

Contract

Between

**United States Department of Health and Human Services
Centers for Medicare & Medicaid Services**

In Partnership with

California Department of Health Care Services

and

Effective: January 1, 2018

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This Contract, effective January 1, 2018 is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the state of California, acting by and through the Department of Health Care Services (DHCS) and _____ (the Contractor). The Contractor's principal place of business is _____.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, DHCS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq and California Welfare and Institutions Code § 14000 et seq, designed to work closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities;

WHEREAS, a purpose of this Contract is to test a new model of payment and service delivery pursuant to 1115A of the Social Security Act;

WHEREAS, the Contractor is in the business of ensuring access to care needed to improve health and quality of life, and CMS and DHCS desire to purchase services from the Contractor to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long-term services and supports; and further the goals of the *Olmstead* Decision;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and state laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contract entered into by CMS, DHCS, and the Contractor executed December 18, 2013 and re-executed on August 31, 2017, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract, but that were not imposed upon the Contractor either in the original version of this Contract executed on December 18, 2013, as amended, or under applicable laws or regulations, shall be prospective in nature only (effective January 1, 2018).

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

1. Definition of Terms

- 1.1. **Actual Non-Service Expenditures** – The Contractor’s actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during each Demonstration Year. These costs will exclude costs incurred by the Contractor prior to the start of the Demonstration. Any reinsurance costs reflected here will be net reinsurance costs.
- 1.2. **Actual Service Expenditures** – The Contractor’s actual amount paid for Covered Services (as defined in Appendix A) delivered during each Demonstration Year. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.
- 1.3. **Adjusted Final Capitation Rate Revenue** – The Adjusted Interim Capitation Rate Revenue with the Minimum Savings Percentages, rather than the County-Specific Interim Savings Percentages, applied. This is determined by multiplying the Adjusted Interim Capitation Rate Revenue by $(1 - \text{the Minimum Savings Percentage}) / (1 - \text{the County-Specific Interim Savings Percentage})$.
- 1.4. **Adjusted Interim Capitation Rate Revenue** – The Total Capitation Rate Revenue excluding the monthly capitation payments for Medicare Part D services, and any risk adjustment or reconciliation associated with Medicare Part D payments.
- 1.5. **Adjusted Non-Service Expenditures** – The Contractor’s Actual Non-Service Expenditures, adjusted to reflect the following:
 - Exclusion of any costs, including care management, associated with Medicare Part D services as identified in CMS bid instructions and other guidance;
 - Exclusion of costs greater than one hundred twenty five percent (125%) of the medical cost per member per month across all participating Contractors during the Demonstration Year. Consideration will be given to any Contractor with significant non-typical membership mixes that may cause this exclusion to come into effect;
 - Exclusion of reinsurance costs (net of reinsurance premiums); and
 - Adjustments resulting from CMS and the state’s review of the Contractor’s

non-service expenditures to address any inappropriate or excessive non-service expenditures (including executive compensation and stop loss expenditures).

- 1.6. **Adjusted Service Expenditures** – The Contractor’s Actual Service Expenditures, adjusted to reflect the following:
 - Exclusion of the net cost of all services provided under Medicare Part D;
 - Reductions to reflect any recoveries from other payors outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care. These adjustments shall exclude any adjustments associated with coverage of Medicare Part D services; and
 - Adjustments resulting from CMS and the state review of Contractor reimbursement methodologies and levels to address any excessive pricing.
- 1.7. **Advance Directive** – An individual’s written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual’s health care if the individual is unable to make his or her health care wishes known.
- 1.8. **Adverse Action:** (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; or (v) the failure to respond to a Grievance or an Appeal in a timely manner; or (vi) for a rural area resident, with only one Contractor, the denial of an Enrollee’s request to obtain services outside the network.
- 1.9. **Adverse Benefit Determination** -- (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Contractor, the denial of an Enrollee’s request to obtain services outside of the Network; or (vii) the denial of an Enrollee’s

request to dispute a financial liability.

- 1.10. **Appeal** - In general, an Enrollee's actions, both internal and external to the Contractor requesting review of the Contractor's denial, reduction or termination of benefits or services, from the Contractor. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by the Contractor of an Adverse Benefit Determination and no longer based on an Adverse Action.
- 1.11. **Behavioral Health** – An all-inclusive term referring to mental health services provided through the mental health plan (MHP) or Contractor and substance use disorder services.
- 1.12. **Cal MediConnect** – California's state-specific name for the Capitated Financial Alignment Model Demonstration.
- 1.13. **Cal MediConnect Plan (also, Contractor)** – A health plan or other qualified entity jointly selected by the state and CMS for participation in this Demonstration.
- 1.14. **Cal MediConnect Ombuds Program**- The independent contractor established to safeguard the rights and dignity of all beneficiaries supported by Cal MediConnect. This office will be responsible for assisting and resolving issues that enrollees may encounter with Cal MediConnect Plans.
- 1.15. **California (or State)** – For purposes of this document, California (or state) is generally used to refer to DHCS, though it may encompass collectively CDA, DHCS, DMHC, and DSS.
- 1.16. **Capitated Financial Alignment Model Demonstration ("the Demonstration")** – A model in which a state, CMS, and a Contractor enter into a three-way Contract, and the Contractor receives a prospective blended capitation payment to provide comprehensive, coordinated care.
- 1.17. **Capitated Financial Alignment Model Memorandum of Understanding (CFAM-MOU)** – For purposes of this Contract, this is a document between CMS and California regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model (signed March 27, 2013). This MOU document

details the principles under which CMS and the state plan to implement and operate the Demonstration. It also outlines the activities CMS and the state plan to conduct in preparation for implementation of the Demonstration, before the parties execute this Contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

- 1.18. **Capitation Rate** – The sum of the monthly capitation payments (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract). Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.
- 1.19. **Care Coordination** – Delineated through requirements, processes and the care model throughout this Contract, care coordination is also detailed in WIC Sections 14182.17(d)(4) and 14186(b).
- 1.20. **Care Coordinator** – A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing care coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.
- 1.21. **Care Plan Option (CPO) Services** – A CPO service is optional under the beneficiary's Individualized Care Plan (ICP). A CPO service is designed to only supplement, not replace, the required Medi-Cal services under the beneficiary's Individualized Care Plan (ICP). CPO services are offered entirely at the Contractor's discretion.
- 1.22. **Centers for Medicare & Medicaid Services (CMS)** – The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
- 1.23. **Chronic Mental Disorder** – To be considered to have a Chronic Mental Disorder, the Enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and

Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilias, (m) Gender Identity Disorders, (n) Eating Disorders, (o) Impulse Control Disorders Not Elsewhere Classified (p) Adjustment Disorders, (q) Personality Disorders, or (r) Medication-Induced Movement Disorders.

- 1.24. **Community Based Adult Services (CBAS)** – Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.
- 1.25. **Contract** – The participation agreement that CMS and DHCS have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.
- 1.26. **Contract Management Team (CMT)** – A group of CMS and DHCS representatives responsible for overseeing the contract management functions outlined in Section 3.1 of the Contract.
- 1.27. **Contract Operational Start Date** – The first date on which enrollment into the Contractor’s Cal MediConnect coverage is effective.
- 1.28. **Contractor** – An entity approved by CMS and DHCS that enters into a Contract with CMS and DHCS in accordance with, and to meet, the purposes specified in this Contract.
- 1.29. **County Organized Health System (COHS)** – A type of Medi-Cal managed care delivery model in which DHCS contracts with a single health plan created by the County Board of Supervisors.
- 1.30. **County Social Services Agency**- Local county agency that administers the IHSS program.
- 1.31. **Covered Services** – The set of services to be offered by the Contractor as defined in Appendix A.
- 1.32. **Denti-Cal** - Adult dental benefits provided through Medi-Cal (California’s

- Medicaid program).
- 1.33. **Department of Aging (CDA)** - In California, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. CDA administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program. CDA certifies CBAS centers for participation in the Medi-Cal Program and provides administrative oversight for the MSSP waiver.
 - 1.34. **Department of Health Care Services (DHCS)** - The State department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the state in this document.
 - 1.35. **Department of Managed Health Care (DMHC)** - The State department charged with overseeing health care service plans licensed under the Knox-Keene Act.
 - 1.36. **Department of Social Services (CDSS)** - The State department responsible for overseeing and providing social services, including the In Home Support Services (IHSS) program.
 - 1.37. **Developmental Disability** - A disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.
 - 1.38. **Drug Medi-Cal Benefits** - The substance use disorder Medi-Cal benefits that are listed in Title 22, California Code of Regulations, section 51341.1(d) and Welfare and Institutions Code section 14132.03 .
 - 1.39. **Dual-Plan Letter (DPL)** - DPLs convey information or interpretation of changes in policy or procedure at the federal or State levels, and about changes in federal or State law and regulations. DPLs provide instruction to the Contractor on how to implement these changes on an operational basis, and about how federal or State law affect the way in which they operate, or deliver services to Enrollees. The Department shall notify and consult with stakeholders, including the Contractor, prior to the issuance of a DPL in compliance with the provisions of Welfare and Institutions Code Section 14186.4(c).
 - 1.40. **Emergency Medical Condition** - A medical condition that manifests itself

by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

- 1.41. **Emergency Services** – Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee’s Emergency Medical Condition.
- 1.42. **Encounter Data** - The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.
- 1.43. **Enrollee** – Any Medicare-Medicaid eligible individual who is enrolled with a Contractor.
- 1.44. **Enrollee Communications** – Materials designed to communicate covered services, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.
- 1.45. **Enrollment Broker** – Entity contracted by DHCS through the Health Care Options Program to provide information and enrollment assistance to Medicare-Medi-Cal beneficiaries.
- 1.46. **Exempt Grievance** – Grievances received by telephone that are not coverage disputes, complaints about quality of care, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.
- 1.47. **External Quality Review Organization** -- An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by the Contractor to their Enrollees.
- 1.48. **Federally-Qualified Health Center (FQHC)** – An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. §

1396d(a)(2)(C).

- 1.49. **First Tier, Downstream and Related Entity** – An individual or entity that enters into a written arrangement that is acceptable to CMS and DHCS with the Contractor, to provide administrative or health care services to the Contractor under this Contract.
- 1.50. **Geographic Managed Care (GMC) County** – A county in which DHCS contracts with two or more Knox Keene licensed health plans for Medi-Cal managed care.
- 1.51. **Grievance:**” Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the Contractor’s or Provider’s operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. A grievance is filed and decided at the Contractor level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee’s rights as provided for in Appendix B of this Contract). Also called a “Complaint.”
- 1.52. **Health Care Options Program (HCO)** -- A program within the California Department of Health Care Services which operates as an Enrollment Broker providing enrollment assistance to eligible MMP beneficiaries.
- 1.53. **Health Outcomes Survey (HOS)** – Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.
- 1.54. **Health Plan Management System (HPMS)** – A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.
- 1.55. **Health Risk Assessment** – An assessment tool which identifies primary, acute, long-term services and supports, and Behavioral Health and functional

needs.

- 1.56. **Healthcare Effectiveness Data and Information Set (HEDIS)** – Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.
- 1.57. **High Risk Enrollee** – For risk stratification purposes, an Enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact by the Contractor within forty-five (45) calendar days after coverage date. The higher risk Enrollees who should be identified from the fee for service utilization data, include but are not limited to Enrollees who:
- Have been on oxygen within the past ninety (90) days,
 - Have been hospitalized within the last ninety (90) days, or have had three (3) or more voluntary and/or involuntary hospitalizations within the past year related to behavioral health illnesses,
 - Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases),
 - Have In Home Supportive Services (IHSS) greater than or equal to one hundred ninety five (195) hours/month,
 - Are enrolled in the Multipurpose Senior Service Program (MSSP),
 - Are receiving Community Based Adult Services (CBAS),
 - Have ESRD, AIDS, and/or a recent organ transplant,
 - Have been currently being treated for cancer,
 - Have been prescribed anti-psychotic medication within the past ninety (90) days,
 - Have been prescribed fifteen (15) or more medications in the past ninety (90) days, or
 - Have other conditions as determined by the Contractor, based on local resources.
- 1.58. **Indian Enrollee** – An Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.) This includes an enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since

1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native Enrollee.

- 1.59. Indian Health Care Provider – A health care program operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).
- 1.60. **Individualized Care Plan (ICP or Care Plan)** – The plan of care developed by an Enrollee and/or an Enrollee’s Interdisciplinary Care Team or health plan.
- 1.61. **Interdisciplinary Care Team (ICT)** – A team comprised of the primary care provider and Care Coordinator, and other providers at the discretion of the Enrollee, that works with the Enrollee to develop, implement, and maintain the ICP.
- 1.62. **In-Home Supportive Services (IHSS)** – Pursuant to Article 7 of California Welfare and Institutions Code (Welf. & Inst. Code) (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956, IHSS is a program that provides in-home care for people who cannot safely remain in their own homes without assistance.
- 1.63. **Long Term Services and Supports (LTSS)** – A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:
 - In-Home Supportive Services (IHSS);

- Community-Based Adult Services (CBAS);
 - Multipurpose Senior Services Program (MSSP) services; and
 - Skilled nursing facility services and subacute care services.
- 1.64. **Low Risk Enrollee** – Enrollee who does not meet the minimum requirements of a High Risk Enrollee.
 - 1.65. **Marketing, Outreach, and Enrollee Communications** – Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260.
 - 1.66. **Medicaid** – The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. California’s state-specific name for this program is Medi-Cal.
 - 1.67. **Medi-Cal Managed Care Behavioral Health Services** - Behavioral Health services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor.
 - 1.68. **Medi-Cal Managed Care Plan** - A health plan directly contracted with the California Department of Health Care Services to provide Medi-Cal services to eligible beneficiaries.
 - 1.69. **Medi-Cal Appeal** - A request for a fair hearing in accordance with California Code of Regulations Title 22, section 51014.1 and Welfare and Institutions Code section 10950.
 - 1.70. **Medically Necessary Services** – Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under the Welfare and Institutions Code section 14059.5.
 - 1.71. **Medi-Cal Specialty Mental Health Services** – The Medi-Cal services specified in California Code of Regulations, Title 9 section 1810.247. Specialty mental health services do not include the Medi-Cal Managed Care Behavioral Health Services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor. Specialty mental health

services are provided through a MHP, in accordance with California Code of Regulations, Title 9, Chapter 11 of Division 1 and include:

- A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
- B. Psychiatric inpatient hospital services;
- C. Targeted Case Management;
- D. Psychiatrist services; and
- E. Psychologist services.

- 1.72. **Medicare** – Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.
- 1.73. **Medicare Advantage** – The Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at 42 C.F.R. Part 422.
- 1.74. **Medicare Appeal** – An Enrollee’s request for formal review of an Adverse Action of the Contractor in regards to a Medicare service in accordance with Section 2.15.
- 1.75. **Medicare-Medicaid Coordination Office** – Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.
- 1.76. **Medicare-Medicaid Enrollee (or Enrollee)** – For the purposes of this Demonstration, an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance

- under a State plan under title XIX of such Act or under a waiver of such plan.
- 1.77. **Medicare-Medicaid Plan (MMP)** -- A health plan contracted with DHCS and CMS to comprehensively manage the full continuum of Medicare and Medi-Cal benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the enrollee.
 - 1.78. **Mental Health Plan (MHP)**: Pursuant to California Code of Regulations, Title 9 section 1810.226, a MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. A MHP may be a county, counties acting jointly or another governmental or non-governmental entity.
 - 1.79. **Minimum Data Set (MDS)** – A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 2.0 for nursing facility residents.
 - 1.80. **Multi-Purpose Senior Services Program (MSSP)** – A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.
 - 1.81. **Network Provider** – An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any First Tier, Downstream, or Related Entity, for the delivery of services covered under the Contract. A Network Provider must meet the requirements in Section 2.9.8.1.
 - 1.82. **Notice of Action (NOA)** – A written notice of any action within the timeframes for each type of action as provided by 42 C.F.R. § 438.404 and 422.568.
 - 1.83. **Passive Enrollment** – An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor’s plan following a minimum sixty (60) day advance notification that includes the opportunity for the Enrollee to choose another plan or opt out prior to the effective date.
 - 1.84. **Post-Stabilization Care Services** – Services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain

the stabilized condition, or are provided, to improve or resolve the condition.

- 1.85. **Primary Care Provider (PCP)** -- A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.
- 1.86. **Privacy** – Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant California privacy laws.
- 1.87. **Program of All-Inclusive Care for the Elderly (PACE)** – As defined in 42 C.F.R. § 460.2-460.210, and authorized under California law at Welfare and Institutions Code section 14591 et seq., PACE is a capitated program for individuals over the age of 55 certified by DHCS for nursing home level of care. PACE organizations cover all Medicare and Medicaid benefits, including medical services and long-term services and support, organizes a comprehensive service delivery system governed by federal regulations, and integrate Medicare and Medicaid financing. PACE is a three-way partnership between the federal Government, California, and the PACE Organizations.
- 1.88. **Provider Network** – A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers, Behavioral Health providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. (See Appendix C of the Contract).
- 1.89. **Public Authority** - An entity established by a county board of supervisors, pursuant to Welfare and Institutions Code section 12306.1(a)(2), to provide for the delivery of in-home supportive services.
- 1.90. **Readiness Review** – Prior to being eligible to accept Demonstration enrollments, each prospective Contractor selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor’s ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Covered Services that are Medically Necessary with Enrollee protections. Only Contractors passing the Readiness Review will

- participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and a site visit to the prospective Contractor's headquarters.
- 1.91. **Recovery Model** – Framework for Behavioral Health that uses “recovery-oriented” services in recognition that systems of care should ensure culturally competent care for persons with severe mental illness and substance use disorders in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community, consistent with the system of care as set forth in California Welfare and Institutions Code sections 5802 and 5806. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The recovery model recognizes that Behavioral Health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors within the care system in order to achieve health and wellness.
 - 1.92. **Request for Solutions** – Document released in December 2011 by DHCS to assess if contractors have the requisite qualifications and resources suited to provide seamless access to the full continuum of medical care and social supports and services that Enrollees need to maintain good health and a high quality of life in the setting of their choice.
 - 1.93. **Rural Health Clinic (RHC)** – An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.
 - 1.94. **Service Area** – The county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by CMS and DHCS to operate under the terms of this Contract. See Appendix I for the Service Area for this contract.
 - 1.95. **Skilled Nursing Facility (SNF)** – As defined in California Code of Regulations, Title 22 section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled

- nursing home", "convalescent hospital", "nursing home", or "nursing facility".
- 1.96. **State Fair Hearing** – A “state fair hearing” is a quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits, made by an agency. An “agency” is a government unit or managed care health plan involved in a hearing as a hearing party. Such agencies include all 58 California counties, the Los Angeles Department of Children and Family Services, the California Department of Aging, the CDSS Office of Services to the Blind, all 27 Medi-Cal Field Offices, and several CDHS units, including: Beneficiary Utilization Review Unit, Benefits Branch-Vision, In-Home Operations, Managed Care Operations Branch, Recovery Section, and Office of Medi-Cal Dental Services.
 - 1.97. **Streamlined Enrollment:** A process to permit Contractors operating in non-COHS counties to submit opt-in enrollments to DHCS on behalf of their members enrolled in the matching plan’s Medi-Cal line of business.
 - 1.98. **Threshold Languages** – As specified in annual guidance to Contractors on specific translation requirements for their service areas.
 - 1.99. **Total Adjusted Expenditures** – The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.
 - 1.100. **Total Capitation Rate Revenue** – The sum of the monthly capitation payments for the Demonstration Year (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medi-Cal services, pursuant to Appendix A of this contract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2; and 2) any payment adjustments as a result of the reconciliation described in Section 4.5. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.
 - 1.101. **Two- Plan County** – A type of Medi-Cal managed care delivery model in which DHCS contracts two plans, offering beneficiaries a choice of health plan a with a “Local Initiative” (LI) and a “commercial plan” (CP). An LI is a non-profit, locally government health plan serving Medi-Cal beneficiaries.
 - 1.102. **Urgent Care** – 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). Medical services required

promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

2. Contractor Responsibilities

Through the Capitated Financial Alignment Model Demonstration (the “Demonstration”), CMS and DHCS will work in partnership to offer Medicare-Medicaid Enrollees the option of enrolling in a Contractor’s plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and Medi-Cal Covered Services for Enrollees.

2.1. Compliance: The Contractor must, to the satisfaction of CMS and DHCS:

- 2.1.1. Comply with all provisions set forth in this Contract.
- 2.1.2. Comply with all applicable provisions of federal and State laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422, Part 423, and Part 438 except to the extent that variances from these requirements are provided in the CFAM-MOU.
- 2.1.3. Maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended and have no adverse actions with regard to enforcement or quality management. County-Organized Health System (COHS) plans are exempt from Knox-Keene licensure for their Medi-Cal business pursuant to WIC Section 14087.95. Despite this exemption from licensure, this Contract obligates all Contractors, including COHS plans, to comply with all provisions of this Contract, including the contractual provisions relating to the Knox-Keene Act, unless otherwise expressly excluded.
- 2.1.4. The Contractor agrees that it will develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.
- 2.1.5. Comply with all current and applicable DPLs issued by DHCS. All current DPLs can be viewed at:
<http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx>
 - 2.1.5.1. All DPLs will be reviewed by CMS prior to issuance.

