Conditions of the California Bridge to Reform Demonstration.

79. **Standing Referral** means a referral by a PCP to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.

80. **State** means the State of California.

81. **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 Enrollees.

    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 Contractor's obligations to DHCS under the terms of this Contract.

82. **Subcontractor** means any party to an agreement with a Contractor which is entered into for the purpose of providing any Covered Services and/or performing administrative activities connected with the obligations under this Contract on behalf of the Contractor.

83. **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).

84. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

85. **Working day(s)** mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit F
PROGRAM TERMS AND CONDITIONS

1. Governing Law

A. This contract will be governed and construed in accordance with:

1) The Special Terms and Conditions of the section 1115(a) California Bridge to Reform Waiver No. 11-W-00193/9, any Demonstration implementation documents approved by the Centers for Medicare & Medicaid Services (CMS), Article 5.2 (commencing with Section 14166) of the Welfare and Institutions Code, and Division 9, Part 3.6 (commencing with Section 15909) of the Welfare and Institutions Code.

2) Title 42 of the Code of Federal Regulations as applicable and all other applicable Federal laws and regulations according to their content on and after the effective dates stipulated in Provision 11, except those provisions or applications of those provisions waived by the Secretary of the DHHS, or otherwise inapplicable under the Special Terms and Conditions of the Demonstration.

B. Any provision of this Contract which is in conflict with current or future applicable Federal or State laws or regulations set forth in A.1. of this Provision 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 statute or regulation necessitating it, and shall be binding on the DHCS and Contractor even though such amendment may not have been reduced to writing and formally agreed upon and executed by DHCS and Contractor.

C. All existing final Policy Letters issued by the LIHP Branch can be viewed at http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx and shall be complied with by Contractor. All Policy Letters issued by the LIHP Branch subsequent to the effective date of this Contract shall provide clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to changes in State or Federal statutes or regulations, or pursuant to judicial interpretation.

In the event DHCS determines that there is an inconsistency between this Contract and a LIHP Branch Policy Letter, the Contract shall prevail.

Exhibit F
PROGRAM TERMS AND CONDITIONS

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party, pursuant to Provision 9, Notices.

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 DHCS and CMS, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the LIHP 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.

Exhibit F
PROGRAM TERMS AND CONDITIONS

B. Contractor's Obligation to Implement

(1) 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.

(2) DHCS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

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 and consistent with authority delegated by the governing board of the public entity, 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, subject to delegated authority from the governing board.

Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Provision 9, Notices of this Exhibit.

Exhibit F
PROGRAM TERMS AND CONDITIONS

6. Authority of the State

Subject to the STCs, the authority to establish, define, or determine the reasonableness, necessity, level, and scope of covered benefits under the LIHP administered in this Contract, or coverage for such benefits, the eligibility of the Enrollees or providers to participate in the LIHP, resides with DHCS.

Subject to the STCs, the 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 Enrollees or providers to participate in the program, without the express, written direction or approval of the Contracting Officer and CMS.

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. Certifications

Contractor shall comply with certification requirements set forth in 42 CFR 438.604, 42 CFR 438.606, and 42 CFR 433.51.

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, that serves as the basis for payment of amounts of Federal Financial Participation, 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 F
PROGRAM TERMS AND CONDITIONS

9. Notices

A. All Notices

All notices to be given under this Contract will be in writing and sent to the other party by first class, certified, or registered mail with postage prepaid, will be deemed to have been delivered five (5) business days after mailing.

California Department of Health Care Services Low Income Health Program Division Attn: Contracting Officer P.O. Box 997436,MS 4519 Sacramento, CA 95899-74137436	County of Los Angeles Quentin O'Brien, Chief Operating Officer 313 N. Figueroa St. Room 531 Los Angeles, CA 90012

10. Term

A. Except as set forth in Exhibit B, Budget Detail and Payment Provisions, regarding claiming of allowable Medicaid Administrative Expenditures, this Contract will become effective July 1, 2011**,** and will continue in full force and effect through December 31, 2013 subject to Federal Contract Funds.