- 2.1.6. In the event an APL applies to an MMP, DHCS and CMS will jointly issue a memo to the plans via HPMS for the interim period between an APL issuance and a DPL issuance.
- 2.1.7. Maintain its contract with DHCS for the provision of covered services under the Medi-Cal program.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS, or its designee, with participation by DHCS, will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2.2.1.2. CMS and DHCS Readiness Review Responsibilities

2.2.1.2.1. CMS and DHCS, or its designees, will conduct a Readiness Review of each Contractor that will include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of beneficiaries into the Contractor's Plan. CMS and DHCS, or its designees, will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

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

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.9;

2.2.1.2.2.2. Staffing, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with Section 2.10;

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care Coordination capabilities, in accordance with Section 2.5.1;

- 2.2.1.2.2.5. Provider contracts templates, including any Provider Performance Incentives, in accordance with Sections 2.9 and 5.1.7;
 - 2.2.1.2.2.6. Enrollee services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.12;
 - 2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and utilization management strategies, in accordance with Section 2.11.5 and 2.16;
 - 2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.14 and 2.15;
 - 2.2.1.2.2.9. Fraud and abuse and program integrity, in accordance with Section 2.1.2;
 - 2.2.1.2.2.10. Financial solvency, in accordance with Section 2.18;
 - 2.2.1.2.2.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.19, including IT testing and security assurances.
- 2.2.1.2.3. For Contractors that are COHS plans, the scope of the Readiness Review will extend to the enrollment functions that the Contractor will be conducting as described in Section 2.3.1.
 - 2.2.1.2.4. No individual shall be enrolled into the Contractor's Cal MediConnect Plan unless and until CMS and the DHCS determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.
 - 2.2.1.2.5. CMS and DHCS or its designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract

and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.6. CMS or DHCS may, in its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start Date for any Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or DHCS that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or DHCS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or DHCS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. Contractor Readiness Review Responsibilities

2.2.1.3.1. The Contractor shall demonstrate to CMS and DHCS satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

2.2.1.3.2. Provide CMS and DHCS or its designee with the corrected materials requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The Contractor must employ a qualified individual to serve as the compliance officer of its Capitated Financial Alignment Model. The compliance officer must be primarily dedicated to the Contractor's program, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program. The compliance officer must act as liaison between the Contractor, CMS, and DHCS, and has responsibilities pursuant to this Contract, DPLs and other relevant guidance

and authorities that include but, are not limited to, the following:

- 2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
- 2.2.2.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the approved Request for Solutions (RFS);
- 2.2.2.1.3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities.
- 2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and DHCS in timeframes and formats specified by CMS and DHCS;
- 2.2.2.1.5. Meet with representatives of CMS or DHCS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;
- 2.2.2.1.6. Ensure the availability to CMS and DHCS upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, utilization management, Provider Network management, and benefit coordination;
- 2.2.2.1.7. Coordinate requests and activities among the Contractor, all First Tier, Downstream and Related Entities CMS, and DHCS;
- 2.2.2.1.8. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or DHCS; and
- 2.2.2.1.9. Meet with CMS and DHCS at the time and place requested by CMS and the state, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with:

2.2.3.1.1. County Organized Health System, Geographic Managed Care, and Two- Plan County: Title 28 CCR Sections 1300.67.3, 1300.75.1, 1300. 76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code, Section 1375.1.

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.3. Enrollment Activities

2.3.1. General Enrollment

2.3.1.1. Contractor shall accept all eligible beneficiaries as defined in Appendix J - Eligible Populations.

2.3.1.2. Eligible beneficiaries residing within the Contractor Service Area may be enrolled at any time up to six (6) months prior to the end of the Demonstration. Eligible beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, need for health care services or disability.

2.3.1.3. Enrollee coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the eligible beneficiary's name is added to the approved list of Enrollees furnished by CMS and the DHCS Enrollment Broker. The term of enrollment shall continue unless this Contract expires, is terminated, or the Enrollee is disenrolled under the conditions described in Section 2.3.2, Disenrollment.

2.3.1.4. Enrollment will proceed unless restricted by CMS or the state. Such restrictions will be defined in writing by CMS or the state and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release.

2.3.1.5. Intelligent Assignment. Enrollment activities specific to Two-Plan Counties and GMC Counties (Los Angeles, San Diego, San Bernardino, Santa Clara, Riverside):

2.3.1.5.1. At least ninety (90) days prior to the start of the Cal MediConnect program, Contractor shall provide DHCS with a complete list of Network Providers and National Provider Identifier (NPI) numbers to assist in the assignment of eligible beneficiaries as part of

the Passive Enrollment process. The Network Provider list will include all network providers for the Provider Network, where applicable.

2.3.1.5.2. Updates to the Network Provider list shall be sent to DHCS on a quarterly basis for the purposes of intelligent assignment, or as changes to the Provider Network are applied.

2.3.1.5.3. As part of the enrollment process, DHCS will initially assign an Enrollee to a Cal MediConnect Plan based on a hierarchical logic in accordance with Section 2.3.1.5.1. Enrollees shall have the ability to change Cal MediConnect Plans at any time.

2.3.1.5.3.1. DHCS shall utilize the following hierarchical logic to determine Primary Contractor Plan assignment:

2.3.1.5.3.1.1. If a beneficiary is in a Medi-Cal Managed Care Plan that is participating in the Cal MediConnect Program and is not enrolled in a Medicare Advantage product, DHCS will assign the beneficiary to the matching Cal MediConnect plan.

2.3.1.5.3.1.2. If the beneficiary is in a Medicare Advantage Dual Special Needs Plan owned by the parent organization of an MMP, DHCS will assign the beneficiary to the matching MMP.

2.3.1.5.3.1.3. If a beneficiary is in fee-for-service Medi-Cal and Medicare, DHCS will match the beneficiary's highest utilized and paid prescribing and/or rendering provider data [based on the most recent and available twelve (12) months of Medicare and Medi-Cal claim data] to the list of Network Providers supplied by the Contractor, in accordance with Section 2.3.1.5.1.

- 2.3.1.5.3.1.4. If only one (1) Cal MediConnect Plan is identified with the beneficiary's provider(s) in its network, DHCS will assign the beneficiary to that Cal MediConnect Plan.
- 2.3.1.5.3.1.5. If two (2) or more Cal MediConnect Plans are identified or if there is insufficient claim data to match to a Cal MediConnect Plan, the system will select a Cal MediConnect Plan based on an equal distribution ratio. For example, if there are two (2) Cal MediConnect Plans in the county, DHCS will assign based on a 50/50 split. In San Diego, the system will divide beneficiary assignments equally across the four (4) Cal MediConnect Plans.
- 2.3.1.5.3.1.6. This distribution is dependent on Contractor capacity and subject to be altered per the direction of the Contract Management Team (CMT).
- 2.3.1.5.4. DHCS will notify CMS and the Contractor of the beneficiary assignments via the enrollment transactions sent to CMS and the 834 Enrollment file.
- 2.3.1.5.5. DHCS will inform the Contractor of the provider NPIs used in the plan selection process.
- 2.3.1.5.6. CMS will notify the Contractor of the beneficiary assignments via the Daily Transaction Response Reply (DTRR) file distributed through the CMS Enrollment Broker.
- 2.3.1.5.7. Contractor is responsible for outreach to the Network Provider for enrollment related activities and for providing data to DHCS.

Contractor shall maintain systems to accept enrollment transactions from CMS' and the state's systems. Contractor shall process enrollment and

disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, posted at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf>

2.3.1.6. Enrollment activities specific to County Organized Health Systems.

2.3.1.6.1. Contractor shall maintain systems to identify eligible beneficiaries as defined in Appendix J, and transmit enrollment transactions to CMS and the state's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance Document.

2.3.1.7. Subject to CMT approval and Section 2.17.1, the Contractor may participate in Streamlined Enrollment.

2.3.1.7.1. Eligible enrollees must be enrolled in the Contractor's Medi-Cal plan product.

2.3.1.8. CMS and DHCS may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

2.3.1.9. The Contractor may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For purposes of this Demonstration, CMS and DHCS will consider financial stability and network adequacy in the determination of a capacity limit.

2.3.2. Disenrollments

2.3.2.1. The Contractor shall have a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and DHCS systems.

2.3.2.2. Contractor in Two-Plan and GMC Counties shall have processes and procedures in place to refer Enrollees that request disenrollment from the Plan to the DHCS Enrollment Broker.

- 2.3.2.3. Enrollees with a share of cost that do not meet the share of cost on the first of the month will be deemed eligible and remain enrolled for up to two (2) months before being disenrolled per California’s state-specific guidance to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (Section 2.3.1.5.7.). Please see Appendix J for eligibility requirements for beneficiaries with a share of cost.
- 2.3.2.4. Enrollees can elect to disenroll from the Cal MediConnect Plan or the Demonstration at any time and enroll in another Cal MediConnect Plan in a Two-Plan County or GMC county, a Medicare Advantage plan, PACE (as otherwise permissible); or elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with DHCS’s Medi-Cal program and any waiver programs. Disenrollments received by DHCS or its contractor, or by CMS or its contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.
 - 2.3.2.4.1. The Contractor shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.
 - 2.3.2.4.2. DHCS and CMS shall terminate an Enrollee’s coverage upon any of the occurrences specified in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including but not limited to the following:
 - 2.3.2.4.2.1. The Enrollee's death. This disenrollment is effective the first day of the calendar month following the month of death. Termination may be retroactive to the month in which the Enrollee dies.
 - 2.3.2.4.2.2. When an Enrollee elects to change Demonstration Plans. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

- 2.3.2.4.2.3. When an Enrollee requests and is enrolled in a new Medicare Advantage plan through 1-800-Medicare. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.
 - 2.3.2.4.2.4. When an Enrollee elects to receive his or her Medicare services through Medicare fee-for-service and a separate Medicare prescription drug plan.
 - 2.3.2.4.2.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the parties.
- 2.3.2.4.3. The Contractor may not request the disenrollment of any Enrollee due to an adverse 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. The Contractor, however, may submit a written request, accompanied by supporting documentation to the CMT to disenroll an Enrollee, for cause, for the following reasons:
- 2.3.2.4.3.1. Enrollee remains out of the Service Area or cannot be located for more than six (6) consecutive months; or
 - 2.3.2.4.3.2. The Enrollee's continued enrollment seriously impairs the Contractor's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse 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.

2.3.2.4.4. The Contractor may not threaten, intimidate, pressure, or otherwise interfere with the Enrollee's right to disenroll.

2.3.2.5. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to Cal MediConnect Plans on discretionary involuntary disenrollment. This Contract and other guidance provide procedural and substantive requirements the Contractor, DHCS, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, DHCS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.2.5.1. Bases for Discretionary Involuntary Disenrollment:

2.3.2.5.1.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that substantially impairs the Contractor's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.2.5.2. Procedural requirements:

2.3.2.5.2.1. The Contractor's request must be in writing and include all of the supporting documentation outlined under the evidentiary standards in section 2.3.2.5.3.

2.3.2.5.2.2. The process requires three (3) written notices. The Contractor must include in the request, submitted to DHCS and CMS, evidence that the advance notice and notice

of intent have already been sent to the Enrollee. The notices are:

- 2.3.2.5.2.2.1. Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered, the grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.
- 2.3.2.5.2.2.2. Notice of intent to request the State and CMS' permission to disenroll the Enrollee; and
- 2.3.2.5.2.2.3. Planned action notice advising that CMS and the State have approved the Contractor's request. This planned action notice is not a procedural prerequisite for approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and DHCS.
- 2.3.2.5.2.3. The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

- 2.3.2.5.2.4. The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and
 - 2.3.2.5.2.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.
 - 2.3.2.5.2.6. If the Contractor is requesting the ability to decline future Enrollments for this individual, the Contractor must include this request explicitly in the submission.
 - 2.3.2.5.2.7. Prior to approval, the complete request must be reviewed by DHCS and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.
- 2.3.2.5.3. Evidentiary standards: At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both DHCS and CMS staff with appropriate clinical or medical expertise:
- 2.3.2.5.3.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.
 - 2.3.2.5.3.2. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:
 - 2.3.2.5.3.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is

efficacious in providing equal access to services and proportional to costs. DHCS and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.2.5.3.2.2. A documented provision of information to the individual of his or her right to use the Grievance procedures.

2.3.2.5.3.2.3. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.2.5.3.3. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.2.5.3.4. The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct;

2.3.2.5.4. Limitations: The Contractor shall not seek to terminate enrollment because of any of the following:

2.3.2.5.4.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating providers explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.2.5.4.2. The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.2.5.4.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.2.5.4.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.2.5.5. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.2.5.5.1. The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor's plan; or if the Enrollee intentionally permits others to use his or her enrollment card to obtain services from the Contractor.

2.3.2.5.5.2. Prior to submission, the Contractor must have and provide to CMS/DHCS credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.2.5.5.3. The Contractor must immediately notify the CMT so that the Enrollment Broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.2.5.5.4. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the plan's decision and information on the Enrollee's access to grievance procedures and a fair hearing.

2.4. Covered Services

2.4.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services include

the Behavioral Health services that become Medi-Cal managed care benefits, pursuant to Welfare and Institutions Code section 14132.03.

- 2.4.2. The Contractor must provide the full range of Covered Services. If either Medicare or Medi-Cal provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program.
- 2.4.3. Care Plan Option (CPO) services may be provided at the sole discretion of the Contractor and in accordance with the ICP.
 - 2.4.3.1. The grievance and appeals process for CPO services shall be the same process as used for others benefits authorized by the Contractor, as described in Sections 2.14 and 2.15, and shall comply with Welfare & Institutions Code Section 14450 and Health & Safety Code Sections 1368 and 1368.1.
 - 2.4.3.2. CPO services may include, but are not limited to:
 - 2.4.3.2.1. Respite care: in home or out-of-home, which shall not supplant authorized IHSS hours;
 - 2.4.3.2.2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; Contractor will notify counties if additional personal care services are provided.
 - 2.4.3.2.3. Nutritional assessment, supplements, and home delivered meals;
 - 2.4.3.2.4. Home maintenance and minor home or environmental adaptation; and
 - 2.4.3.2.5. Supplemental protective supervision.
 - 2.4.3.3. Other services and requirements in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.
- 2.4.4. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

- 2.4.4.1. Furnished by the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2);
- 2.4.4.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);
- 2.4.4.3. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;
- 2.4.5. The Contractor may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.5. Care Delivery Model

- 2.5.1. Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or DHCS unless otherwise requested.
- 2.5.2. Care Coordination. The Contractor shall offer care coordination and case management services to all Enrollees, as described in Welfare and Institutions Code sections 14182.17(d)(4) and 14186(b).
 - 2.5.2.1. Contractor will coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and LTSS.
 - 2.5.2.2. Contractor will focus on providing services in the least restrictive setting.
 - 2.5.2.3. Care coordination will be led by the Care Coordinator with participation by members of the ICT.

- 2.5.2.4. Contractor shall ensure effective linkages of clinical and management systems among Network Providers. Such linkages shall be established in plan policies and procedures.
 - 2.5.2.4.1. Such linkages shall include communication protocols among First Tier, Downstream, and Related Entities.
- 2.5.2.5. Contractor's policies and procedures shall clarify all communications and reporting protocols related to coordination of services including but not limited to how Contractor shall oversee all such coordination activities.
- 2.5.2.6. Contractor will ensure that care coordination services:
 - 2.5.2.6.1. Reflect a person-centered, outcome-based approach, consistent with the, CFAM-MOU, and DHCS' RFS; Follow Enrollee's direction about the level of involvement of his or her caregivers or medical providers;
 - 2.5.2.6.2. Span medical and LTSS systems, including coordination with IHSS, with a focus on transitions;
 - 2.5.2.6.3. Reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health services;
 - 2.5.2.6.4. Reflect coordination with county agencies, if applicable, for IHSS services;
 - 2.5.2.6.5. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3;
 - 2.5.2.6.6. Are performed by nurses, social workers, primary care providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan care coordinators, as applicable; and
 - 2.5.2.6.7. Reflect access to appropriate community resources, as defined in Welfare and Institution Code sections 14132.275(f)(7) and 14182.17(d) (4)(G) and (6)(B) and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

- 2.5.2.7. Contractor will have a process for assigning a Care Coordinator to each Enrollee. Assignment will be made to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs.
 - 2.5.2.7.1. Contractor shall ensure an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination as required through this Contract. The CMT shall monitor the ratio of Care Coordinators to Enrollees on a regular basis.
- 2.5.2.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health Services delivered by a county Behavioral Health agency and IHSS services, when applicable.
 - 2.5.2.8.1. Every Enrollee will have access to an ICT.
 - 2.5.2.8.2. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.1.8.3.2 to stabilize medical conditions, increase compliance with care plans, maintain functional status, and meet individual Enrollees care plan goals. ICT functions will include, at a minimum:
 - 2.5.2.8.2.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.1.9 and 2.8.3;
 - 2.5.2.8.2.2. Conduct ICT meetings periodically, including at the Enrollee's discretion;
 - 2.5.2.8.2.3. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;
 - 2.5.2.8.2.4. Maintain a call line or other mechanism for Enrollee inquiries and input , and a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;

- 2.5.2.8.2.5. Conduct conference calls among the Contractor, providers, and Enrollees;
- 2.5.2.8.2.6. Maintain a mechanism for monitoring Enrollee complaints and grievances ; and
- 2.5.2.8.2.7. Use secure email, fax, web portals or written correspondence to communicate. The ICT must take the Enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the Enrollee.
- 2.5.2.8.3. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.
 - 2.5.2.8.3.1. The ICT will be led by professionally knowledgeable personnel. If the ICT is led by a PCP, the PCP must be credentialed.
 - 2.5.2.8.3.2. ICT will include the Enrollee and/or authorized representative, family and/or caregiver if approved by the Enrollee, PCP (this may be a specialist, if a specialist is serving as the PCP), care coordinator, and may include the following persons, as needed and if applicable:
 - 2.5.2.8.3.2.1. Hospital discharge planner;
 - 2.5.2.8.3.2.2. Nursing facility representative;
 - 2.5.2.8.3.2.3. Social Worker, including the IHSS social worker if IHSS services are provided;
 - 2.5.2.8.3.2.4. Specialized providers, such as pharmacists and physical therapists;
 - 2.5.2.8.3.2.5. If receiving IHSS, the IHSS provider, if authorized by Enrollee;

- 2.5.2.8.3.2.6. If enrolled in CBAS, the CBAS provider, if authorized by Enrollee;
 - 2.5.2.8.3.2.7. MSSP coordinator;
 - 2.5.2.8.3.2.8. Behavioral Health specialist, which may include, but is not limited to, a specialty mental health provider or a substance use disorder counselor; and
 - 2.5.2.8.3.2.9. Other professionals, as appropriate, and as delineated in applicable and current DPLs
- 2.5.2.8.4. Communication with ICT. Contractor will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. Contractor will have a documented process for coordinating the exchange of information amongst all ICT members.
- 2.5.2.8.5. Contractor will have procedures for notifying the ICT of emergency department use, hospital admission (psychiatric or acute) or SNF and coordinating a discharge plan.
- 2.5.2.8.6. Competencies of ICT. Contractor will provide training for ICT members initially and on an annual basis. Required training topics include:
- 2.5.2.8.6.1. Person-centered planning processes;
 - 2.5.2.8.6.2. Cultural competence;
 - 2.5.2.8.6.3. Accessibility and accommodations;
 - 2.5.2.8.6.4. Independent living and recovery and wellness principles; and
 - 2.5.2.8.6.5. Information about LTSS programs, eligibility for these services, and program limitations.
 - 2.5.2.8.6.6. Coordination with counties on IHSS.

- 2.5.2.8.7. Nothing in this contract shall be construed as requiring the Enrollee to participate on the ICT. The Contractor shall allow the Enrollee to opt-out of the ICT at any time and the ICT shall be able to continue its operations. Enrollees may not be disenrolled for lack of participation on the ICT. Criteria for disenrollment are discussed in Section 2.3.2.3.2.
- 2.5.2.8.8. If an Enrollee refuses an ICT, at a minimum the care coordinator must provide his or her contact information to the Enrollee and re-visit the refusal at the time of reassessment, or if the Enrollee's PCP changes.
- 2.5.2.8.9. The administration of the ICT will also follow all applicable current DPLs.
- 2.5.2.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will regularly engage Enrollees and/or their representatives in the design, reassessment and updates of the ICPs.
- 2.5.2.10. If an Enrollee refuses to be involved in ICP development, the Contractor must seek to re-visit the refusal at least at the time of reassessment, or if the Enrollee's PCP changes.
- 2.5.2.11. ICPs will include:
 - 2.5.2.11.1. The name and contact information for the Enrollees current, assigned care coordinator. Enrollee service numbers may be used only if the number will transfer the Enrollee to her/his assigned care coordinator;
 - 2.5.2.11.2. The name and contact information for the Enrollee's PCP and any specialists;
 - 2.5.2.11.3. A complete, current list of the Enrollee's medications;
 - 2.5.2.11.4. Enrollee goals and preferences;
 - 2.5.2.11.5. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS;
 - 2.5.2.11.6. Timeframes for reassessment and updating of care plan, to be done at least annually or if a significant change in condition occurs;

2.5.2.11.7. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

2.5.2.11.7.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

2.5.2.11.7.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

2.5.2.11.7.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, evidence of creation or adjustment of care goals, as described in the plans' models of care reviewed and approved by the National Committee on Quality Assurance (NCQA).

2.5.2.11.8. If the Enrollee is receiving IHSS, the ICP will also include:

2.5.2.11.8.1. The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and

2.5.2.11.8.2. The name and contact information for the IHSS worker.

2.5.2.11.9. Additional components discussed in current and applicable DPLs.

2.5.2.12. The Contractor will transfer, to another MMP, or its designated Contractor for Enrollees, information necessary to support continuity of care when an Enrollee transfers to another MMP. This information includes, but is not limited to, assessment, ICP, and other pertinent information.

2.5.2.12.1. The information shall be provided no later than thirty (30) calendar days from receipt of the notice of disenrollment to the Contractor and no later than the effective date of transfer in the method and format specified by DHCS and CMS.

2.5.2.12.2. This data sharing package and process will be subject to CMT approval following a joint planning process in the first half of 2018 with CMS, DHCS, and the Contractor.

2.5.2.12.2.1. Detail regarding data transfer methods, the content of the transfer package, look back periods, eligible beneficiaries, and other transfer specifics will be determined via this planning process

2.5.2.13. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.

2.5.2.13.1. Enrollees may choose to refuse any treatment, including case management.

2.5.2.13.2. Basic case management services include:

2.5.2.13.2.1. A review of clinical information from the provider;

2.5.2.13.2.2. Completion of the HRA. (see Section 2.8);

2.5.2.13.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);

2.5.2.13.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS, Behavioral Health, Care Plan Option Services, and for covered and non-covered services;

2.5.2.13.2.5. Direct communication with Enrollee, Enrollee providers, and family;

2.5.2.13.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.10.8); and

2.5.2.13.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services or

specialty mental health or Drug Medi-Cal services or to IHSS service agency.

2.5.2.14. Complex Case Management. Contractor will develop methods to identify Enrollees who may benefit from complex case management services, using the risk stratification and HRA results (see sections 2.8.1 and 2.8.2) as well as utilization and clinical data and any other available information across medical, LTSS, and Behavioral Health domains, as well as self and provider referrals.

2.5.2.14.1. Complex case management services will include:

2.5.2.14.1.1. Basic case management services (see Section 2.5.1.10)

2.5.2.14.1.2. Management of acute or chronic illness

2.5.2.14.1.3. Intense coordination of resources to ensure Enrollee maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization when appropriate and possible.

2.5.2.15. Coordination of Care Management. Contractor shall coordinate with external organization(s) for provision of Covered Services (described in Appendix A) as appropriate for the Enrollee (see Sections 2.6 and 2.7).

2.5.2.15.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollee to MSSP organization for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.15.2. Contractor shall develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible, in accordance with WIC section 14182.17(d)(4)(H) and in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

- 2.5.2.16. Coordination of Care Management with external organization for provision of IHSS as appropriate for the Enrollee.
 - 2.5.2.16.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollees to county IHSS agency for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.
- 2.5.2.17. Care Plan Option services. A CPO service is optional under the Enrollee's ICP. Please see Section 2.4.3.
- 2.5.2.18. Annual Evaluation of Care Management Program. Contractor will conduct annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.
 - 2.5.2.18.1. Contractor will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings.
- 2.5.2.19. Discharge Planning and Care Coordination. Contractor shall ensure provision of discharge planning when Enrollee is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee and/or caregiver. Minimum criteria for discharge planning checklist must include:
 - 2.5.2.19.1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received. Documentation of pre-discharge factors, including an understanding of the medical condition or functional status by Enrollee or a representative of the Enrollee as applicable, physical and mental health status, financial resources, and social supports.

- 2.5.2.19.2. Per current and applicable DPLs regarding discharge planning, services needed after discharge, type of placement preferred by the Enrollee/representative of the Enrollee and hospital/institution, type of placement agreed to by the Enrollee/representative of Enrollee, specific agency/home recommended by the hospital, specific agency/home agreed to by the Enrollee/representative of the Enrollee, and pre-discharge counseling recommended.
- 2.5.2.19.3. Post-transition discharge policies and procedures will cover criteria to include, but not limited to, access to necessary medical care and follow up, medications, durable medical equipment and supplies, transportation, and integration of community based LTSS programs, as well as coordination with IHSS services authorized by the counties.
- 2.5.2.19.4. Coordination, as appropriate, with: 1) county agencies for IHSS and Behavioral Health services (through social worker and providers, as needed); 2) MSSP providers; 3) CBAS centers; 4) community organizations such as Area Agencies on Aging and DHCS Care Transition projects; 5) LTSS providers, including nursing facilities; 6) specialized providers (including, but not limited to specialists, pharmacists, physical/occupational therapists; and, 7) others as deemed appropriate. For IHSS, the Contractor's coordination process must be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning.
- 2.5.2.19.5. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Contractor's care coordination process for Enrollees who are being discharged from the hospital or at risk of immediate placement in a SNF.
- 2.5.2.19.6. Summary of the nature and outcome of Enrollee involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

2.5.2.19.7. For Enrollees receiving Behavior Health services, Contractor will have procedures developed jointly with the MHP for:

2.5.2.19.7.1. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan, if applicable.

2.5.2.19.7.2. Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address an Enrollee's medical problems based on changes in the Enrollee's mental health or medical condition.

2.5.2.20. In addition to the oversight of plan complaints, Grievances, and Cal MediConnect Ombuds Program activity via the CMT, the Contractor shall include ombudsman reports in quarterly updates to local advisory convenings and shall participate in all statewide stakeholder and oversight convenings as delineated in DPLs.

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for: 1) CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.2.1, and 2), MSSP for Enrollees who meet the eligibility criteria for MSSP pursuant to Welfare and Institutions Code s 9560.

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age twenty-one (21) or older and derive their Medi-Cal eligibility from the State Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the state and meet "Nursing Facility Level

of Care A" (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer's Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.1.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.1.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are

enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.1.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on care coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.1.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.1.9 and 2.8.3.

2.6.2. The Contractor will ensure referral to IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to Welfare and Institutions Code section 12305.6.

2.6.2.1. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help pursuant to the California Welfare and Institutions Code (commencing with section 12300) of Chapter 3, and sections 14132.95, 14132.952, and 14132.956.).

2.6.2.1.1. Contractor will coordinate with county agencies to facilitate IHSS participation on the ICT. Contractor will ensure Network Providers coordination with IHSS.

2.6.2.1.2. Contractor will coordinate with county agencies to develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.2.1.2.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC Section 12301.1 and how that

information is coordinated and shared with the ICT.

2.6.2.1.2.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.2.1.3. DHCS and CDSS will continue to provide the Contractor with IHSS assessment data.

2.6.3. Nursing Facilities

2.6.3.1. Contractor shall contract with SNFs, as defined in California Code of Regulations Title 22 section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.3.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

2.7. Coordinated Primary Care and Behavioral Health.

2.7.1. Contractor shall provide Enrollee access to Behavioral Health services covered by Medicare and Medi-Cal with a focus on the Recovery Model (See Covered Services in Appendix A). Coordination of Behavioral Health services financed and administered by county agencies shall include at a minimum the following:

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.7.1.1.1. To determine responsibility for covering Medi-Cal Specialty Mental Health Services, the Contractor and county will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in the California Code of Regulations Title

9sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis - one or more of the specified diagnoses; 2) impairment - significant impairment or probability of deterioration of an important area of life functioning; or; 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

2.7.1.1.2. To determine medical necessity for Drug Medi-Cal Benefits, Contractor and counties will follow California Code of Regulations Title 22 sections 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in California Code of Regulations Title 22 section 51159.

2.7.1.1.3. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code section 14132.03, the Contractor shall use medical necessity criteria set forth current and applicable DPL(s) as described in Section 2.1.5.

2.7.1.2. Contractor will have a Memorandum of Understanding (MOU) with county agencies that finance and administer Behavioral Health services. The MOU must be approved by CMS and DHCS. It will include:

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2) and ICP (see Section 2.9.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

- 2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;
 - 2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and
 - 2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.
- 2.7.1.2.2. Administrative coordination: Contractor will clearly delineate administrative responsibilities and provider contracting responsibilities, including:
- 2.7.1.2.2.1. Point of contacts and communication processes to address administrative coordination;
 - 2.7.1.2.2.2. Process for annual review and evaluation of administrative management programs; and
 - 2.7.1.2.2.3. Process for demonstrating how administrative problem identification and resolution occurs.
- 2.7.1.2.3. Information exchange: Contractor will develop data sharing mechanisms with the county Behavioral Health agencies, to the greatest extent practicable under state and federal privacy laws, to share accurate and timely information to inform care delivery. It will describe:
- 2.7.1.2.3.1. Information flow between Contractor and county agencies; and
 - 2.7.1.2.3.2. Processes for exchange of health information.
- 2.7.1.2.4. Performance measures: Contractor is required to report on measures related to Behavioral Health services for which they have direct contracts with providers including Medicare Behavioral Health benefits.
- 2.7.1.2.4.1. Contractor is required to show evidence of data sharing agreement with county agencies

that provide Medi-Cal Behavioral Health services. The data sharing agreements shall provide for the exchange of data in compliance with all applicable state and federal laws.

2.7.1.2.4.2. Shared financial accountability is discussed in Section 4.3.6.4.

2.8. Health Risk Assessments, ICP, and Care Coordination

2.8.1. Risk Stratification. Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance applicable DPL(s) as indicated in Section 2.1.5

2.8.1.1. Contractor shall use the following data sources to identify an Enrollees' risk level.

2.8.1.1.1. Medicare utilization data, including Medicare Parts A, B, and D.

2.8.1.1.2. Medi-Cal utilization data, including IHSS, MSSP, SNF, and Behavioral Health pharmacy data.

2.8.1.1.3. Results of previously administered assessments.

2.8.1.1.4. Other population- and individual-based tools.

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and state laws WIC Section 14182.17(d)(2), and in accordance with applicable DPL(s) as indicated in Section 2.1.5. Contractor will complete HRAs for all Enrollees.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:

2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;

2.8.2.2.2. Caregivers, Enrollees, and authorized representatives participation;

- 2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;
- 2.8.2.2.4. Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;
- 2.8.2.2.5. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and
 - 2.8.2.2.5.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.1.11 and 2.5.1.12.
 - 2.8.2.2.5.2. Other elements in accordance with applicable DPL(s) as indicated in Section 2.1.5.
- 2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5.
- 2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5.
- 2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.
- 2.8.2.6. Reassessments will be conducted at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires.

- 2.8.2.6.1. When determining the mode for completing reassessment, the Contractor will consider the reason the assessment needs to be updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee.
 - 2.8.2.7. Contractor will regularly use electronic health records and claims data to inform reassessments and to identify Enrollees at high risk, with newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or Behavioral Health referral.
- 2.8.3. Individualized Care Plan (ICP). A comprehensive, person-centered ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.1.9.
 - 2.8.3.1. ICPs must be developed in accordance with the timeframes and other requirements in the current and applicable DPL(s) as indicated in Section 2.1.5.
- 2.8.4. The Contractor will provide the ICP to the Enrollee no less than annually. Continuity of Care. Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers as described below and in accordance with applicable DPL(s) as indicated in Section 2.1.5.
 - 2.8.4.1. Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:
 - 2.8.4.1.1. A period up to twelve (12) months for Medicare services if all of the following criteria are met under WIC Section 14132.275(l)(2)(A):
 - 2.8.4.1.1.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network PCP or specialist at least once within the previous twelve (12) months from the date of enrollment
The link between the new Enrollee and the out-

of-network provider may be established by the Contractor using Medicare data provided by DHCS or by documentation by the provider or Enrollee;

2.8.4.1.1.2. Provider is willing to accept payment from the Contractor based on the current Medicare fee schedule; and

2.8.4.1.1.3. Contractor would not otherwise exclude the provider from its Provider Network due to documented quality of care concerns or state or federal exclusion requirements.

2.8.4.1.2. A period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).

2.8.4.1.2.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least twice within the previous twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the state or by documentation from the provider or Enrollee.

2.8.4.1.2.2. Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and

2.8.4.1.2.3. Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or state or federal exclusion requirements.

- 2.8.4.1.3. Enrollees will not be required to change nursing facilities during the duration of the Demonstration if they resided in the nursing facility prior to enrollment in MediConnect, the facility is licensed by CDPH, meets acceptable quality standards, and the facility and Contractor agree to rates in accordance with Section 2.8.4.1.2.2.
- 2.8.4.1.4. Sections 2.8.4.1.1 and 2.8.4.1.2 do not apply to providers of the following: durable medical equipment, medical supplies, transportation, other ancillary services, or carved-out services.
- 2.8.4.1.5. Contractor must inform Enrollees of its new Network Providers.
- 2.8.4.1.6. If an Enrollee receives care from an out-of-network provider, Contractor must advise the Enrollee and provider that they have received care from an out-of-network provider that would not otherwise be covered at an in-network level.
- 2.8.4.1.7. Part D transition rules and rights will continue as provided for in current law and regulation for the entire integrated formulary associated with the Cal MediConnect Plan.
- 2.8.4.1.8. The DHCS will distribute an enrollment choice packet that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment choice packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.
 - 2.8.4.1.8.1. Contractors in COHS will distribute an enrollment package that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.
- 2.8.4.1.9. Out of Network Reimbursement Rules – For reimbursement of out-of-network emergency services

or urgent care services, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts that the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medi-Cal FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. For emergency services and poststabilization care services, as defined by 42 C.F.R. § 438.114(a), for which Medi Cal is the primary payor, the Contractor must comply with 42 C.F.R. § 438.114 and an out-of-network provider is required to accept the applicable Medi-Cal fee-for-service payment amount as payment in full by the Contractor consistent with 42 U.S.C. § 1396u-2(b)(2)(D). Enrollees maintain balance billing protections as provided in Section 5.1.12.

- 2.8.4.1.9.1. Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracted Health Care Professionals and section 1861(u) providers of services the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers) regardless of setting and

type of care for authorized out-of-network services.

2.8.4.1.10. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1.11. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.8.4.1.12. If Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is otherwise unable to provide them, as required by 42 C.F.R. § 438.206(b)(4). Provider Network

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the state to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

- 2.9.2.1. Contractor will be required to comply with 42 C.F.R. § 438.56(d)(2).
- 2.9.3. The Contractor must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days, following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 2.9.10.2, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.
- 2.9.4. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.
- 2.9.5. The Contractor may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; this does not include IHSS providers.
- 2.9.6. The Contractor may also offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the Contractor's Provider Network, 2) currently serving Enrollees, 3) willing to continue serving them at the Contractor in-network rate of payment, under the following circumstances:
 - 2.9.6.1. The Contractor's Provider Network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;
 - 2.9.6.2. Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or
 - 2.9.6.3. Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

- 2.9.7. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.
- 2.9.7.1. Contractor shall have a cultural and linguistic services program that incorporates the requirements of California Code of Regulations Title 22 section 53876 regardless of whether it operates in a Two-Plan County. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update its cultural and linguistic services consistent with the group needs assessment requirements as specified by DHCS.
- 2.9.7.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:
- 2.9.7.2.1. An organizational commitment to deliver culturally and linguistically appropriate health care services;
- 2.9.7.2.2. Goals and objectives;
- 2.9.7.2.3. A timetable for implementation and accomplishment of the goals and objectives;
- 2.9.7.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described; and
- 2.9.7.2.5. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

- 2.9.7.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).
- 2.9.7.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under state and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.
- 2.9.7.5. The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.
- 2.9.7.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Area.
- 2.9.7.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.
- 2.9.7.8. The Contractor shall ensure that its Network Providers have an understanding of disability-competent care.
- 2.9.7.9. Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. Section 12101 et seq.), 45 C.F.R. Part 84 and 28 C.F.R. Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

2.9.8. Provider Qualifications and Performance

2.9.8.1. All Network 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 good standing in the Medicare and Medi-Cal programs and a valid NPI number, as applicable. Providers that have been terminated from or suspended either Medicare or Medi-Cal cannot participate in Contractor's Provider Network.

2.9.8.1.1. Contractor is responsible for the oversight of all Network Providers delivering non-Covered Services (e.g., CPO Services).

2.9.9. Subcontracting Requirements

2.9.9.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.9.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per this Contract and 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and California Code of Regulations Title 22 section 53867.

2.9.9.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and State laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.9.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC Sections 14186 through 14186.4.

2.9.9.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and state financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

2.9.9.6. The Contractor must:

2.9.9.6.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

2.9.9.6.2. Contract only with qualified or licensed providers who continually meet federal and state requirements, as applicable, and the qualifications contained in Appendix C.

2.9.9.6.3. This section does not apply to the California Department of Social Services or any other state department contracting with the Contractor for the provision of services under the Demonstration.

2.9.10. Provider Education and Training

2.9.10.1. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures as well as the Cal MediConnect program and the Contractor model of care.

2.9.10.2. Provider Training. Contractor shall ensure that all Network Providers receive training regarding the MediConnect Program in order to operate in full compliance with the

Contract and all applicable federal and state statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract.. Contractor shall ensure that Network Provider training relates to MediConnect services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that Network Provider training includes information on all Enrollee rights including the right to full disclosure of health care information and the right to actively participate in health care decisions. The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its network providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

- 2.9.10.2.1. Contractor shall develop and implement a process to provide information to Network Providers and to train Network Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction. This process shall include an educational program for Network Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.
- 2.9.10.3. Provider Orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.
- 2.9.10.4. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups

in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs including limited English proficiency; and diverse cultural and ethnic backgrounds.

2.9.10.5. Provider Manual. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, care management programs and Enrollee rights.

2.9.10.5.1. Except as otherwise required or authorized by CMS, DHCS or by operation of law, ensure that Network Providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Network Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

2.9.10.6. Provider Directory. Contractor shall make its Provider Directory available to Providers via Contractor's web-portal and as described in Section 2.17.

2.9.10.7. Provider-based Health Education for Enrollees. Contractor shall encourage Network Providers to provide health education to Enrollees as described in Section 2.9.10.8. Contractor shall ensure that Network Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

2.9.10.8. Health Education. Contractor shall implement and maintain a health education program that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Enrollees. This includes helping the Enrollee understand their health plan and the benefits the plan provides.

- 2.9.10.8.1. Contractor shall ensure administrative oversight of the health education program by a qualified full-time health educator.
- 2.9.10.8.2. Contractor shall provide health education programs and services at no charge to Enrollees directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Enrollee population.
- 2.9.10.8.3. Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Enrollees and effective in achieving behavioral change for improved health.
- 2.9.10.8.4. Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.
- 2.9.10.8.5. Contractor shall maintain a health education program that provides educational interventions addressing the following health categories and topics:
 - 2.9.10.8.5.1. Appropriate use of health care services – e.g., managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.
 - 2.9.10.8.5.2. Risk-reduction and healthy lifestyles – e.g., tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity.
 - 2.9.10.8.5.3. Self-care and management of health conditions – e. g., pregnancy; asthma; diabetes; and, hypertension.
- 2.9.10.8.6. Contractor shall ensure that Enrollees receive point of service education as part of preventive and primary health care visits. Contractor shall provide education,

training, and program resources to assist Network Providers in the delivery of health education services for Enrollees.

2.9.10.8.7. Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness, as approved by the Contractor's quality improvement committee.

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

2.9.10.9. Health, Safety and Welfare Education. As part of its Provider education, Contractor shall include information related to identifying, preventing and reporting abuse, neglect, exploitation, and critical incidents.

2.9.10.10. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers. (see Section 2.9.7.8).

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

- 2.10.1.1.4. The number of Network Providers who are not accepting new patients; and
- 2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.
- 2.10.1.2. The Contractor will work in collaboration with Network Providers to actively improve the quality of care provided to Enrollees, consistent with the quality improvement goals and all other requirements of this Contract.
- 2.10.1.3. The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its Service Area are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:
 - 2.10.1.3.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.
 - 2.10.1.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.