11. Service Area

The Service Area covered under this Contract includes:

Los Angeles County

12. Contract Extension

This Contract will not be extended beyond December 31, 2013.

Exhibit F
PROGRAM TERMS AND CONDITIONS

13. Termination for Cause and Other Terminations

Contractor agrees to the following:

1. 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, as set forth below.

A. Termination With or Without Cause

1) Contractor may terminate this Contract, with or without cause, by written notice to the DHCS delivered in accordance with Provision 9. Termination will be effective thirty (30) calendar days after delivery or such date as set forth in the notice. Termination by Contractor under this paragraph will constitute Contractor's withdrawal from participation in the LIHP.

2) DHCS may terminate this Contract with or without cause, by written notice to the Contractor delivered in accordance with Provision 9. Termination will be effective thirty (30) calendar days after delivery or such date as set forth in the notice. Notwithstanding the foregoing, Contractor will first have the opportunity to cure whatever breach or other matter constitutes cause for termination. If Contractor effectuates such cure prior to the expiration of the thirty (30) day notice period, this Contract will not terminate. If the nature of the cause for termination is such that is not reasonably susceptible of cure within thirty (30) days, then this Contract will not terminate so long as Contractor has commenced a cure within said thirty (30) day period and thereafter diligently pursues it to completion.

3) If changes to State or Federal law, or changes in the applicable Demonstration requirements, result in a determination by either DHCS or Contractor that continued participation in the LIHP is not in either party's best interests, then the party making such determination must provide written notice to the other, stating the notifying party's desire to terminate this Contract. DHCS and Contractor will thereupon meet and confer within thirty (30) calendar days following such notice. If, following such meet and confer, either party still believes that it is not in its best interests for this Contract to remain in effect, then that party may terminate this Contract for cause upon an additional thirty (30) calendar days written notice.

Exhibit F
PROGRAM TERMS AND CONDITIONS

4) Contractor will remain entitled to reimbursement for all allowable costs of providing Covered Services and all allowable direct and indirect allowable Medicaid Administrative Expenditures incurred prior to the effective date of termination, or to any capitated payments.

14. Sanctions

Contractor is subject to sanctions and civil penalties as described in Subpart I of Part 438 of Title 42 of the Code of Federal Regulations. Such sanctions and civil penalties shall not be imposed in an amount greater than corresponding sanctions and civil penalties as described in W & I Code Section 14304, , Section 53872 of Title 22 of the California Code of Regulations, and 42 CFR, 438.704. If notified by DHCS, Contractor shall ensure Subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of Enrollees, 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. For purposes of the Sanctions described above, Welfare and Institutions Code, Section 14304 and Title 22 CCR Section 53872 are applied as follows:

1) Subsection (b)(1) is applied by replacing “Article 2” with “Article 6”

2) Subsection (b)(2) is applied by replacing “Article 3” with “Article 7”

B. 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) A substantial failure to provide Medically Necessary services required under this Contract or law to an Enrollee.

3) Non-compliance with the Contract or applicable Federal and State law or regulation.

4) Contractor has accrued claims that have not or will not be recompensed.

Exhibit F
PROGRAM TERMS AND CONDITIONS

C. Sanctions in the form of denial of payments provided for under the contract for new Enrollees shall be taken, when and for as long as, payment for those Enrollees is denied by the CMS under 42 CFR Section 438.730.

15. Disputes

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 the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.

A. Disputes Resolution by Negotiation

DHCS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

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, or within 15 calendar days of the date Contractor concludes that further informal negotiations, as contemplated in section A above, will not resolve the dispute, whichever is later, 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.