- 2.10.1.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.
- 2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:
 - 2.10.2.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>);
 - 2.10.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. § 423.120; or
 - 2.10.2.3. For Medi-Cal providers and facilities, the Contractor contract with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), MSSP, CBAS and County Social Services Agencies located in the Contractor's Service Area.
 - 2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).
 - 2.10.2.3.2. Contractor shall ensure the provision of acceptable accessibility standards in accordance with 42 CFR 438.206(c) and Title 28 CCR Section 1300.67.2.2 and as specified below.
 - 2.10.2.4. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.
- 2.10.3. Appropriate Clinical Timeframes. Except for LTSS, Contractor shall communicate, enforce, and monitor providers' compliance with these standards:

- 2.10.3.1. Contractor shall ensure that Enrollees are offered appointments for covered health care services within a time period appropriate for their condition.
- 2.10.3.2. Enrollees must be offered appointments within the following timeframes:
 - 2.10.3.2.1. Urgent care appointment for services that do not require prior authorization – within forty-eight (48) hours after request;
 - 2.10.3.2.2. Urgent appointment for services that do require prior authorization within ninety-six (96) hours after request;
 - 2.10.3.2.3. Non-urgent primary care appointments – within ten (10) business days after request;
 - 2.10.3.2.4. Appointment with a specialist – within fifteen (15) business days after request;
 - 2.10.3.2.5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days after request.
- 2.10.3.3. Shortening or Expanding Timeframes: Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Enrollee’s medical record that a longer timeframe will not have a detrimental impact on the Enrollee’s health.
- 2.10.3.4. Contractor will monitor providers regularly to determine compliance with the timely access requirements
- 2.10.3.5. Contractor will take corrective action if it, or its providers, fail to comply with timely access requirements.
- 2.10.4. PCP Assignment
 - 2.10.4.1. The Contractor will allow each Enrollee to choose his or her PCP to the extent possible and appropriate. If the Enrollee

does not select a PCP within thirty (30) calendar days of the effective coverage date, Contractor shall assign that Enrollee to a PCP and notify the Enrollee and the assigned PCP in writing no later than forty (40) calendar days after the Enrollee's coverage date.

2.10.4.2. If an Enrollee does not select a PCP within thirty (30) calendar days of the effective date of coverage date, Contractor shall use FFS utilization data or other data sources, including electronic data, to:

2.10.4.2.1. Establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic, if an Enrollee indicates a preference for either. Contractor shall comply with all federal and state privacy laws in the provision and use of this data.

2.10.4.3. Contractor shall notify the PCP that an Enrollee has selected or been assigned to the PCP within ten (10) calendar days from when selection or assignment is completed by the Enrollee or the Contractor, respectively.

2.10.4.4. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Enrollees who do not choose a PCP.

2.10.4.5. If, at any time, an Enrollee notifies the Contractor of a PCP choice, such choice shall override Enrollee assignment to a PCP in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5. Provider Credentialing, Recredentialing, and Board Certification

2.10.5.1. Credentialing and Recredentialing: Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including PCPs and specialists in accordance with the DHCS Policy Letter 02-03, check to see if a provider is suspended or excluded suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medical program pursuant to WIC Section 14043.61 and 42 C.F.R. § 455.436;, and adhere to managed care standards at 42

C.F.R. § 422.204. Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.1.1. Contractor shall ensure those policies and procedures are reviewed and approved by the plan governing body, or designee.

2.10.5.1.2. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.2. Credentialing Site Review: A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's Provider Network. If a provider is added to Contractor's Provider Network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5.3. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: Contractor will use procedures consistent with DHCS policy for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify CMS ninety (90) days prior of any such changes.

2.10.6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): Contractor shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Contractor shall reimburse FQHCs and RHCs in accordance with current federal and state laws and regulations. If FQHC and RHCs services are not available in the Provider Network, Contractor shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

2.10.6.1. FQHC and RHCs Reimbursements: The Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of:

2.10.6.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC and RHCs, and

2.10.6.1.2. The amount of cost-sharing that would have been paid to the FQHC for serving the Enrollee if the Enrollee were in Medicare fee-for-service, consistent with how such amounts are included in the Medi-Cal component of the capitation rates.

2.10.6.1.3. The intent of these provisions is to ensure that Contractors pay FQHCs and RHCs amounts consistent with Medicare and Medi-Cal managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

2.10.7. IHSS Network. Contractor shall develop and execute an MOU with County Social Services Agency responsible for IHSS that reflects an agreement between the Contractor and County Social Services Agency regarding roles and responsibilities for Cal MediConnect and IHSS. This MOU will specify the role of the county in:

2.10.7.1. Assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, in addition to sharing those assessments with the Enrollee's ICT.

2.10.7.2. Sharing confidential data regarding IHSS authorized hours and services as necessary and as permissible under applicable state and federal law.

2.10.7.3. Determining whether the Enrollees' desires to have his or her IHSS providers involved in care planning or coordination, and if so, obtain express consent from the Enrollee or his or her authorized representative.

2.10.7.4. Support an Enrollee who is at risk for out-of-home placement in obtaining IHSS services.

2.10.7.5. Report documentation that Contractor has developed and will conduct a benefit orientation and training program specific to IHSS for First Tier, Downstream and Related Entities. The Contractor also provides documentation that it

has trained personnel of IHSS organizations regarding the Contractor's Covered Services and policies and procedures to access services and coordinate care.

2.10.8. Emergency Services Programs (ESPs)

2.10.8.1. Contractor shall have, as a minimum, a designated emergency service facility, providing care on a twenty-four (24) hour-a-day, seven (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.

2.10.9. Emergency Care

2.10.9.1. Contractor shall cover Emergency Services without prior authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Contractor shall coordinate access to emergency care services in accordance with 42 C.F.R. § 438.114 and the Contractor's DHCS-approved emergency department protocol.

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

2.10.9.3. Contractor shall ensure that a contracting physician is available twenty-four (24) hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Enrollees in an emergency department, if necessary.

2.10.9.4. Contractor may not specify what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

2.10.9.5. Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's PCP, MCO, PIHP, PAHP or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services.

2.10.9.6. An Enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and

treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.10.9.7. May not deny payment for treatment obtained under either of the following circumstances:

2.10.9.7.1. An Enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.

2.10.9.7.2. The Contractor's representative instructs the Enrollee to seek emergency services.

2.10.9.8. 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 on the entities as responsible for coverage and payment.

2.10.10. Post-Stabilization Care Services

2.10.10.1. The Contractor must cover and pay for Post-Stabilization Care Services.

2.10.10.2. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Contractor's provider or other Contractor representative.

2.10.10.3. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's organization that are not pre-approved by a Network Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.

2.10.10.4. The Contractor is financially responsible for Post-Stabilization Care Services obtained from within or outside the Contractor that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if the Contractor:

2.10.10.4.1. Does not respond to a request for pre-approval within one (1) hour;

2.10.10.4.2. Cannot be contacted; or

2.10.10.4.3. Or the Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Network Provider is not available for consultation.

2.10.10.4.4. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network Provider and the treating physician may continue with care of the Enrollee until a Network Provider is reached or one of the criteria in 42 C.F.R. § 113(c)(3) is met.

2.10.10.5. The 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 the services through the Contractor.

2.10.10.6. End of Contractor's financial responsibility. The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when:

2.10.10.6.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

2.10.10.6.2. A Network Provider assumes responsibility for the Enrollee's care through transfer;

2.10.10.6.3. Contractor's representative and the treating physician reach an agreement concerning the Enrollee's care; or

2.10.10.6.4. The Enrollee is discharged

2.10.11. Long Term Services and Supports Providers Network

2.10.11.1. Contractor shall develop policies and procedures to train:

2.10.11.1.1. All Contractor staff involved in care coordination:

- 2.10.11.1.1.1. Person-centered planning processes;
 - 2.10.11.1.1.2. Linguistic, cultural, and cognitive competence;
 - 2.10.11.1.1.3. Core concepts of the Olmstead Decision, i.e. serving Enrollees in the least restrictive settings as appropriate;
 - 2.10.11.1.1.4. Accessibility and accommodations; independent living;
 - 2.10.11.1.1.5. Wellness principles;
 - 2.10.11.1.1.6. Criteria for safe transitions, transition planning, care plans after transitioning; and,
 - 2.10.11.1.1.7. Along with other required training as specified by DHCS – both initially and on an annual basis.
- 2.10.11.1.2. Specially designated care coordination staff in dementia care management including but not limited to:
- 2.10.11.1.2.1. Understanding dementia;
 - 2.10.11.1.2.2. Symptoms and progression;
 - 2.10.11.1.2.3. Understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,
 - 2.10.11.1.2.4. Community resources for Enrollees and caregivers.
- 2.10.11.1.3. Specially designated care coordination staff in MSSP including but not limited to:
- 2.10.11.1.3.1. An overview of the characteristics and needs of MSSP’s target population;
 - 2.10.11.1.3.2. MSSP’s eligibility criteria;

2.10.11.1.3.3. Assessment and reassessment processes, services, and service authorization process; and,

2.10.11.1.3.4. How to refer Enrollees to MSSP for assessment and eligibility determination.

2.10.11.1.4. All Contractor staff generally on the addition of LTSS and social services to Contractor operations. For all trainings, Contractor shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

2.10.12. Women's Health Services: Contractor shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventive health care services. Such access may be in addition to the enrollee's PCP.

2.10.13. Family Planning Provider Network

2.10.13.1. Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by contracted provider or an out-of-network provider.

2.10.13.2. Contractor agrees to abide by 42 C.F.R. § 438.206.

2.10.14. Indian Health Network: The Contractor shall permit Indian Enrollees eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Health Care Provider has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network;

2.10.14.1. The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the provider network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;

2.10.14.2. For services provided prior to January 1, 2018, the Contractor shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the DHCS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the

amount that the Contractor would pay for the Covered Service provided by a non-Indian health care provider;

2.10.14.3. For services provided on or after January 1, 2018, the Contractor shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Contractor shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider;

2.10.14.4. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian health care provider, including any supplemental payment from the state to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

2.10.14.5. When the amount the in-network Indian Health Care Provider receives from the contractor is less than the amount the IHCP would receive FFS, the state must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

2.10.14.6. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians regardless of payer. The Contractor must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical

and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor by:

- 2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;
- 2.11.1.2.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency;
- 2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:
 - 2.11.1.2.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments;
 - 2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;
 - 2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;
 - 2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;
 - 2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;
 - 2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders,

videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

- 2.11.1.3. The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance; and
 - 2.11.1.4. If the Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.
 - 2.11.1.5. When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.
 - 2.11.1.6. Contractor shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.
- 2.11.2. Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians,

administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.

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

2.11.2.1.1. Appointments: Contractor shall implement and maintain procedures for Enrollees to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2.11.2.1.2. First Prenatal Visit: Contractor shall ensure that the first prenatal visit for a pregnant Enrollee will be available within two (2) weeks upon request.

2.11.2.1.3. Waiting Times: Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in 2.11.2.1.1 appointments, above.

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

2.11.2.1.5. After Hours Calls: At a minimum, Contractor shall ensure that all Enrollees have access to appropriate licensed professional for after-hours calls.

2.11.2.1.6. Unusual Specialty Services: Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if

unavailable within Contractor's network, when determined medically necessary.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.3.1.2. Urgent Care sought outside of the Service Area;

2.11.3.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.11.3.1.4. Preventative services;

2.11.3.1.5. Family planning services;

2.11.3.1.6. Out-of-area renal dialysis services;

2.11.3.1.7. Basic prenatal care;

2.11.3.1.8. Sexually transmitted disease services; and

2.11.3.1.9. HIV testing.

2.11.4. The Contractor must have a mechanism in place to allow Enrollees with special health care needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.

2.11.5. Authorization of Services. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.5.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.5.1.1. Have in place and follow written policies and procedures;

- 2.11.5.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;
 - 2.11.5.1.3. Have in place procedures to allow Enrollees to initiate requests for provision of services; and
 - 2.11.5.1.4. Consult with the requesting Network Provider when appropriate.
- 2.11.5.2. The Contractor shall ensure that an authorized care coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.
- 2.11.5.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.
- 2.11.5.4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient and pharmacy benefits.
- 2.11.5.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an

amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

- 2.11.5.5.1. Be produced in a manner, format, and language that can be easily understood;
 - 2.11.5.5.2. Be made available in Threshold Languages, upon request;
 - 2.11.5.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency: and
 - 2.11.5.5.4. In any written communication to a physician or other health care provider of a denial, delay or modification of a request, include the name and telephone number of the health care professional responsible for the denial, delay or modification.
- 2.11.5.6. The Contractor must make authorization decisions in the following timeframes:
- 2.11.5.6.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:
 - 2.11.5.6.1.1. The Enrollee or the Provider requests an extension, or
 - 2.11.5.6.1.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:
 - 2.11.5.6.1.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.1.2.2. There is a need for additional information where:

2.11.5.6.1.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.4.7.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.2.1. The Enrollee or the provider requests an extension; or

2.11.5.6.2.2. The Contractor can justify (to DHCS and/or CMS upon request) that:

2.11.5.6.2.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.2.2.2. There is a need for additional information where:

2.11.5.6.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.3. In accordance with 42 C.F.R. §§ 438.3(i), 438.210(e), and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

2.11.6. Utilization Management

2.11.6.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.6.1.1. Qualified staff responsible for the utilization management program.

2.11.6.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.6.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.6.1.4. 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.

- 2.11.6.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
- 2.11.6.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.
- 2.11.6.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.
- 2.11.6.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.
- 2.11.6.1.9. Procedures to identify, communicate, and implement actions to correct potential over and under-utilization issues that are identified.
- 2.11.6.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. § 422.112, , 422.152, 422.202, and 422.4.
- 2.11.6.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:
 - 2.11.6.3.1. 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.

- 2.11.6.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.
- 2.11.6.3.3. 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.
- 2.11.6.3.4. Reasons for decisions are clearly documented.
- 2.11.6.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made as specified in Section 2.11.6.
- 2.11.6.3.6. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
- 2.11.6.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
- 2.11.6.3.8. Records, including any NOA, shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.
- 2.11.6.3.9. Contractor must notify the requesting provider or Enrollee 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.

2.11.7. Timeframes for Authorization

- 2.11.7.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
- 2.11.7.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.
- 2.11.7.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.
- 2.11.7.4. Non Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC Section 14185 or any future amendments thereto.
- 2.11.7.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. 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 state 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.
- 2.11.7.6. 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 seventy-two (72) hours after receipt of the request for services. The Contractor may extend this 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.

2.11.7.7. LTSS Authorization as follows:

2.11.7.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.7.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.7.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.3).

2.11.7.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker may participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

2.11.8. Review of Utilization Data

2.11.8.1. Contractor shall include within the utilization management 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.

2.11.9. Delegating Utilization Management Activities

2.11.9.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

2.11.10. Availability of Services

2.11.10.1. Access to Services for Emergency Conditions and Urgent Care. The Contractor must ensure access to twenty-four (24) hour emergency services for all Enrollees, whether they reside in institutions or in the community.

2.11.10.1.1. The Contractor must cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. § 438.114(c).

2.11.10.1.2. Emergency Medical Treatment and Labor Act (EMTALA): The Contractor and Network Providers must comply with EMTALA, including the requirements for qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and, as applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.11.10.1.3. An Enrollee who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.11.10.1.4. 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 on the Contractor as responsible for coverage and payment.

2.11.10.1.5. The Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, the Contractor or applicable state entity of the enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services.

2.12. Enrollee Services

2.12.1. Enrollee service representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

- 2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;
- 2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;
- 2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;
- 2.12.1.4. Inform callers that interpreter services are free;
- 2.12.1.5. Be knowledgeable about Medi-Cal, Medicare, the CFAM-MOU, and the terms of the Contract;
- 2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;
- 2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL and how to access those services;
- 2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption

decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

- 2.12.1.9. Demonstrate sensitivity to culture, including disability competent care and the independent living philosophy;
- 2.12.1.10. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of sixth grade and below, and individualized guidance from ESRs to ensure materials are understood;
- 2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;
- 2.12.1.12. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and
- 2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:
 - 2.12.1.13.1. Enrollees' rights and responsibilities;
 - 2.12.1.13.2. The procedures for an Enrollee to change plans or to opt out of Cal MediConnect;
 - 2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;
 - 2.12.1.13.4. The identity, locations, qualifications, and availability of Network Providers;
 - 2.12.1.13.5. Information on all Covered Services and other available services or resources (e.g., state agency services) either directly or through referral or authorization;
 - 2.12.1.13.6. Be able to direct enrollees to the Denti-Cal program for any fee-for-service dental benefits available from Medi-Cal;

- 2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Actions or Adverse Benefit Determinations (denials); and
- 2.12.1.13.8. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the Cal MediConnect.

2.12.2. Enrollee Service Telephone Responsiveness

- 2.12.2.1. The Contractor must operate a call center during normal business hours seven (7) days a week, consistent with the required Medicare Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Enrollee must be able to speak with a live ESR, Monday through Friday, during normal business hours, consistent with the required Medicare Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor may use alternative technologies on Saturdays, Sundays, and state and federal holidays (except New Year's Day). The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five percent (5%). The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.12.3. Coverage Determinations and Appeals Call Center Requirements

- 2.12.3.1. The Contractor must operate a toll-free call center with live ESRs available to respond to Network Providers or Enrollees for information related to requests for coverage under Medicare or Medi-Cal, and Medicare and Medi-Cal appeals

(including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medi-Cal covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call centers. The call centers must operate during normal business hours, as specified in the Medicare Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor must accept requests for Medicare or Medi-Cal coverage, including Medicare coverage determinations / redeterminations, outside of normal business hours, but is not required to have live enrollee service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

- 2.12.3.1.1. Indicates that the mailbox is secure;
- 2.12.3.1.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);
- 2.12.3.1.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and
- 2.12.3.1.4. For Appeals calls, articulates the process, information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Part D Appeal requests and thirty (30) days for other standard Appeal requests.

2.12.4. Enrollee Advisory Committee

- 2.12.4.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the

Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

- 2.12.4.1.1. Meets at least quarterly throughout the Demonstration.
- 2.12.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DHCS reserve the right to review and approve Enrollee membership.

2.12.4.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DHCS and/or CMS.

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, grievances, or appeals related to IHSS, Contractor must comply with the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC 10950

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a grievance through 1-800 Medicare. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file grievances on behalf of Enrollees to the extent allowed under applicable federal or state law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a

system in place for addressing Enrollee grievances, including grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, grievances, appeals, and resolutions related to Cal MediConnect, in compliance with 42 C.F.R. § 438.416 and as described in WIC Section 14182.17(e)(4)(E), in the format specified by DHCS in accordance applicable DPL(s) as indicated in Section 2.1.5. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a grievance process under which Enrollees may submit their grievance regarding all covered services and benefits to the Contractor. Contractor shall establish and maintain a grievance process approved by DHCS under which enrollees may submit their grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated thereunder, Welfare and Institutions Code Section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all grievance activities, and notify CMS and DHCS of all internal grievances. The system must meet the following standards:

2.14.2.1.2.1. Timely acknowledgement of receipt of each Enrollee grievance;

2.14.2.1.2.2. Timely review of each Enrollee grievance;

2.14.2.1.2.3. Response, electronically, orally or in writing, to each Enrollee grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the grievance;

- 2.14.2.1.2.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the grievance to each Enrollee grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and
- 2.14.2.1.2.5. Availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeals in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
- 2.14.2.1.2.6. Procedures to ensure that decision makers on grievances were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:
 - 2.14.2.1.2.6.1. A grievance regarding denial of expedited resolutions of an appeal.
 - 2.14.2.1.2.6.2. Any grievance or appeal involving clinical issues.
- 2.14.2.1.2.7. In addition to grievance logs required by Medicare and Medi-Cal rules, per CA Health and Safety Code section 1368(a)(4)(B) and Title 28 CCR 1300.68(d)(8), the Contractor shall maintain a log of all Exempt Grievances. The log shall be periodically reviewed by the plan and shall include the following information for each Exempt Grievance:
 - 2.14.2.1.2.7.1. The date of the call

2.14.2.1.2.7.2. The name of the complainant

2.14.2.1.2.7.3. The complainant's member identification number

2.14.2.1.2.7.4. The nature of the grievance

2.14.2.1.2.7.5. The nature of the resolution

2.14.2.1.2.7.6. The name of the plan representative who took the call and resolved the grievance

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external grievance for Medicare only covered benefits and services through 1-800-Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombudsman program. The Contractor must display a link to the electronic grievance form on the Medicare.gov Internet Web site on the Contractor's main web page per 42 C.F.R. § 422.504(a)(15)(ii).

2.14.3.1. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee grievance may be filed.

2.14.3.2. Consistent with Health & Safety Code Section 1368(b), Contractor, except for non-Knox Keene Act Licensed COHS plans, shall inform Enrollees that they may file an External Grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address pursuant to Health & Safety Code Section 1368.02

2.15. Enrollee Appeals

2.15.1. Integrated Notice of Action – In accordance with 42 C.F.R. §§ 42 C.F.R. 431.206, 438.404 and 42 C.F.R. §§ 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Action or Adverse Benefit Determination. Enrollees will be notified of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights through a single notice. The form and content of the notice must be approved by CMS

and DHCS. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action.

2.15.1.1. The notice must explain:

- 2.15.1.1.1. The action the Contractor has taken or intends to take;
- 2.15.1.1.2. The reasons for the action;
- 2.15.1.1.3. The citation to the regulations supporting such action
- 2.15.1.1.4. The Enrollee's or the provider's right to file an Appeal;
- 2.15.1.1.5. Procedures for exercising Enrollee's rights to Appeal;
- 2.15.1.1.6. Circumstances under which expedited resolution is available and how to request it; and
- 2.15.1.1.7. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the plan level Appeal.

2.15.1.2. Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days from the day Contractor receives the appeal. An Enrollee notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

- 2.15.1.2.1. Enrollee's right to request a State Fair Hearing;
- 2.15.1.2.2. How to request a State Fair Hearing;
- 2.15.1.2.3. Right to continue to receive benefits pending a State Fair Hearing;
- 2.15.1.2.4. How to request the continuation of benefits;
- 2.15.1.2.5. That Enrollee may be liable for cost of any continued benefits if the Contractor's action is upheld on appeal;

2.15.1.2.6. Enrollee's right to file an external grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.; and

2.15.1.2.7. How to file an external grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC.

2.15.1.2.8. COHS plans that have not obtained a Knox-Keene license are not required to comply with 2.15.1.2.6 and 2.15.1.2.7 of this Contract.

2.15.1.3. Contractor may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must provide the Enrollee with written notice of the reason for the extension and inform the Enrollee of the right to file a grievance if they disagree with the delay.

2.15.1.4. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.15.2. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

- 2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.
- 2.15.2.3. The Contractor must maintain written records of all Appeals activities.
- 2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.
 - 2.15.3.1. Enrollee or provider may file an Appeal with the Contractor either orally or in writing. The Contractor shall assist the Enrollee in confirming an oral Appeal in writing..
 - 2.15.3.2. Enrollee, the Enrollee's authorized representative, or a Provider with the Enrollee's written consent, may file the oral or written Enrollee Appeal with the Contractor within sixty (60) calendar days after date of the Integrated Notice of Action.
 - 2.15.3.3. Contractor must:
 - 2.15.3.3.1. Timely acknowledge receipt of each Enrollee Appeal;
 - 2.15.3.3.2. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those inquiries in writing unless the Enrollee or provider requests expedited resolution.
 - 2.15.3.3.3. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.
 - 2.15.3.3.4. Allow the Enrollee and representative opportunity, before and during the Appeal process to examine the Enrollee's case file, including medical records, and any other documents and records.
 - 2.15.3.3.5. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

- 2.15.3.3.6. Ensure that decision makers on Appeals were not involved in previous levels of review or decision-making and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:
 - 2.15.3.3.6.1. A denial of an Appeal based on lack of medical necessity;
 - 2.15.3.3.6.2. A grievance regarding denial of expedited resolution of an Appeal; or
 - 2.15.3.3.6.3. Any Appeal involving clinical issues.
- 2.15.3.4. Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and state laws and regulations, including but not limited to the following:
 - 2.15.3.4.1. Federal Medicaid regulations governing Medi-Cal Managed Care Appeals and Medi-Cal Appeals in general, at 42 C.F.R. 431 Subpart E and 42 C.F.R. 438 Subpart F.
 - 2.15.3.4.2. Standards for expedited review of grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;
 - 2.15.3.4.3. Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, and external Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder; and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections 51014.1, 51014.2, 53894, and 53858, as well as 42 C.F.R. § 431.244 related to standard and expedited fair hearings decisions;

- 2.15.3.4.4. Twelve (12) month continuity of care under certain circumstances. WIC §14182.17 (d)(7)(A)(ii).
- 2.15.3.5. Expedited internal Medi-Cal Appeals. Contractor shall comply with all state law and regulations pertaining to expedited Appeals, as well as the following requirements:
 - 2.15.3.5.1. Contractor shall implement and maintain procedures as described below to resolve expedited internal Appeals for Medi-Cal services. These procedures shall be followed whenever Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.
 - 2.15.3.5.2. Enrollee or provider may file an expedited Appeal either orally or in writing, and no additional Enrollee follow-up is required.
 - 2.15.3.5.3. Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.
 - 2.15.3.5.4. Contractor must provide an Enrollee notice as quickly as the Enrollee's health condition requires, not exceeding 72 hours from the Contractor's receipt of the Appeal.
 - 2.15.3.5.5. Contractor may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must provide the Enrollee with written notice of the reason for the extension and inform the Enrollee of the right to file a grievance if they disagree with the delay.
 - 2.15.3.5.6. Contractor must provide written notice and must make a reasonable effort to provide oral notice of expedited Appeal decision.

- 2.15.3.5.7. Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.
- 2.15.3.5.8. If Contractor denies a request for expedited resolution of an Appeal, it must
 - 2.15.3.5.8.1. Transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the Contractor receives the Appeal with a possible fourteen (14) day extension, and
 - 2.15.3.5.8.2. Give the Enrollee prompt oral notice of the denial of a request for expedited resolution and a written notice within two (2) calendar days.
- 2.15.3.6. Responsibilities in State Fair Hearings Related to Medi-Cal Benefits and Services. Contractor shall comply with all regulations and procedures regarding State Fair Hearings, set forth in the Manual of Policies and Procedures issued by the California Department of Social Services, pursuant to Title 22, CCR, Section 50953. Contractor shall have the following responsibilities with respect to State Fair Hearings that are expedited, in compliance with CDSS All County Letter 13-40.
 - 2.15.3.6.1. An Enrollee, or an Enrollee's authorized representative, may request a State Fair Hearing either orally or in writing, consistent with 42 C.F.R. § 431.221.
- 2.15.3.7. Parties to an internal Medi-Cal Appeal or State Fair Hearing.
 - 2.15.3.7.1. The parties to an internal plan Appeal or the State Fair Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.
- 2.15.3.8. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor, except for non-Knox Keene Act licensed COHS plans, shall comply with

all statutes, regulations and procedures regarding DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

- 2.15.3.8.1. Enrollees may request an IMR regarding Medi-Cal services from DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination, in whole or in part, that the service is not medically necessary. Health & Safety Code Section 1374.30.
- 2.15.3.8.2. Enrollees shall not be required to participate in Contractor's internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).
- 2.15.3.8.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Grievance process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.30(j)(3).
- 2.15.3.8.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Section 1368.03 and 1374.31(a); Title 28, CCR Section 1300.70.4(b)(2).
- 2.15.3.8.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Title 28, CCR Section 1300.70.4(b); Health & Safety Code Section 1370.4(c)(1).
- 2.15.3.8.6. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3).
- 2.15.3.8.7. If DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through

DMHC's consumer complaint process. Health & Safety Code Section 1368(b).

2.15.4. Medicare Appeals rights and protections will be maintained and enhanced for Medicare services only.

2.15.4.1. Federal Regulations and law will continue to govern all Medicare Appeals regarding Medicare services. As outlined in the MOU, Enrollees will continue to have access to the existing Medicare Part C and Part D Appeals processes. The Medicare Part C process is set forth at 42 C.F.R. Part 422, Subpart M and in Chapter 13 of the Medicare Managed Care Manual. The Medicare Part D process is set forth at 42 C.F.R. Part 423, Subparts M and U and in Chapter 18 of the Medicare Prescription Drug Benefit Manual.

2.15.4.1.1. Hospital Discharge Appeals

2.15.4.1.1.1. The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.15.4.1.2. The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.1. Medicare Benefits and Services

2.15.5.1.1. The Contractor must continue providing benefits for all prior approved non-Part D Medicare benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending a plan level Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first.

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.16.1.1.1. Quality of physical health care, including primary and specialty care;

2.16.1.1.2. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation;

2.16.1.1.3. Quality of LTSS;

2.16.1.1.4. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services;

2.16.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.16.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

- 2.16.2.1. Quantitative and qualitative data collection and data-driven decision-making;
- 2.16.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
- 2.16.2.3. Feedback provided by Enrollees and providers in the design, planning, and implementation of its CQI activities;
- 2.16.2.4. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS;
- 2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and
- 2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

2.16.3. QI Program Structure

- 2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.
- 2.16.3.2. The Contractor shall:
 - 2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

- 2.16.3.2.2. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;
- 2.16.3.2.3. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;
- 2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract and, in addition, the following elements:
 - 2.16.3.2.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;
 - 2.16.3.2.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DHCS;
 - 2.16.3.2.4.3. A process to measure Provider Network and Enrollees, at least

annually, regarding their satisfaction with the Contractor's plan. The Contractor shall submit a survey plan to DHCS for approval and shall submit the results of the survey to DHCS and CMS;

- 2.16.3.2.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures;
 - 2.16.3.2.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in consumer advisory boards; and
 - 2.16.3.2.4.6. In collaboration with and as further directed by DHCS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.
- 2.16.3.2.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall include the following:
- 2.16.3.2.5.1. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.
 - 2.16.3.2.5.2. Organizational chart showing the key staff and the committees and bodies responsible for quality improvement activities including reporting relationships of QI committee(s) and staff within the Contractor's organization.

- 2.16.3.2.5.3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.
- 2.16.3.2.5.4. The role, structure, and function of the Quality Improvement Committee.
- 2.16.3.2.5.5. The processes and procedures designed to ensure that all Covered Services that are Medically Necessary 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 that are Medically Necessary are provided in a culturally and linguistically appropriate manner.
- 2.16.3.2.5.6. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that Enrollees are able to obtain appointments within established standards.
- 2.16.3.2.5.7. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.
- 2.16.3.2.5.8. Description of the activities, including activities used by persons with chronic conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to

assure availability and access to care, clinical services and care management.

2.16.3.2.5.9. A description of the mechanisms used to provide feedback to staff and providers regarding QI outcomes.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral Health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:

2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;

2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and grievances and utilization management.

2.16.3.2.7. Plans in Los Angeles and Orange counties must initiate QI activities for Enrollees in Medicare LTI status per Section 4.2.2.2.6.4.

2.16.3.2.7.1. QI activities under this initiative are subject to CMT approval.

2.16.3.3. Delegation of Quality Improvement Activities

- 2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.
- 2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:
 - 2.16.3.3.2.1. Evaluates First Tier, Downstream and Related Entity's ability to perform the delegated activities including an initial review to assure that the First Tier, Downstream, and Related Entity has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
 - 2.16.3.3.2.2. Ensures First Tier, Downstream, and Related Entity meets standards set forth by the Contractor and DHCS; and
 - 2.16.3.3.2.3. Includes the continuous monitoring, evaluation and approval of the delegated functions.
- 2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:
 - 2.16.3.3.3.1. Planned clinical and non-clinical initiatives;
 - 2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;
 - 2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;
 - 2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;
 - 2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how

those issues are tracked and resolved over time;

2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to DHCS and CMS. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.16.3.3.5. Contractor shall develop a QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1. An Assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program, including but not limited to:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.16.3.3.5.1.2. The review of quality of services rendered; and

2.16.3.3.5.1.3. Outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

2.16.3.3.5.2. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the

Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

2.16.3.3.5.3. An assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities.

2.16.3.3.6. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for quality management. QI staff shall include:

2.16.3.3.6.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated Behavioral Health provider, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.16.3.3.6.2. A qualified individual to serve as the Cal MediConnect QI Director.

2.16.4. QI Activities

2.16.4.1. Performance Measurement

2.16.4.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance

data as described in 42 C.F.R. §§ 422.516(a), 422.152, 423.514, 438.242(a) and (b), and 330.

2.16.4.1.2. Performance improvement projects must involve:

- 2.16.4.1.2.1. Measurement of performance using objective quality indicators
- 2.16.4.1.2.2. Implementation of systems interventions to achieve improvement in quality
- 2.16.4.1.2.3. Evaluation of the effectiveness of the interventions
- 2.16.4.1.2.4. Planning and initiation of activities for increasing and sustaining improvement

2.16.4.1.3. Measurement and improvement projects shall be conducted in accordance with requirements in the CFAM-MOU, Figure 7-1 core quality measures, and as specified in this Contract, and shall include, but are not limited to:

2.16.4.1.3.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Figure 7-1 core quality measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.16.4.1.3.2. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by DHCS and CMS, as follows:

2.16.4.1.3.2.1. Collect and submit to DHCS, CMS and/or CMS' contractors, in a timely manner, data for the measures;

2.16.4.1.3.2.2. Contribute to all applicable DHCS and CMS data quality assurance processes, shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DHCS and rectifying those inadequacies, as directed by DHCS

2.16.4.1.3.2.3. The Contractor shall demonstrate how to utilize results of the measures specified in any CMS and DHCS reporting requirements documents in designing QI initiatives.

2.16.4.2. Consumer Satisfaction Survey:

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

2.16.4.3. Quality Improvement Project (QIP) Requirements

2.16.4.3.1. The Contractor shall implement and adhere to all processes relating to the QIP requirements, as directed by DHCS and CMS, and as follows:

2.16.4.3.1.1. In accordance with 42 C.F.R. § 438.330 (b) and (d), and 42 C.F.R. § 422.152 (d), collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified by DHCS and CMS in annual guidance provided for the upcoming Contract year;

2.16.4.3.1.2. The Contractor is required to conduct or participate in two (2) QIPS approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in no more than two (2) QIPS for each Contract.

2.16.4.3.1.2.1. One (1) QIP must be an internal quality improvement project (IQIP), the requirements of which may be met by the completion of the Medicare QIP process.

2.16.4.3.1.2.2. One (1) QIP must be a DHCS facilitated statewide collaborative in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.16.4.4. Implement the QIP requirements, in a culturally competent manner;

2.16.4.5. Evaluate the effectiveness of QIP interventions, completed in a reasonable time period 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;

2.16.4.6. Plan and initiate processes to sustain achievements and continue improvements;

2.16.4.7. Submit to DHCS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by DHCS and CMS. Such reports shall include information regarding progress on QIP requirements, barriers encountered and new knowledge gained. As directed by DHCS and CMS, the Contractor shall present this information to DHCS and CMS at the end of the QI requirement project cycle as determined by DHCS and CMS; and

2.16.4.8. In accordance with 42 C.F.R. § 422.152 (c), develop a Chronic Care Improvement Program (CCIP) and establish

criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, DHCS and CMS may require them to address specific topic areas.

2.16.5. External Quality Review (EQR) Activities

2.16.5.1. The Contractor shall take all steps necessary to support the EQRO contracted by DHCS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. Contractor shall address the findings of the external review through its QI program. Contractor shall develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor's QI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in Contractor's QI program. DHCS may also require separate submission of an improvement plan specific to the findings of the EQRO. EQR activities shall include, but are not limited to the following:

2.16.5.1.1. Annual validation of performance measures reported to DHCS, as directed or calculated by DHCS;

2.16.5.1.2. Annual validation of QI projects required by DHCS and CMS; and

2.16.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of DHCS, regarding access, structure and operations, and quality of care and services furnished to DHCS. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.16.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum perform the following activities:

2.16.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.16.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, DHCS and CMS staff in a timely manner;

2.16.5.1.3.1.3. Serve as the liaison to the EQRO, QIO, DHCS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and DHCS in a timely manner; and

2.16.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or DHCS.

2.16.5.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The contractor shall maintain such documentation for a minimum of ten (10) years;

2.16.5.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or

- 2.16.5.1.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and DHCS;
- 2.16.5.1.5. Implementing actions, as directed by DHCS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, and CMS in subsequent years; and
- 2.16.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by DHCS and CMS.

2.16.6. CMS-Specified Performance Measurement and Performance Improvement Projects

- 2.16.6.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330.

2.16.7. Clinical Practice Guidelines

- 2.16.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that are:
 - 2.16.7.1.1. Based on valid and reliable clinical evidence or a consensus of health care professionals;
 - 2.16.7.1.2. -Consider the needs of Enrollees;
 - 2.16.7.1.3. Developed in consultation with contracting health care professionals;
- 2.16.7.2. Contractor will review and update practice guidelines periodically as appropriate
- 2.16.7.3. Contractor will disseminate the practice guidelines to all affected providers and upon request, to Enrollees and potential Enrollees.
- 2.16.7.4. Delegated Credentialing: Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with:

- 2.16.7.4.1. Credentialing Provider Organization Certification: Contractor and their Network Providers (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA.
 - 2.16.7.5. 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.
 - 2.16.7.6. Disciplinary Actions: Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider Appeal process.
 - 2.16.7.7. Health Plan Accreditation: If Contractor has received a rating of "Excellent," "Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of credentialing.
 - 2.16.7.8. Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.
 - 2.16.7.9. 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.
- 2.16.8. The Contractor's decisions regarding UM, Enrollee education, coverage of services, and other areas included in the practice guidelines must be consistent with the Contractor's clinical practice guidelines.

2.16.9. Quality Improvement Committee: Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. Contractor must ensure that Enrollees and Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the committee or medical sub-committee that reports to the QIC.

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

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

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.1. General Marketing, Outreach, and Enrollee Communications Requirements

2.17.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, 423.2260, 438.10, ; and the Medicare Marketing Guidelines, with the following exceptions or modifications:

2.17.1.1.1. Contractor may complete an application for enrollment from a potential Cal MediConnect Enrollee and submit it to the state Enrollment Broker;

2.17.1.1.2. If approved to participate in Streamlined Enrollment, the Contractor may collect enrollment information from a potential eligible Enrollee and submit that request to the state per Section 2.3.1.7.

2.17.1.1.3. The Contractor may refer Enrollees and potential Enrollees who inquire about Capitated Financial

Alignment model eligibility or enrollment to the Enrollment Broker, although the Contractor may provide Enrollees and potential Enrollees with information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker;

- 2.17.1.1.4. The Contractor must make available to CMS and DHCS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or potential Enrollees;
- 2.17.1.1.5. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or potential Enrollees, including persons with disabilities and persons using public transportation.
- 2.17.1.1.6. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;
- 2.17.1.1.7. The Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and
- 2.17.1.1.8. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:
 - 2.17.1.1.8.1. The recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;
 - 2.17.1.1.8.2. The Contractor is endorsed by CMS, Medicare, Medi-Cal, the federal government, DHCS, or similar entity.

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

- 2.17.2.1. Made available in alternative formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;
- 2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; and
- 2.17.2.3. Translated into Threshold Languages for all required vital materials, as specified in the Marketing Guidance for California Medicare-Medicaid Plans and annual guidance to Contractors on specific translation requirements for their Service Areas; and
- 2.17.2.4. Mailed with a multi-language insert or alternate language taglines that indicate that the Enrollee can access free interpreter services to answer questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines and Marketing Guidance for California Medicare-Medicaid Plans provisions on the multi-language insert and alternate language taglines.
- 2.17.2.5. Distributed to the Contractor's entire Service Area, as specified in Appendix I of this Contract.

2.17.3. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

- 2.17.3.1. The Contractor must receive prior approval of all Marketing, Outreach, and Enrollee Communications in categories of materials that CMS and DHCS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and DHCS. CMS and DHCS may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module. The Contractor that is a non-Knox-Keene licensed COHS plan shall ensure that

Marketing, Outreach, and Enrollee Communications involving Medi-Cal based services are consistent with the requirements of the Knox-Keene Act and the regulations promulgated thereunder. The Contractor, unless it is a non-Knox-Keene licensed COHS plan, shall submit to DMHC any Marketing, Outreach, and Enrollee Communications required to be reviewed by DMHC pursuant to the Knox-Keene Act.

2.17.3.2. CMS and DHCS may conduct additional types of review of Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.17.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.17.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.17.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or DHCS determine it is appropriate to investigate.

2.17.3.2.4. "Secret shopper" activities where CMS or DHCS request Contractor materials, such as enrollment packets.

2.17.4. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.17.4.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to Enrollees or potential new Enrollees more than ninety (90) days prior to the effective date of coverage for the following Contract year.

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1. Consistent with the timelines specified in the Marketing Guidance for California Medicare-Medicaid Plans, the Contractor must provide new Enrollees with the following materials which, with the exception of the materials

specified in 2.17.5.4, must also be provided annually thereafter:

- 2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMSM and DHCS.
 - 2.17.5.1.1.1. Enrollee rights (see Appendix B);
 - 2.17.5.1.1.2. An explanation of the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;
 - 2.17.5.1.1.3. How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;
 - 2.17.5.1.1.4. How to obtain access to services, including specialty, Behavioral Health, pharmacy and LTSS providers;
 - 2.17.5.1.1.5. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:
 - 2.17.5.1.1.5.1. What constitutes emergency medical condition, Emergency Services, and Post-Stabilization Care Services, with reference to the definitions in 42 C.F.R. § 438.114(a);
 - 2.17.5.1.1.5.2. The fact that prior authorization is not required for Emergency Services;
 - 2.17.5.1.1.5.3. The process and procedures for obtaining Emergency Services,

including the use of the 911 telephone system or its local equivalent;

2.17.5.1.1.5.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

2.17.5.1.1.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.17.5.1.1.5.6. The Post-Stabilization Care Services rules as outlined under 42 C.F.R. § 422.113(c).