Exhibit F
PROGRAM TERMS AND CONDITIONS

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 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 LIHP. 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

Exhibit F
PROGRAM TERMS AND CONDITIONS

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 thirty (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 thirty (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 thirty (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's 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,

Exhibit F
PROGRAM TERMS AND CONDITIONS

Contractor shall exhaust all procedures provided for in this Provision 15, 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 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 alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 15, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

16. Appeal Rights

Contractor (the governmental entity) will be entitled to pursue all administrative and judicial review available pursuant to Welfare and Institutions Code Section 14166.24 for costs incurred under the LIHP. In the event of a disallowance, DHCS shall comply with Welfare and Institutions Code Section 14166.24(d) regarding consultation with Contractor and appeal of the disallowance.

17. Audit

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this Contract. These books and records 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.

Exhibit F
PROGRAM TERMS AND CONDITIONS

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to DHCS; financial records; all medical records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Enrollees.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, these books and records will be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the Contract is terminated, or, in the event the Contractor has been duly notified that DHCS, DHHS, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

18. Inspection Rights

Through the end of the records retention period specified in Provision 17, Audit, Paragraph B. Records Retention above, Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, and other authorized State agencies, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor and Subcontractors pertaining to these services at any time during normal business hours with at least 72 hours notice.

Books and records 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 Enrollees. Upon request, through the end of the records retention period specified in Provision 17, 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.

Exhibit F
PROGRAM TERMS AND CONDITIONS

A. Facility Inspections

DHCS shall conduct validation reviews on a number of the Contractor's primary care sites, selected at DHCS's 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 during the Contractor's or other Facility's normal business hours with at least seventy-two (72) hour notice. The monitoring activities will be either announced or unannounced.

19. 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. 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 Enrollees 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 or PHI made in accordance with applicable law.

B. With respect to any identifiable information concerning a Enrollee 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

Exhibit F
PROGRAM TERMS AND CONDITIONS

requests for Medical records or PHI in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract or in accordance with applicable law, any such information to any party other than DHCS without DHCS's prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 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.

20. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor may Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to an Enrollee whenever an Enrollee'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 Enrollees.

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 LIHP 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 an Enrollee whose LIHP eligibility record indicates third party coverage, or Medicare coverage, without proof that the provider has first exhausted all sources of payments. Contractor shall have written procedures implementing this requirement.

E. Post-Payment Recovery

1) If Contractor is unaware of third party coverage or Medicare coverage at the time it receives the claim of a provider reimbursed on a FFS basis, Contractor shall pay the provider's claim and then when it receives information indicating third party coverage, seek to recover the cost of the claim by billing the liable third parties:

Exhibit F
PROGRAM TERMS AND CONDITIONS

2) In instances where Contractor does not reimburse the provider on a FFS basis, Contractor shall pay for services provided to an Enrollee whose eligibility record indicates third party coverage, 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 Enrollees who are retroactively identified by Contractor as having OHCS.

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 OHCS unknown to DHCS, Contractor shall report this information to DHCS within ten (10) calendar days of discovery in automated format as prescribed by DHCS.

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.

21. Declaration That Enrollees in the Low Income Health Program Are Not Third Party Beneficiaries Under This Contract

Notwithstanding mutual recognition that Covered Services under this Contract will be rendered to Enrollees through Contractor's LIHP, it is not the intention of either DHCS or Contractor that such Enrollees occupy the position of intended third party beneficiaries of the obligations assumed by either DHCS or Contractor. Instead, Enrollees are entitled to pursue remedies through the procedures outlined in the California Bridge to Reform Demonstration Hearings and Appeals Process for Low Income Health Programs.

Exhibit F
PROGRAM TERMS AND CONDITIONS

22. 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.

23. Conflict of Interest

A. Contractor is subject to the terms and conditions of Section 51466 of Title 22 of the California Code of Regulations as applicable pursuant to Sections 14022, 14124.5, 14030 and 14031 of the Welfare and Institutions Code.

B. No State officer or State employee responsible for development, negotiation, contract management, or supervision of this Contract will have a financial interest in the Contract as that term is defined in Section 87103 of the Government Code and the regulations adopted pursuant thereto.

24. Fraud and Abuse Reporting

A. For purposes of this Exhibit F, 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 LIHP program, or in reimbursement for services that are not Medically

Exhibit F
PROGRAM TERMS AND CONDITIONS

Necessary or that fail to meet professionally recognized standards for health care to the LIHP (42 CFR 455.2)

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).

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)

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 shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the LIHP, and provide for the development of corrective action initiatives relating to the contract.

2) Contractor shall provide effective training and education for the compliance officer and all employees.

3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.

4) Fraud and Abuse Reporting

Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by Subcontractors, Enrollees, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected

Exhibit F
PROGRAM TERMS AND CONDITIONS

fraud and/or abuse within ten (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:

c) Number of complaints of fraud and abuse submitted that warranted preliminary investigation.
d) For each complaint which warranted a preliminary investigations, supply:
    1) Name and/or SSN or CIN;
    2) Source of complaint;
    3) Type of provider (if applicable);
    4) Nature of complaint;
    5) Approximate dollars involved; and
    6) 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 LIHPDHCS-SNFD@dhcs.ca.gov;
b) Fax at (916) 552-9139; or
c) U.S. Mail at:

Department of Health Care Services
Low Income Health Program Division
P.O. Box 997436, MS 4519
Sacramento, CA 95899-7436

Contractor shall submit the following components with the report or explain why the components are not submitted with the report: police report, LIHP documentation (background information, investigation report, interviews, and any additional investigative information), Enrollee information (patient history chart, patient profile, claims detail report), provider enrollment data, confirmation of services, list items or services furnished by the provider, pharmaceutical data from manufacturers, wholesalers and retailers and any other pertinent information.

5) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are

Exhibit F
PROGRAM TERMS AND CONDITIONS

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 Contracting Officer 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.

C. Federal False Claims 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.

25. 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.

26. Discrimination Prohibitions

A. Enrollee Discrimination Prohibition

Contractor shall not discriminate against Enrollees or Potential Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as

Exhibit F
PROGRAM TERMS AND CONDITIONS

otherwise provided by law or regulations. For the purpose of this Contract, discriminations on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include, but are not limited to, the following:

1) Denying any Enrollee any Covered Services or availability of a Facility;

2) Providing to an Enrollee any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Enrollees under this Contract except where medically indicated;

3) Subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting an Enrollee in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating an Enrollee or Potential Enrollee 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, gender, marital status, sexual orientation, health status, or disability of the participants to be served.

Contractor shall take affirmative action to ensure that Enrollees are provided Covered Services without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, 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.

Exhibit F
PROGRAM TERMS AND CONDITIONS

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 Enrollee's health.

C. Discrimination Complaints

Contractor agrees that copies of all grievances alleging discrimination against Enrollees or Potential Enrollees because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, will be forwarded to DHCS for review and appropriate action.

27. Americans with Disabilities Act Of 1990 Requirements

Contractor shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12101 et seq.), Title 45, CFR, Part 84 and Title 28, CFR, Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

28. 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.

29. 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.

30. 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

Exhibit F
PROGRAM TERMS AND CONDITIONS

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.

31. Additional Incorporated Provisions

A. The following documents and any subsequent updates are not attached, but are incorporated herein and made a part hereof by this reference. These documents may be updated periodically by DHCS, as required by program directives. DHCS shall provide the Contractor with copies of said documents and any periodic updates thereto, under separate cover. DHCS will maintain on file, all documents referenced herein and in any subsequent updates.
   1) STCs
   2) Policy Letter or other similar instructions

32. Priority of Provisions

In the event of a conflict between the provisions of this Exhibit F and any other Exhibit of this Contract, excluding Exhibit C, Provisions for Federally Funded Programs, the provisions of Exhibit F shall prevail.

33. Amendment

No amendment or variation of the terms of this Contract shall be valid unless made in writing, signed by the parties and approved as required. No oral understandings or agreement not incorporated in the Contract is binding on any of the parties.