2.17.5.1.2. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128), including Enrollee rights under the law of California; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience; that complaints concerning noncompliance with the advance directive requirements may be filed with DHCS; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and that information provided must reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective date of the change;

2.17.5.1.3. How to obtain assistance from ESRs;

2.17.5.1.4. How to file grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

- 2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a grievance or an Appeal by phone;
- 2.17.5.1.4.3. A statement that when requested by the Enrollee, benefits will continue at the Contractor level for all benefits during the Contractor Appeal process, and the Enrollee may be required to pay to DHCS the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and, how the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;
- 2.17.5.1.4.4. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DHCS or CMS may identify, including an Ombudsperson;
- 2.17.5.1.5. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;
- 2.17.5.1.6. How and where to access any benefits that are available under the state plan but are not covered under the Contract, including any cost sharing, and how transportation is provided;
- 2.17.5.1.7. How to change providers;
- 2.17.5.1.8. How to disenroll from Cal Medi-Connect voluntarily;
- 2.17.5.1.9. How to receive counseling and referral services that are not covered under the Contract because of moral or religious objections;
- 2.17.5.1.10. The structure and operation of the Contractor; and
- 2.17.5.1.11. The structure and operation of any physician incentive plans the Contractor may have in place.

- 2.17.5.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and DHCS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for Enrollees enrolled through Passive Enrollment. For current Enrollees, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Marketing Guidance for California Medicare-Medicaid Plans.
- 2.17.5.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medi Cal, and Flexible Benefits and is consistent with the requirements in Section 2.17.5.10, or a distinct and separate notice on how to access this information online and how to request a hard copy.
- 2.17.5.4. A single identification (ID) card for accessing all covered services under the plan that uses the model document developed by CMS and DHCS.
- 2.17.5.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and DHCS's outpatient prescription drug benefit and that uses the model document developed by CMS and DHCS.
- 2.17.5.6. The procedures for an Enrollee to change Cal MediConnect Plans or to opt out of Cal MediConnect.
- 2.17.5.7. The Contractor must provide the following materials to current Enrollees on an ongoing basis:
 - 2.17.5.7.1. An ANOC that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and DHCS.

- 2.17.5.7.2. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services under the Contractor;
- 2.17.5.7.3. The Contractor must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.
- 2.17.5.8. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least sixty (60) days advance notice regarding changes to the comprehensive, integrated formulary.
- 2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:
 - 2.17.5.9.1. Made available in large print (at least 16 point font) to Enrollees as an alternative format, upon request;
 - 2.17.5.9.2. For vital materials, available in Threshold Languages, as provided for in the Marketing Guidance for California Medicare-Medicaid Plans;
 - 2.17.5.9.3. Written with cultural sensitivity and at a sixth grade reading level; and
 - 2.17.5.9.4. Available in alternative formats, according to the needs of Enrollees and potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.3 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.
- 2.17.5.10. Provider/Pharmacy Network Directory
 - 2.17.5.10.1. The Contractor must comply with the following maintenance and distribution requirements:

- 2.17.5.10.1.1. Maintain a combined Provider/Pharmacy Network directory that uses the model document developed by CMS and DHCS;
 - 2.17.5.10.1.2. Provide either a print copy or a distinct and separate notice about how to access this information online or request a hard copy, as specified in Chapter 4 of the Medicare Managed Care Manual and the Marketing Guidance for California Medicare-Medicaid Plans, to all new Enrollees at the time of enrollment and annually thereafter;
 - 2.17.5.10.1.3. When there is a significant change to the network, the Contractor must send a special mailing to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual, immediately;
 - 2.17.5.10.1.4. The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);
- 2.17.5.10.2. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and
- 2.17.5.10.3. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.
- 2.17.5.11. Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a

minimum, the following information for all providers in the Contractor's Provider Network:

- 2.17.5.11.1. The names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).
- 2.17.5.11.2. As applicable, Network Providers with training in and experience treating:
 - 2.17.5.11.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;
 - 2.17.5.11.2.2. Homeless persons;
 - 2.17.5.11.2.3. Persons who are deaf or hard-of-hearing and blind or visually impaired;
 - 2.17.5.11.2.4. Persons with co-occurring disorders; and
 - 2.17.5.11.2.5. Other conditions.
- 2.17.5.11.3. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Pacific Time) weekdays and on weekends;
- 2.17.5.11.4. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;
- 2.17.5.11.5. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Provides, licensing information, such as license number or National Provider Identifier;

- 2.17.5.11.6. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;
- 2.17.5.11.7. Whether the Network Provider is accepting new patients as of the date of publication of the directory;
- 2.17.5.11.8. Whether the Network Provider is on a public transportation route;
- 2.17.5.11.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;
- 2.17.5.11.10. As applicable, whether the Network Provider has access to language line interpreters;
- 2.17.5.11.11. For Behavioral Health Providers, training in and experience treating trauma, child welfare, and substance use;
- 2.17.5.11.12. A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.

2.17.5.12. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:

- 2.17.5.12.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies; and
- 2.17.5.12.2. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee services telephone line (as described in Section 2.12.2.1) for assistance in finding a convenient pharmacy.

2.18. Financial Requirements

2.18.1. Financial Viability

2.18.1.1. As specified in the DHCS Request for Solutions procurement, the Contractor must meet and maintain financial viability/standards compliance for each of the following elements:

2.18.1.1.1. Minimum Required Tangible Net Equity

2.18.1.1.1.1. Contractor at all times shall be in compliance with the Tangible Net Equity (TNE) requirements in accordance with 28 CCR 1300.76. If the Contractor does not meet TNE in a given period, the CMT shall have the power and authority to take one or more of the following sanctions against the Contractor for non-compliance:

2.18.1.1.1.1.1. Require the Contractor to submit a Corrective Action Plan within thirty (30) days of request by the CMT;

2.18.1.1.1.1.2. Appointment of temporary management if the Contractor has repeatedly failed to meet the contractual requirements or applicable federal and state law or regulation. The Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur; and

2.18.1.1.1.1.3. Take other appropriate action as determined necessary by DHCS.

2.18.1.1.2. Contractor must provide assurances satisfactory to the state showing that its provision against the risk of financial instability is adequate to ensure that its Enrollees will not be liable for the entity's

debts if the entity becomes insolvent. Contractor shall demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1.

2.18.2. Administrative costs

2.18.2.1. Contractor's administrative costs shall not exceed the guidelines established under 28 CCR section 1300.78.

2.18.2.2. Standards of Organization and Financial Soundness

2.18.2.2.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.

2.18.2.3. Working Capital Requirements

2.18.2.3.1. Contractor shall maintain a working capital and current ratio in accordance with 22 CCR 53864, which requires a TNE as defined in Title 28, Section 1300.76, or one of the following:

2.18.2.3.1.1. Current ratio of at least 1:1, or prior demonstration that the Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two (2) years, or evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current; or

2.18.2.3.1.2. Demonstration through its history of plan operations that the plan's arrangements for health care are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of

existing and proposed indebtedness, or enrollment growth.

2.18.2.3.2. The Contractor receiving Cal MediConnect enrollment, must demonstrate and maintain adequate working capital as required in California Health and Safety Code Section 1375.1, which requires consideration of:

2.18.2.3.2.1. The financial soundness of the Contractor's arrangements for covered services and the schedule of rates and charges used by the Contractor;

2.18.2.3.2.2. The adequacy of working capital; and

2.18.2.3.2.3. Arrangements with providers for the provision of Covered Services.

2.18.3. Financial Stability

2.18.3.1. Throughout the term of the Contract, the Contractor must:

2.18.3.1.1. Remain financially stable;

2.18.3.1.2. Maintain adequate protection against insolvency in an amount determined by the DMHC as described in Title 28, CCR, Section 1300.75.1.

2.18.3.1.3. Demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1 as follows:

2.18.3.1.3.1. Demonstrate through its history of operations and through projections, (which shall be supported by a statement as the facts and assumptions upon which they are based) that the Contractor's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness; and

- 2.18.3.1.3.2. Attest that the Contractor's arrangements for Covered Services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.
- 2.18.3.1.4. Demonstrate that its working capital is adequate, including provisions for contingencies;
- 2.18.3.1.5. Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the Contract period for which payment has been made, the continuation of benefits to subscribers and Enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered; and
- 2.18.3.1.6. Obtain insurance or make other arrangements:
 - 2.18.3.1.6.1. For the cost of providing to any Enrollee covered health care services the aggregate value of which exceeds \$5,000 in any year;
 - 2.18.3.1.6.2. For the cost of Covered Services provided to its Enrollees other than through the Contractor because medical necessity required their provision before they could be secured through the Contractor; and
 - 2.18.3.1.6.3. For not more than ninety percent (90%) of the amount by which its costs for any of its fiscal years exceed one hundred fifteen percent (115%) of its income for such fiscal year.

2.18.4. Insolvency Reserve

- 2.18.4.1. The insolvency reserve shall have the same definition as minimum required TNE (see 2.17.1.1.1). The minimum TNE is defined by Title 28, CCR, Section 1300.76.

2.18.4.2. According to Title 28, CCR, Section 1300.76(e), California defines TNE as net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

2.19. Data Submissions, Reporting Requirements, and Surveys

2.19.1. General Requirements for Data. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.19.1.1. All information CMS and DHCS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.19.1.2. Any information CMS and DHCS require to comply with all applicable federal or state laws and regulations; and

2.19.1.3. Any information CMS or DHCS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals and enrollment/disenrollment rates.

2.19.2. General Reporting Requirements. The Contractor shall:

2.19.2.1. Submit to DHCS all applicable Medi-Cal reporting requirements in compliance with 42 C.F.R. § 438.602-606.

2.19.2.2. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, 438.604, and 438.606.

2.19.2.3. Submit to CMS and DHCS all applicable MMP reporting requirements.

- 2.19.2.4. Submit to CMS and DHCS all required data in accordance with the specifications, templates and time frames described in this Contract.
- 2.19.2.5. Report HEDIS, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medi-Cal measures required by DHCS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and DHCS.
- 2.19.2.6. Report rates for an under/over-utilization monitoring measure set based upon selected HEDIS use of service measures or any other standardized or DHCS-developed utilization measures selected by DHCS.
- 2.19.2.7. Submit additional reporting requirements as specified throughout this Contract, relevant regulation or law, or as provided through guidance.
- 2.19.2.8. Submit to CMS and DHCS all required reports and data in accordance with the specifications, templates, and time frames described in this Contract, unless otherwise directed or agreed to by CMS and DHCS.
- 2.19.2.9. Submit at the request of CMS or DHCS additional ad hoc or periodic reports or analyses of data related to the Contract.
- 2.19.2.10. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by DHCS in accordance with applicable DPL(s) as indicated in Section 2.5.1.
- 2.19.2.11. Submit to DHCS Part D subcontractor conflict of interest letters on an annual basis. For Part D PDE data requests, securing and submitting appropriate letter from the First Tier, Downstream Entity to address potential conflicts of interests for First Tier, Downstream Entity users that may be affiliated with Part D Contractor sponsors. Letters should indicate either (a) no affiliation or, (b) if there is affiliation,

how the data will be kept separate and secure from Part D Contractor plan operations.

2.19.3. Management Information Systems Capability. The Contractor shall:

2.19.3.1. Maintain Information Systems that will enable the Contractor to meet all of DHCS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current DHCS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following DHCS standards:

2.19.3.1.1. The capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data completeness, timeliness, reasonability, and accuracy requirements of DHCS's encounter data submission. Contractor shall have and maintain a System that provides, at a minimum:

2.19.3.1.1.1. Eligibility data,

2.19.3.1.1.2. Information of Enrollees enrolled in Contractor's plan,

2.19.3.1.1.3. Provider claims status and payment data,

2.19.3.1.1.4. Health care services delivery encounter data,

2.19.3.1.1.5. Provider Network information, and

2.19.3.1.1.6. Financial information, as specified by DHCS.

2.19.3.2. Processes that support the interactions between financial, eligibility; provider; encounter claims; quality management/QI/utilization; and report generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2.19.3.3. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and DHCS and any other entity deemed appropriate by DHCS. Such files shall

be transmitted to DHCS through secure FTP, HTS, or a similar secure data exchange as determined by DHCS;

- 2.19.3.4. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information. If directed by DHCS, establish appropriate links on the Contractor's website that direct users back to the DHCS website portal; and,
- 2.19.3.5. The Contractor shall cooperate with DHCS in its efforts to verify the accuracy of all Contractor data submissions to DHCS.
 - 2.19.3.5.1. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.
 - 2.19.3.5.2. The Contractor shall demonstrate controls to maintain information integrity.
 - 2.19.3.5.3. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DHCS.

2.19.4. Accepting and Processing Assessment Data

- 2.19.4.1. System Access Management and Information Accessibility Requirements
 - 2.19.4.1.1. The Contractor shall make all systems and system information available to authorized CMS, DHCS and other agency staff as determined by CMS or DHCS to evaluate the quality and effectiveness of the Contractor's data and systems.
 - 2.19.4.1.2. The Contractor is prohibited from sharing or publishing CMS or DHCS data and information without prior written consent from CMS or DHCS.

2.19.5. System Availability and Performance Requirements

- 2.19.5.1. The Contractor shall ensure that its Enrollee and provider web portal functions and phone-based functions are

available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.19.5.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DHCS upon request. In the event of system failure or unavailability, the Contractor shall notify DHCS upon discovery and implement the COOP immediately.

2.19.5.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.20. Encounter Reporting

2.20.1. The Contractor must meet any diagnosis and encounter reporting requirements that are in place for Medicare Advantage plans and Medi-Cal managed care organizations. Furthermore, the Contractor's systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS and DHCS and updated from time to time. CMS and DHCS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.20.2. Encounter Data Submission

2.20.2.1. Contractor shall implement policies and procedures for ensuring the submission of complete, timely, reasonable, and accurate Encounter Data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements.

2.20.2.2. Contractor shall require First Tier, Downstream and Related Entities and non-contracting providers to provide claims and Encounter Data to Contractor, which allow Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure Encounter Data is complete, timely, reasonable, and accurate prior to submission to CMS.

- 2.20.2.3. Contractor shall submit complete, timely, reasonable, and accurate Encounter Data to CMS no less than monthly in the form and manner specified by DHCS and CMS. CMS will forward Encounter Data directly to the state.
- 2.20.2.4. Contractor shall submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS and DHCS. The Contractor must also correct and resubmit denied encounters as necessary.
- 2.20.2.5. A percentage of the monthly capitation payments will be withheld as described in Section 4.3.6.

3. CMS and DHCS Responsibilities

3.1. Contract Management

3.1.1. Administration. CMS and DHCS will:

3.1.1.1. Designate a CMT that will include at least one (1) contract officer from CMS and at least one (1) contract officer from DHCS authorized and empowered to represent CMS and DHCS about all aspects of the Contract. Generally, the CMS part of the team will include the state Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representative and DHCS representatives will act as liaisons between the Contractor and CMS and DHCS for the duration of the Contract. The CMT will:

- 3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.
- 3.1.1.1.2. Coordinate periodic audits and surveys of the Contractor;
- 3.1.1.1.3. Receive and respond to complaints;
- 3.1.1.1.4. Conduct regular meetings with the Contractor;
- 3.1.1.1.5. Coordinate requests for assistance from the Contractor and assign CMS and DHCS staff with appropriate expertise to provide technical assistance to the Contractor;
- 3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DHCS;
- 3.1.1.1.7. Inform the Contractor of any discretionary action by CMS or DHCS under the provisions of the Contract;
- 3.1.1.1.8. Coordinate review of marketing materials and procedures;

- 3.1.1.1.9. Coordinate review of grievance and Appeals data, procedures; and
- 3.1.1.1.10. Review, approve, and monitor the Contractor's outreach and orientation materials and procedures.
- 3.1.1.2. Review, approve, and monitor the Contractor's complaint and Appeals procedures;
- 3.1.1.3. Apply one or more of the sanctions provided in Section 5.3.13, including termination of the Contract in accordance with Section 5.5, if CMS and DHCS determine that the Contractor is in violation of any of the terms of the Contract stated herein;
- 3.1.1.4. Conduct site visits as determined necessary by CMS and DHCS to verify the accuracy of reported data; and
- 3.1.1.5. Coordinate the Contractor's external quality reviews conducted by the EQRO.
- 3.1.2. Performance Evaluation. CMS and DHCS will, at their discretion:
 - 3.1.2.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.18 and 2.19, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and DHCS will provide the Contractor with the written results of these evaluations;
 - 3.1.2.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;
 - 3.1.2.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys.

3.2. Enrollment and Disenrollment Systems

- 3.2.1. CMS and DHCS will maintain systems to provide:
 - 3.2.1.1. Enrollment and disenrollment information to the Contractor;

- 3.2.1.2. Continuous verification of eligibility status; and
 - 3.2.1.3. For counties operating under COHS, DHCS will facilitate the Contractor in its responsibility for enrollment and disenrollment activities for Cal MediConnect.
- 3.2.2. Customer Service Team (CST) Enrollment Broker. DHCS or its designee shall assign a staff person(s) who shall have responsibility to:
- 3.2.2.1. Develop generic materials to assist potential Enrollees in choosing whether to enroll in Cal MediConnect. Said materials shall present the Cal MediConnect in an unbiased manner to potential Enrollees eligible to select a Cal MediConnect Plan. DHCS may collaborate with the Contractor in developing Cal MediConnect-specific materials;
 - 3.2.2.2. Present the Cal MediConnect in an unbiased manner to potential Enrollees or those seeking to transfer from one Cal MediConnect to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:
 - 3.2.2.2.1. The rights and responsibilities of participation in Cal MediConnect;
 - 3.2.2.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the HRA, and the ICT;
 - 3.2.2.2.3. Orientation and other Enrollee services made available by the Contractor;
 - 3.2.2.3. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;
 - 3.2.2.4. Be knowledgeable about the Contractor's policies, services, and procedures; and
 - 3.2.2.5. At its discretion, develop and implement processes and standards to measure and improve the performance of the Enrollment Broker staff. The state shall monitor the activities of the Enrollment Broker.

4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. **Capitation Payments.** CMS and DHCS will each contribute to the total capitation payment. CMS and DHCS will each make monthly payments to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three (3) monthly payments for each Enrollee: one (1) amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Part A/B Component), one (1) amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from DHCS reflecting coverage of Medi-Cal services (Medi-Cal Component).

4.1.1.1. On a regular basis, CMS will provide DHCS with the Contractor-level payment information in the Medicare Plan Payment Report. The use of such information by DHCS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, DHCS will also provide to CMS Contractor-level payment information including the Medicaid Capitation Payments.

4.1.2. **Demonstration Year Dates.** Capitation Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to savings percentages applicable on a Demonstration Year basis, as follows. Rate updates for the Medi-Cal component of the rates will take place at least once each calendar year. CMS and DHCS will provide the Contractor with a rate report at least annually to show applicable rates for the upcoming calendar year.

4.1.2.1. **Demonstration Year Dates**

Figure 4.1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	April 1, 2014 - December 31, 2015
2	January 1, 2016 - December 31, 2016
3	January 1, 2017 - December 31, 2017
4	January 1, 2018 - December 31, 2018
5	January 1, 2019 - December 31, 2019

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medi-Cal Component

4.2.1.1. The Medi-Cal component will be paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in the Contractor's Cal MediConnect Plan and is weighted accordingly. The population will be categorized into four risk adjustment population categories:

4.2.1.1.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.2. HCBS High: Enrollees identified as high utilizers of home and community-based services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.2.1. Enrollees who receive CBAS.

4.2.1.1.2.2. Enrollees who are clients of MSSP sites; or Enrollees who receive IHSS and are classified under the IHSS program as "severely impaired" (SI).

4.2.1.1.3. HCBS Low: Enrollees identified as low utilizers of home and community-based services. These Enrollees are IHSS recipients and classified under the IHSS program as "not severely impaired."

4.2.1.1.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.2. The Medi-Cal component will utilize the risk adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population.

4.2.1.2.1. The Medi-Cal component will employ the population categories described above. Relative cost factors (RCF) will be established for each of

the four (4) populations based on evaluation of the per member per month (PMPM) for each of the individual population groups, relative to the total Medi-Cal rate. As the total Medi-Cal rate incorporates incremental changes in population distribution (e.g. fewer Enrollees in institutional settings, increase in HCBS low for higher cost community well that may be more appropriately served by HCBS benefits), the calculation of the RCFs is also impacted by the assumed population distribution.