A. Amendments requiring Federal approval, pursuant to the Special Terms and Conditions of the Demonstration, must be submitted to DHCS no later than one hundred twenty (120) calendar days prior to the date of implementation of the change and may not be implemented until approved by CMS.

B. Amendments not requiring Federal approval must be submitted to DHCS no later than thirty (30) calendar days prior to the date of implementation of the change and may not be implemented until approved by DHCS.

34. Disputes

Contractor shall continue with the responsibilities under this Contract during any dispute.

Exhibit G
DUTIES OF THE STATE

1. Payment for Services

Except with respect to those Services for which payment is based on Certified Public Expenditures, as set forth in Exhibit B, Budget Detail and Payment Provisions Provision 2.B, DHCS shall pay to Contractor the appropriate capitation payments set forth in Exhibit B, Budget Detail and Payment Provisions, Provision 4, Payment of Capitation Rates , for each eligible Enrollee under this Contract, and ensure that such payments are based on actuarially sound capitation rates as defined in 42 CFR, Section 438.6(c) and Welfare & Institutions Code § 15910.3. Capitation payments will be made quarterly for the duration of this Contract. DHCS may accept qualified Intergovernmental Transfers from the Contractor, a governmental entity with which it is affiliated, or any other eligible public entity, obtain Federal Financial Participation, and issue capitated payments, as provided in Section 15911 of the Welfare and Institutions Code.

A. Claiming for Federal Financial Participation

1. Covered Services

DHCS will claim Federal Financial Participation for the reimbursement of Certified Public Expenditures incurred by Contractor under its LIHP for Covered Services with respect to those Services for which payment is based on Certified Public Expenditures, as set forth in Exhibit B, Budget Detail and Payment Provisions, Provision 2.B. DHCS will timely pay Contractor the total Federal Financial Participation amount received pursuant to such claims which are accurate and consistent with the Federally approved Certified Public Expenditures for Covered Services claiming methodology under the Special Terms and Conditions of the Demonstration.

2. Capitation Payments

DHCS will claim Federal Financial Participation for capitation rates paid to Contractor, as set forth in Exhibit B, Budget Detail and Payment Provisions. DHCS will timely pay Contractor the total capitation rates consistent with the Federally approved claiming methodology for capitated payments under the Special Terms and Conditions of the Demonstration. In the event an Intergovernmental Transfer provided to DHCS for the purpose of paying capitation rates paid to Contractor exceeds the amount necessary to provide the non-federal share of such rates. DHCS

Exhibit G
DUTIES OF THE STATE

shall pay the excess amount to the public entity that provided the Intergovernmental Transfer.

B. Administrative Activities

DHCS will claim Federal Financial Participation for the reimbursement of allowable costs associated with Federally approved direct and indirect Medicaid Administrative Expenditures. DHCS will pay Contractor the total Federal Financial Participation amount received pursuant to such claims which are accurate and consistent with the Federally approved direct and indirect administrative activities and cost claiming methodology in Attachment J of the Special Terms and Conditions of the Demonstration.

2. 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.

B. Within sixty (60) calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS. DHCS shall 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 sixty (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.

3. 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 thirty (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 thirty (30) calendar days, in writing, of the reason for the delay and when Contractor may expect the information.

Exhibit G
DUTIES OF THE STATE

4. Catastrophic Coverage Limitation

DHCS shall limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Enrollees which results from or is greatly aggravated by, a catastrophic occurrence or disaster as stated in Exhibit B, Provision 8.

5. 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 Enrollees.

6. State Procurement Process

To the extent that payment is made under this contract on the basis of capitated rates, the State shall comply with 45 CFR Section 74.43.

7. Provider Bulletin

The State will issue a provider bulletin indicating the requirement that providers must accept the LIHP out of network emergency service rates as reimbursement in full and are not permitted to balance bill patients.