- 4.2.1.2.2. Contractor specific relative mix factors (RMF) will be computed through the use of RCFs and the proportion of each of the population category Enrollees in the plan. The RMFs will be computed by multiplying each Contractor's distribution of each of the population categories with the established RCFs to calculate a weighted average Contractor-specific RMF.
- 4.2.1.2.3. Contractor RMFs will be multiplied by the established Capitation Rate to determine the risk-adjusted Medi-Cal component payment rate.
- 4.2.1.3. The risk adjustment process will include three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.
 - 4.2.1.3.1. Phase I: The risk adjustment methodology will be applied monthly and retroactively to match actual enrollment into the Contractor's Cal MediConnect Plan. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the next fiscal quarter. For example, in a county with a 12-month phase-in that begins enrollment in April 2014, this phase would last through the end of March 2015. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, there will be no Phase I.
 - 4.2.1.3.2. Phase II: This phase will be for one (1) fiscal quarter. The risk adjustment methodology will be

prospectively applied at the start of the quarter. Weighting the risk categories will be based on the preceding month to the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, the county will immediately enter Phase II of the risk adjustment. The Phase II for San Mateo will be done according to a separate timeline, such that the risk adjustment methodology will be prospectively applied at the start of the Demonstration in April 2014 and again for a second quarter from July 2014 through September 2014 after which San Mateo will move into Phase III.

4.2.1.3.3. Phase III: Contractor rates will be based on a targeted relative mix of the population and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year. Phase III for the county of San Mateo will begin with the fiscal year starting October 2014. The targeted relative mix of the population for the year would be based on enrollment in the plan leading up to the start of the phase III year and will include an assumed shift in population mix.

4.2.1.3.3.1. Specific to Phase III, a targeted relative mix will be projected by the state and its actuaries. This mix will be designed to be achievable by the Contractor, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.

- 4.2.1.3.3.2. If the population mix for the Contractor for the year results in a greater than 2.5% impact to the Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the Contractor and Medicaid would share equally in any cost increases/decreases beyond the 2.5%. Actual plan gain or loss does not factor into this calculation.
- 4.2.1.4. With the structure as described above, DHCS and its actuaries will establish actuarially sound Capitation Rates for the contracts that support the 1115(a) demonstration program for beneficiaries in the target population for Cal MediConnect. These rates will be consistent with 42 C.F.R. § 438.4 and reviewed by the CMS Regional Office. The CMS approved rates will serve as the baseline Medicaid costs.
- 4.2.1.5. Upon request prior to and throughout the Demonstration, the state and its actuaries will provide to CMS the underlying data for the rate calculations associated with the contracts that support the 1115(a) demonstration.
- 4.2.1.6. Medicaid payment rates will be determined by applying annual savings percentages in Figure 4.2 to the applicable Capitation Rates for the contracts that support the 1115(a) demonstration.
- 4.2.1.7. As allowed under the rates for the contracts that support the 1115(a) demonstration, DHCS and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper rates. The application of the savings percentage will apply to all rates, including any prospective or retroactive adjustments, within actuarially sound rate range.
- 4.2.1.8. Consistent with the Medicare rate updates at 4.2.2.2.6, the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect in Los Angeles and Orange counties beginning in 2017 will be considered during Medicaid rate development for 2017 and subsequent years, as applicable.

4.2.2. Underlying Rate Structure for Medicare Components of the Capitation Rate.

4.2.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.3.3.2. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare FFS standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population projected to otherwise be in each program in the absence of the Demonstration. (The proportion expected to otherwise be in Medicare Advantage may be small or negligible based on the enrollment process and other factors.) The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the

corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

- 4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county as of January 2015 (for CY 2014 the baseline was the 3-star county rate).
- 4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.
- 4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.
- 4.2.2.2.5. If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Cal MediConnect Plan, but will obtain the hospice service through the Medicare FFS benefit and the Cal MediConnect Plan would no longer receive the Medicare Parts A/B component for that Enrollee as described in this section. Medicare hospice services and hospice drugs and all other original Medicare services would be paid for under Medicare FFS. Cal MediConnect Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. Cal MediConnect Plans would continue to receive the Medicare Part D component for all non-hospice covered drugs.

Election of hospice services does not change the Medi-Cal component unless otherwise specified in the DHCS 1115(a) demonstration.

4.2.2.2.6. Beginning January 2017, CMS will make an outlier adjustment for the Medicare A/B payments for non-ESRD beneficiaries served by the Contractor in Los Angeles and Orange Counties.

4.2.2.2.6.1. This adjustment will reflect the historical ratio of actual Medicare A/B FFS costs for the long term institutional (LTI) population in this county/counties to the predicted costs for this population, based on the standardized FFS county rates and the HCC risk adjustment model. This payment adjustment will be made retroactively after the end of each demonstration year, beginning in CY 2017 and going forward.

4.2.2.2.6.2. The outlier adjustment is a multiplicative factor equal to 95% of [the historical ratio minus 1 (one)] times the predicted rate for a baseline period. Specifically, the adjustment would be equal to: (the outlier adjustment percentage of 95%) times (this historical ratio from 4.2.2.2.6.1 minus 1(one)) times (the standardized FFS county rate for the applicable calendar year for the applicable county) times (the average final HCC risk score for the applicable calendar year for the population that meets the criteria in 4.2.2.2.6.3) times (the number of member months for the applicable calendar year associated with the population that meets the criteria in 4.2.2.2.6.3).

4.2.2.2.6.3. This adjustment is limited to those new Cal MediConnect members who newly enroll in the CalMediConnect demonstration as of January 1, 2017, or later; were in Medicare LTI status at the time of their Cal MediConnect enrollment; and were in

Medicare FFS at the time of their Cal MediConnect enrollment.

4.2.2.2.6.4.Plans must initiate and report on corresponding quality improvement activities focused on Cal MediConnect members in Medicare LTI status per Section 2.16.3.2.7.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B and Medi-Cal components of the capitated rate, provided that such savings percentages may be adjusted in accordance with Sections 4.2.1.3. and 4.2.2.3.2. herein.

Figure 4.2: Savings Percentages

	Demonstration Year 1	Demonstration Year 2	Demonstration Years 3- 5
Minimum Savings Percentages	1.00%	2.00%	4.00%
County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the			

	Demonstration Year 1	Demonstration Year 2	Demonstration Years 3- 5
county-specific addition			
Los Angeles	+ 0.00%	+ 1.50%	+ 1.50%
Orange	+ 0.42%	+ 1.50%	+ 1.50%
Riverside	+ 0.22%	+ 1.50%	+ 1.14%
San Bernardino	+ 0.44%	+ 1.50%	+ 1.50%
San Diego	+ 0.23%	+ 1.50%	+ 1.10%
San Mateo	+ 0.47%	+ 0.33%	+ 0.00%
Santa Clara	+ 0.23%	+ 1.45%	+ 0.95%

4.2.3.2. Limited risk corridors will be applied as described in Section 4.3.4. on a Contractor basis and be reconciled after application of any risk adjustment methodologies and any other adjustments, as described in Section 4.2.1.2.

4.2.3.2.1. Risk corridors will be reconciled as if the Contractor had received the full quality withhold payment.

4.2.3.2.2. The application of county-specific interim savings percentages in Section 4.2.3.1. establishes the initial Capitation Rates for purposes of the risk corridor calculation.

4.3. Risk Corridors: Risk corridors will be established for Demonstration Years 1-3.

4.3.1. General Provisions

4.3.1.1. Calculation of Gains and Losses: The risk-sharing arrangement described in this section of the Contract may result in payment by the state and CMS to the Contractor or by the Contractor to the state and CMS.

4.3.1.1.1. All payments to be made by the state and CMS to the Contractor or by the Contractor to the state and CMS will be calculated and determined jointly by the state and CMS.

4.3.1.1.2. All calculations, determined jointly by the state and CMS, will be based on the Contractor's reporting of Actual Non-Service Expenditures and

Adjusted Non-Service Expenditures, as required in Section 4.3.3.1.2. All financial reporting will be subject to review and/or audit at the state's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.3.1.1.3. CMS and the state will perform a final settlement of the payments made by the Contractor to CMS and the state, or by CMS and the state to the Contractor, as described in Section 4.3.2.1.6.

4.3.1.2. Risk corridors will apply for Demonstration Years 1-3.

4.3.1.3. Allowable Expenditures

4.3.1.3.1. CMS and the state shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the state's rate development template) submitted by the Contractor (as required by Section 4.3.3.1.2, and Section 2.17-2.19 of this Contract). CMS and the state reserve the right to audit Actual Non-Service Expenditure and Adjusted Non-Service Expenditure data.

4.3.1.3.2. CMS, the state, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the state and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement.

The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the state, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the state

will jointly have the final decision on the resolution of any differences in the expenditure data reported.

- 4.3.1.3.3. The state and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties).

The state and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the state for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.3.2. Risk Corridor Parameters

- 4.3.2.1. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

- 4.3.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.3.2.1.3.

- 4.3.2.1.2. Adjusted Interim Capitation Rate Revenue and Adjusted Final Capitation Rate Revenue: As described in Section 4.2.3.1, the application of county-specific interim savings percentages in Figure 4-2, with the adjustments described in Section 4.3.2.1.6, establishes the Adjusted Interim Capitation Rate Revenue. The Adjusted Final Capitation Rate Revenue is the revenue, with the adjustments described under Section 4.3.2.1.6, that the Contractor would have received if the minimum savings percentages, rather than the county-specific interim savings percentages, were applied.
- 4.3.2.1.3. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.
- 4.3.2.1.4. Down-Side Risk Corridor Payment/Recoupment
- 4.3.2.1.4.1. Losses will be compared to Contractor's underwriting profit/risk/contingency load. If losses exceed this amount, the difference of the loss less the underwriting profit/risk/contingency load shall be eligible for payment under the risk corridor. No payment shall be made for losses that are less than the underwriting profit/risk/contingency load.
- 4.3.2.1.4.2. First Band: For losses in excess of the underwriting profit/risk/contingency load, the state and CMS will make payment to the Contractor of sixty-seven percent (67%) of the loss, with the maximum CMS/state payment to the Contractor not exceeding the Adjusted

Final Capitation Rate Revenue minus the Adjusted Interim Capitation Rate Revenue. The share of the payment made by the state and CMS will be as described in Section 4.3.2.1.1. All losses in excess of the CMS/state payment are the responsibility of the Contractor.

4.3.2.1.5. Up-Side Risk Corridor Payment/Recoupment:
For gains, the following bands apply:

4.3.2.1.5.1. First Band: The first band is equal to the difference between the Adjusted Interim Capitation Rate Revenue and the Adjusted Final Capitation Rate Revenue. For the purposes of the up-side risk corridor, for Contractors in counties where the interim saving percentage is equal to the minimum savings percentage, for the purposes of the up-side risk corridor, the Adjusted Interim Capitation Rate Revenue shall be further modified by applying savings percentages of one and a half percent (1.5%) in Demonstration Year 1, three and a half percent (3.5%) in Demonstration Year 2 and 5.5% in Demonstration Years 3, where applicable, rather than one percent (1.0%), two percent (2.0%) and four percent (4.0%), respectively; this is determined by multiplying the initial Adjusted Interim Capitation Rate Revenue by $(1 - \text{the applicable } 1.5\%, 3.5\% \text{ or } 5.5\% \text{ savings percentages above}) / (1 - \text{Interim Savings Percentage})$.

4.3.3. For the portion of gains in the first band, no payment will be made by the Contractor to the state and CMS.

4.3.3.1.1.1. Second Band: The second band is the same size as the first band. For the portion of gains in the second band, the

Contractor will make payment to the state and CMS of fifty percent (50%) of this portion of the gain, with the share of the payment made to the state and CMS as described in Section 4.3.2.1.1.

- 4.3.3.1.1.2. Third Band: For the portion of gains greater than the upper limit of the second band, no payment will be made by the Contractor to the state and CMS.

Figure 4-3 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	Incremental Loss or Gain¹	% Contractor Risk Sharing	% the State & CMS Risk Sharing	% CMS Risk Sharing	% the State Risk Sharing²
Loss Band 1	All Losses in Excess of Underwriting Profit/Risk/Contingency Load	33%	67% (up to maximum not exceeding Adjusted Final Capitation Rate Revenue - Adjusted Interim Capitation Rate Revenue)	(67%) * (Medicare A/B Percent of Rate)	(67%)*(Medi-Cal Percent of Rate)
Gain Band 1	Gains ≤ (Adjusted Interim Capitation Rate Revenue – Adjusted Final Capitation Rate Revenue) ³	100%	0%	0%	0%
Gain Band 2	Gains ≤ Band equal to size of <i>Gain Band 1</i>	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains > Upper Limit of <i>Gain Band 2</i>	100%	0%	0%	0%

¹ Loss and gain reflected on an incremental basis. Gains in Gain Bands 3 still results in risk sharing reconciliation for the gain in Gain Band 2.

² All State Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

³ The Adjusted Interim Capitation Rate Revenue is modified for counties in which the Interim Savings Percentage equals the Minimum Savings Percentage.

4.3.3.1.2. Risk Sharing Settlement: CMS and the state shall determine a final settlement of payments made by the Contractor to CMS and the state, or by CMS and the state to the Contractor under this section.

If any significant determinant of revenues or costs remains outstanding such that the timelines in this section do not apply, CMS and the state will establish reasonable timeframes for reporting payment and related final settlement timeframes.

4.3.3.1.2.1. Final settlement: CMS and the state shall determine a final settlement based on fifteen (15) months of claims run-out and an IBNR estimate.

4.3.3.1.2.1.1.1. For the purpose of the final settlement, the Contractor will jointly provide to CMS and the state the following within four hundred eighty (480) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the state. A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the applicable Demonstration Year;

4.3.3.1.2.1.1.2. A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including fifteen (15) months of claims run-out;

- 4.3.3.1.2.1.1.3. The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;
- 4.3.3.1.2.1.1.4. A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. § 423.514(a)(1) of this Contract;
- 4.3.3.1.2.1.1.5. A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care;
- 4.3.3.1.2.1.1.6. A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;
- 4.3.3.1.2.1.1.7. Financial reports;
- 4.3.3.1.2.1.1.8. Encounter Data, as required under Section 2.19 of this Contract;

4.3.3.1.2.1.2. CMS and the state shall provide the Contractor with a final reconciliation under the risk corridor arrangement within five hundred ten (510) calendar days following the end of each applicable Demonstration Year or within a timeline jointly agreed upon by CMS and the state. Any balance due between the Contractor and CMS and the state shall be paid within sixty (60) days of the Contractor receiving the final reconciliation from CMS and the state; and

4.3.3.1.2.1.3. The Contractor shall provide any additional information upon request from CMS and the state necessary to calculate Total Adjusted Expenditures.

4.3.4. Medicare Risk Adjustment Methodology

4.3.4.1. Medicare Parts A/B: The Medicare A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified in Section 4.3.3.2, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for Cal MediConnect.

4.3.4.2. Coding Intensity Adjustment Factor

4.3.4.2.1. CMS will calculate calendar year 2014 rates as if the coding intensity adjustment factor were not applied, to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B baseline for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.

- 4.3.4.2.2. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in Section 4.3.3.2.4. This will apply the prevailing Medicare Advantage coding intensity adjustment, on a county-specific basis, proportional to the anticipated proportion of Cal MediConnect Enrollees in 2015 with Medicare Advantage or Cal MediConnect experience in 2014, prior to September 30, 2014.
- 4.3.4.2.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Cal MediConnect Enrollees, with the exception of Cal MediConnect Enrollees in Orange County given the start date of enrollment in this county.
 - 4.3.4.2.3.1. For Orange County in CY 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Orange County Cal MediConnect Enrollees in 2016 with Medicare Advantage or demonstration experience prior to September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to Cal MediConnect Enrollees in Orange County.
- 4.3.4.2.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts will not be risk adjusted.

4.3.4.3. Medi-Cal Component: For the Medi-Cal Component of the capitated rate, DHCS will rely on the methodology described in Section 4.2.1.3 to account for differences in risk among the eligible population.

4.3.5. Payment Terms

4.3.5.1. CMS and DHCS will each make monthly, prospective capitation payments to the Contractor, with retroactive adjustments, as applicable, as described in Sections 4.2.2.2.6.1, 4.2.2.3.1, 4.3.6, and 4.6.

4.3.5.1.1. The Medicare Parts A/B component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts. The payment period will commence on the Contract Operational Start Date.

4.3.5.1.2. DHCS shall remit to the Contractor a capitation payment each month for each Enrollee that appears on the approved list of Enrollees supplied to Contractor by DHCS. The Capitation Rate shall be the amount specified in Section 4.2.1.6. The payment period for health care services shall commence on the Contract Operational Start Date.

4.3.5.1.2.1. DHCS will pay an IHSS interim payment on behalf of the Contractor for IHSS Provider payroll as a portion of the covered Medicaid services. The IHSS interim payment will be reconciled as described in Section 4.5.2. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for

service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

- 4.3.6. Modifications to Capitation Rates. CMS and DHCS will jointly notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in Section 4.7.
- 4.3.6.1. Rates will be updated using a similar process for each calendar year. Subject to Section 4.3.5.2., changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcements will be made only if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for Cal MediConnect. Such changes may be based on the following factors: shifts in enrollment assumptions; changes due to litigation; changes or discrepancies in federal law and/or state policy compared to assumptions about federal law and/or state law or policy used in the development of baseline estimates; changes in coding intensity; and other factors as determined appropriate and approved by CMS and the state.
- 4.3.6.2. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.
- 4.3.6.3. Subject to Section 4.3.5.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DHCS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.
- 4.3.6.4. Changes to the savings percentages will be made if and when CMS and DHCS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines or if and when CMS and DHCS jointly determine the change

is necessary to calculate reasonable, appropriate and attainable payment rates for Cal MediConnect.

4.3.6.5. IHSS wage adjustments may occur during Cal MediConnect. Changes to the Medi-Cal Component will be made annually by county and may be retroactively applied to account for IHSS wage adjustments that occurred during the calendar year, subject to CMS review. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.3.7. Quality Withhold Policy for Medi-Cal and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.3.7.1. Under Cal MediConnect, both payers will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.3.7.1.1. In Demonstration Year 1 of Cal MediConnect, the withhold will be 1% of the respective components of the Capitation Rate. **See Figure 4.3.**

4.3.7.1.2. For Demonstration Year 1, which crosses calendar years, the Contractor will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2014 and at the end of CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 4.3: Quality Withhold Measures for Demonstration Year 1

Domain	Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Assessments	Percent of Enrollees with initial health assessments completed within 90 days of enrollment	CMS/State defined process measure	X	
Beneficiary governance board	Establishment of beneficiary advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly Enrollees get appointments and care <ul style="list-style-type: none"> In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? 	AHRQ/CAHPS	X	
Customer (Enrollee) Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed. <ul style="list-style-type: none"> In the last 6 months, how often did your health plan's customer service give you the information or help you needed? In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? In the last 6 months, how often were the forms for your health plan easy to fill out? 	AHRQ/CAHPS	X	

Domain	Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Behavioral Health Shared Accountability Process Measure	Policies and procedures attached to an MOU with county Behavioral Health agency(ies) around assessments, referrals, coordinated care planning and information sharing	CMS/State defined process measure		X
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Ensuring physical access to buildings, services and equipment	The health plan has an established work plan and identified an individual who is responsible for physical access compliance.	CMS/State defined process measure		X
Case manager contact with Enrollees	Percent of Enrollees who have a case manager and have at least one case manager contact during the measurement year.	State defined process measure		X

4.3.7.1.3. The quality withhold will increase to two percent 2% in Demonstration Year 2 and three percent 3% for Demonstration Years 3-5. **See Figure 4.4.**

4.3.7.1.4. If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Figure 4.4 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy will be made available in separate technical guidance.

Figure 4.4: Quality Withhold Measures for Demonstration Years 2 -5

Domain	Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Encounter data	Encounter data submitted in compliance with contract requirements	CMS/State defined process measure	X	
Plan all-cause readmissions	Percent of Enrollees discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	

Domain	Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Annual flu vaccine	Percent of plan Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	
Screening for clinical depression and follow-up care	Percentage of Enrollees ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	
Reducing the risk of falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS	X	
Controlling blood pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for diabetes medications	Percent of Enrollees with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	
Behavioral Health Shared Accountability Process Measure (DY 3 Only)	Percent of Enrollees receiving Medi-Cal specialty mental health services that received care coordination with the primary mental health provider.	State-defined process measure		X

Domain	Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Behavioral Health Shared Accountability Outcome Measure	Reduction in emergency department use for seriously mentally ill and substance use disorder Enrollees	State-defined measure		X
Documentation of care goals	Percent of Enrollees with documented discussions of care goals.	CMS/State defined process measure		X
Case manager contact with Enrollee	Percent of Enrollees who have a case manager and have at least one case manager contact during the measurement year.	State defined process measure		X

4.3.7.2. CMS and DHCS will evaluate the Contractor’s performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.3.7.3. Whether or not the Contractor has met the quality requirements in a given year will be made public, as will relevant quality results in all Demonstration Years.

4.3.7.4. Shared Financial Accountability Strategy for Incentive Payments for Behavioral Health Services

4.3.7.4.1. Shared accountability between the Cal MediConnect Plan and county Behavioral Health agencies aims to promote care coordination to ensure Enrollees have access to all needed services. Shared accountability builds on the performance-based quality withhold from the plans’ Capitation Rates of one percent, two percent, and three percent (1%, 2%, and 3%) in years one, two, and years three through five of the Demonstration. By meeting specified quality measures, the Contractor can earn back the withheld capitation revenue by meeting specified quality objectives. Under this shared accountability strategy, one (1) withhold measure in year one, one (1) withhold measure in year two, two (2) withhold measures in year three, and one (1) withhold measure in years four and five will be

tied to Behavioral Health coordination with the county.

- 4.3.7.4.2. The Contractor will be required to share with the applicable county Behavioral Health agencies a minimum amount of funds earned back through the shared accountability quality withhold measure each year. Contractor may choose to go above and beyond this minimum. This must be executed as directed in future guidance from DHCS.
- 4.3.7.4.3. The Contractor must provide an incentive payment each year to the county Behavioral Health agency that is equal to or greater than the value of each quality withhold measure multiplied by the proportion of Enrollees identified as having Behavioral Health needs and who are receiving county services. The proportion is defined as follows:
 - 4.3.7.4.3.1. The denominator will be the total number of Enrollees with mental illness or substance use disorders, as defined for the emergency department reduction quality withhold measure for Years 2 through 5. The numerator would be the subset of those Enrollees who are receiving services through the county Behavioral Health agency.
 - 4.3.7.4.3.2. In all counties except Los Angeles, the mental health and substance use departments are administratively combined. In Los Angeles County, the proportion of Enrollees with substance use disorders receiving county drug and alcohol services would be calculated separately from the Enrollees with mental illness population to identify the incentive payment amount paid to the Department of Public Health.

4.3.7.4.3.3. Assuming successful completion and equal weighting of each measure, total Behavioral Health shared accountability incentive payments in each year would equal:

- Year 1 Measure A = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 1 Measure B = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 2: ED Measure = 0.002 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 3-5: ED Measure = 0.003 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.3.8. American Recovery and Reinvestment Act of 2009. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.3.8.1. Suspension of Payments. DHCS shall suspend payments to Cal MediConnect in accordance with 42 C.F.R. § 455.23as as determined necessary or appropriate by DHCS.

4.3.8.2. Non-Payment and Reporting of Provider Preventable Conditions. Pursuant to 42 C.F.R. § 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance

with all provisions related to Provider Preventable Conditions in accordance with the applicable DPL(s) as indicated in Section 2.1.5.

4.4. Medical Loss Ratio (MLR)

- 4.4.1 For Medicaid rating periods beginning on or after July 1, 2017, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74, unless a joint MLR covering both Medicare and Medicaid experience is calculated and reported consistent with CMS and DHCS requirements.
- 4.4.2 Prior to the applicability of the requirements in 4.4.1 for all Demonstration Years in which the risk corridor applies, the Medicare Advantage MLR requirements are waived. To the extent the risk corridor ceases prior to the applicability of the requirements in 4.4.1 the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect.

4.5. Risk Score Changes

- 4.5.1 Medicare Risk Score Changes: Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.6. Reconciliation

- 4.6.1. CMS and DHCS will implement a process to reconcile enrollment and capitation payments for the Contractor that will take into consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or Enrollee contribution amounts; changes in CMS-HCC and RxHCC risk scores; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.
- 4.6.2. Medi-Cal Component Reconciliation. The Medi-Cal Component reconciliation will occur a minimum of once a month. The monthly reconciliation process will reconcile retroactively up to twelve (12) months of historical enrollment changes or up to the effective date of the contract, whichever is sooner.
 - 4.6.2.1. The Contractor is at full risk for IHSS Provider payments. On a quarterly basis, DHCS shall reconcile Actual IHSS

expenditures against the IHSS Interim Payment. If Actual IHSS expenditures exceed the Interim Payment amount, DHCS shall invoice the Contractor for the difference with a thirty (30) day due date. DHCS shall pay California Department of Social Services within two (2) weeks of receipt from the Contractor. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.6.3. Medicare Capitation Reconciliation: Medicare capitation reconciliation will comply with prevailing Medicare Advantage regulations and processes.

4.6.3.1. Final Medicare Reconciliation and Settlement: In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to joint Medicare A/B-Medicaid risk corridors, quality withholds, and medical loss ratios, as applicable, that are outstanding at the time of termination.

4.6.4. Audits/Monitoring: CMS and DHCS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and DHCS.

4.7. Payment in Full

4.7.1. The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.7.2. Notwithstanding any contractual provision or legal right to the contrary, the three (3) parties to this Contract (CMS, DHCS, and the Contractor), for Cal MediConnect agree there shall be no redress against either of the other two (2) parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.7.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the federal government to the Contractor, any entity participating in Cal MediConnect must rely on their own resource to project likely experience under Cal MediConnect.

5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes. The Contractor must notify CMS and DHCS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and DHCS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and DHCS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and DHCS which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents, or employees of the federal government, or DHCS.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated, as provided for in Appendix C.

5.1.4. Subrogation. Subject to CMS and DHCS lien and third-party recovery rights, the Contractor must:

5.1.4.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer for other than Medi-

Cal and Medicare covered benefits, to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

5.1.4.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6. Disclosure Requirements . The Contractor must disclose to CMS and DHCS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance 42 C.F.R. § 1002.3, and as specified by DHCS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DHCS in accordance with this Contract and relevant state and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. In addition, the Contractor shall make the information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to its Enrollees upon reasonable request.

5.1.7. Physician Incentive Plans.

5.1.7.1. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the DHCS in the manner and format specified by CMS and the DHCS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the DHCS that results from the Contractor's or its First Tier, Downstream, or Related Entities' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the DHCS, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

5.1.7.3. Contractor may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

5.1.7.4. Contractor must provide information on its PIP to any Enrollee upon request as provided in 42 C.F.R. § 422.208.

5.1.8. Physician Identifier. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and DHCS for each of its PCPs in the format and time-frame established by CMS and DHCS in consultation with the Contractor.

5.1.9. Timely Provider Payments. The Contractor must make timely payments to its Network Providers consistent with 42 C.F.R. § 447.45. The Contractor must ensure that ninety percent (90%) of claims from Network Providers (including Indian Health Care Providers) who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of all clean claims from Network Providers will be paid within ninety (90) days of the date of receipt of the claim. The Contractor and its Network Providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.9.1. Pharmacy providers will be reimbursed in accordance with the prompt payment provisions at 42 C.F.R. § 423.505(i)(3)(vi).

5.1.9.2. The Contractor shall pay ninety-five percent (95%) of clean claims from non-contracted providers within thirty (30) days of request. All other claims shall be paid or denied within sixty (60) days of request.

5.1.10. Provider Payments. The Contractor shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits, per WIC Section 14182.16 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

5.1.10.1. Medi-Cal Alignment. The Contractor shall pay providers, including institutional providers, in accordance with the prompt payment provisions in compliance with 42 CFR 447.45, ARRA 5006(d) and as contained in each Contractor's Medi-Cal managed care contract with DHCS, including the ability to accept and pay electronic claims, excluding Part D.

5.1.10.2. Date of Receipt. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.10.3. Nursing Facility Rates. The Contractor shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and

chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services. The Contractor shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

5.1.11. Protection of Enrollee-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.12. Protecting Enrollee from Liability for Payment. The Contractor must:

5.1.12.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.12.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.12.1.2. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or DHCS for such services; or

5.1.12.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.12.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A below;

- 5.1.12.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge; and
- 5.1.12.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

5.1.13. Third Party Liability (TPL)

5.1.13.1. General Requirements.

5.1.13.1.1. Coordination of Benefits means the process of utilizing TPL resources to ensure that Medi-Cal is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

5.1.13.1.2. DHCS shall refer to the Contractor the Enrollee's name and pertinent information where DHCS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

5.1.13.1.3. The Contractor shall identify and notify the DHCS's TPL and Recovery Division of all instances or cases in which Contractor believes an action by the Enrollee involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Enrollee of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC. Contractor shall make no claim for recovery of the value of Covered Services rendered to an Enrollee in such cases or instances and such case or instance shall be referred to state's TPL Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

- 5.1.13.1.3.1. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an Enrollee, Contractor shall deliver the requested information within thirty (30) calendar days of the request. Service information includes First Tier, Downstream, or Related Entity and out of plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to First Tier, Downstream, or Related Entity providers or out of plan providers for similar services, whichever is applicable under WIC Section 14124.90(c)(2).
- 5.1.13.1.3.2. Designate a TPL Benefit Coordinator who shall serve as a contact person for benefit coordination issues related to this Contract.
- 5.1.13.1.3.3. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

5.1.14. Medicaid Drug Rebate

- 5.1.14.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.
- 5.1.14.2. Contractor shall submit to DHCS, on a timely and periodic basis, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as DHCS determines necessary.

5.1.15. Moral or Religious Objections. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, pay for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.15.1. To the State;

5.1.15.2. With its application for a contract;

5.1.15.3. Whenever it adopts the policy during the term of the Contract; and the information provided must be:

5.1.15.3.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.15.3.2. Provided to Eligible Beneficiaries before and during enrollment; and

5.1.15.3.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.2. Confidentiality

5.2.1. Statutory Requirements. The Contractor understands and agrees that CMS and DHCS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., Parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal information under the California Information Practices Act (Civil Code Section 1798 et seq.). The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under

this Contract in accordance with applicable state and federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C. § 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

- 5.2.2. Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.
- 5.2.3. Data Security. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, subpart C, the HIPAA Security Rule. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).
- 5.2.4. Return of Personal Data. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or DHCS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or DHCS will destroy such data or material.
- 5.2.5. Research Data. The Contractor must seek and obtain prior written authorization from CMS and DHCS for the use of any data pertaining

to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3. General Terms and Conditions

- 5.3.1. **Applicable Law.** The term "applicable law," as used in this Contract, means, without limitation, all federal and California law, and the regulations, policies, procedures, and instructions of CMS and DHCS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.
- 5.3.2. **Sovereign Immunity.** Nothing in this Contract will be construed to be a waiver by the state of California or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.
- 5.3.3. **Advance Directives.** Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medi-Cal program.
- 5.3.4. **Loss of Licensure.** If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or state approvals, the Contractor must report such loss to CMS and DHCS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.
- 5.3.5. **Indemnification.** The Contractor shall indemnify and hold harmless CMS, the federal government, and DHCS from and against any and all liability, loss, damage, costs, or expenses which CMS and or DHCS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:
 - 5.3.5.1. The Contractor is notified of any claims within a reasonable time from when CMS and DHCS become aware of the claim; and
 - 5.3.5.2. The Contractor is afforded an opportunity to participate in the defense of such claims.
- 5.3.6. **Prohibition against Discrimination.**

- 5.3.6.1. In accordance with 42 USC § 1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or state law, solely on the basis of such license or certification. This section does not prohibit the Contractor: from including providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees; from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.
- 5.3.6.2. Contractor will give written notice of the reason for its decision when it declines to include individual or groups of providers in its network.
- 5.3.6.3. If a Complaint or claim against the Contractor is presented to DHCS or CMS, the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.
- 5.3.7. Anti-Boycott Covenant. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by DHCS. Without limiting such other rights as it may have, CMS and DHCS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the Contractor.
- 5.3.8. Other Contracts. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those eligible for coverage in the Contract; provided, however, that the Contractor must provide CMS and DHCS with a complete list of such plans and services, upon request. CMS and DHCS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or DHCS

from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.9. Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.10. Entire Contract. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.11. No Third-Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.12. Corrective Action Plan. If, at any time, CMS and DHCS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and DHCS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and DHCS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by CMS and DHCS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and DHCS or other intermediate sanctions as described in Section 5.3.13.

5.3.13. Intermediate Sanctions.

5.3.13.1. In addition to termination under Section 5.5, CMS and DHCS may, impose any or all of the sanctions in Section 5.3 upon any of the events below; provided, however, that CMS and DHCS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. CMS and DHCS may choose to provide warning notices and/or corrective action plans before sanctions. Sanctions may be imposed in accordance with this section for any failure to comply with this Contract, including but not limited to, if the Contractor:

- 5.3.13.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;
- 5.3.13.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;
- 5.3.13.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;
- 5.3.13.1.4. Misrepresents or falsifies information provided to CMS, DHCS, Enrollees, or its Provider Network;
- 5.3.13.1.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);
- 5.3.13.1.6. Fails to comply with federal or state statutory or regulatory requirements related to this Contract;
- 5.3.13.1.7. Violates restrictions or other requirements regarding marketing;
- 5.3.13.1.8. Fails to comply with quality management requirements consistent with Section 2.16;
- 5.3.13.1.9. Fails to comply with any corrective action plan required by CMS and DHCS;
- 5.3.13.1.10. Fails to comply with financial solvency requirements;
- 5.3.13.1.11. Fails to comply with reporting requirements;
or
- 5.3.13.1.12. Fails to comply with any other requirements of this Contract.

5.3.13.2. Such sanctions may include, but are not limited to:

- 5.3.13.2.1. Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O or § 438 Subpart I;
 - 5.3.13.2.2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);
 - 5.3.13.2.3. Suspension of enrollment (including assignment of Enrollees);
 - 5.3.13.2.4. Suspension of payment to the Contractor;
 - 5.3.13.2.5. Disenrollment of Enrollees; and
 - 5.3.13.2.6. Suspension of marketing.
 - 5.3.13.2.7. Denial of payment as set forth in 42 C.F.R. § 438.730.
- 5.3.13.3. If CMS or DHCS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.12, CMS and DHCS may:
- 5.3.13.3.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and DHCS; or
 - 5.3.13.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.
- 5.3.13.4. Additional Administrative Procedures. CMS and DHCS may, from time to time, issue program memoranda, bulletins, and DPLs clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda, bulletins, and letters as may be issued from time to time.

- 5.3.13.5. Effect of Invalidity of Clauses. If any clause or provision of this Contract is in conflict with any federal or state law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.
- 5.3.14. Before imposing any intermediate sanctions, consistent with 42 C.F.R. § 438.710, DHCS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DHCS and CMS elect to provide.
- 5.3.15. Conflict of Interest. Neither the Contractor, nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and DHCS with the performance of services under the Contract, or that may be otherwise anticompetitive. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.
- 5.3.16. Insurance for Contractor's Employees. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including but not limited to, worker's compensation and unemployment compensation, and must provide CMS and DHCS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or DHCS, provide certification of professional liability insurance coverage.
- 5.3.17. Waiver. The Contractor, CMS, or DHCS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or DHCS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and DHCS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.
- 5.3.18. Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audit

- 5.4.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years from the end of the final contract period or completion of audit, whichever is later.
- 5.4.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and DHCS and other regulatory agencies, available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the state of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.
- 5.4.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the state Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.
- 5.4.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.
- 5.4.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and state requirements.
- 5.4.6. Disputes. The Disputes procedure set forth in Appendix L will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

5.5. Termination of Contract

- 5.5.1. Termination without Prior Notice. In the event the Contractor substantially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Medi-Cal programs, CMS or DHCS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract in accordance with regulations that are current at the time of the termination.
- 5.5.2. Without limiting the above, if CMS or DHCS determine that participation of the Contractor in the Medicare or Medi-Cal program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Medi-Cal program, CMS or DHCS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or DHCS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medi-Cal services to Medicare-Medi-Cal beneficiaries.
- 5.5.3. United States law and California law, as appropriate, will apply to resolve any claim of breach of this Contract.
- 5.5.4. Termination with Prior Notice.
- 5.5.4.1. CMS or DHCS may terminate this Contract without cause upon no less than one hundred eighty (180) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.8, the Contractor may choose to non-renew this Agreement prior to the end of each term pursuant to 42 C.F.R. § 422.506(a). In considering requests for termination under 42 C.F.R. § 422.508, CMS and DHCS will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and DHCS prior to their use.
- 5.5.4.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph 5.5.2.1 and non-renewal of

this Contract as described in Section 5.8 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

- 5.5.5. Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- 5.5.6. Termination for Cause. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or DHCS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or DHCS may expedite the termination.
 - 5.5.6.1. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. § 422.510 and § 438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or DHCS must:
 - 5.5.6.1.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or
 - 5.5.6.1.2. Notify the Contractor of its appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.
 - 5.5.6.2. If Contractor fails to comply with the provisions of Section 5.5, CMS or DHCS may terminate this agreement upon thirty days' notice.
- 5.5.7. Termination due to a Change in Law. In addition, CMS or DHCS may terminate this agreement upon thirty (30) days notice due to a material change in law, or by operation of law, including a change in the state law authorizing the state's participation in the program, or with less or no notice if required by law.
- 5.5.8. Continued Obligations of the Parties.

- 5.5.8.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Medi-Cal programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and DHCS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.
- 5.5.8.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:
 - 5.5.8.2.1. If CMS or DHCS, or both, elect to terminate or not renew the Contract, CMS and DHCS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care under applicable laws, regulations, and provisions of this Contract. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and state requirements and the terms of this Contract;
 - 5.5.8.2.2. The Contractor must promptly return to CMS and DHCS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and
 - 5.5.8.2.3. The Contractor must supply to CMS and DHCS all information necessary for the payment of any outstanding claims determined by CMS and DHCS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Impact of Termination

- 5.6.1. In the event this Contract is terminated, expires, or is not renewed for any reason, the state shall have the authority to crosswalk Enrollees

into a Medi-Cal Managed Care Plan for the purposes of the seamless provision of Medi-Cal managed care covered services.

- 5.6.2. The state shall provide such Enrollees with notice of this crosswalk and of any options Enrollees have to change Medi-Cal managed care plans for the provision of Medi-Cal covered services.

5.7. Order of Precedence

- 5.7.1. The following documents are incorporated into and made a part of this Contract:

- 5.7.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;
- 5.7.1.2. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;
- 5.7.1.3. CFAM-MOU, a document between CMS and DHCS regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27, 2013);
- 5.7.1.4. The Contractor's Medi-Cal managed care contract;
- 5.7.1.5. All applicable federal and state regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, the annual rate report, plan letters, bulletins and guidance memoranda.
- 5.7.1.6. The Contractor's response to the Request for Solutions.

- 5.7.2. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

- 5.7.2.1. The Contract terms and conditions, including all appendices;
- 5.7.2.2. Capitated Financial Alignment Application;
- 5.7.2.3. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

- 5.7.2.4. CFAM-MOU, a document between CMS and DHCS Regarding a federal-state partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27, 2013);
- 5.7.2.5. The Contractor's Medi-Cal managed care contract;
- 5.7.2.6. All applicable federal and state regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, bulletins, and guidance memoranda; and
- 5.7.2.7. The Contractor's response to the RFS.

5.7.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.8. Contract Term.

5.8.1. This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2019, so long as the Contractor has not provided CMS and the state with a notice of intention not to renew, and CMS/state have not provided the Contractor with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above. Notwithstanding the foregoing, Contractors shall not non-renew or terminate this contract during Demonstration Year 1, unless provided for in Section 5.5 of this contract. This contract will terminate, or its effectuation will be delayed, unless the state receives all necessary approvals from CMS, including but not limited to § 1115(a) demonstration authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the state has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary § 1115(a) authority, the readiness review approval, or the effective date of this contract.

5.9. Amendments

5.9.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the

parties may amend this Contract where such amendment does not violate federal or state statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of all three parties, and attached hereto.

5.10. Written Notices

5.10.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

E-mail Copies To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

Copies to:

E-mail Copies: California Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413

E-mail Copies to:

To:

E-mail Copies to:

In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Contractor:

TYPE NAME AND TITLE HERE

Date

<MMP Name>

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Jennifer Kent, Medicaid Director
California Department of Health Care Services

Date

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Henrietta Sam-Louie
Associate Regional Administrator
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

Date

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Kathryn Coleman

Date

Director

Medicare Drug & Health Plan Contract Administration Group

Centers for Medicare & Medicaid Services

United States Department of Health and Human Services

SECTION 6: Appendices

Appendix A: Covered Services

The Contractor shall provide services to Enrollees as follows:

- A.1 Medical Necessity. The Contractor shall provide services to Enrollees as follows:
 - A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Covered Services that are Medically Necessary as specified in Section 2.4, in accordance with the requirements of the Contract.
 - A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:
 - A.1.2.1. Prevent, diagnose, or treat health impairments;
 - A.1.2.2. Attain, maintain, or regain functional capacity.
 - A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.
 - A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.
 - A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:
 - A.1.5.1. Developed with input from practicing physicians in the Cal MediConnect's Service Area;
 - A.1.5.2. Developed in accordance with standards adopted by national accreditation organizations;
 - A.1.5.3. Developed in accordance with the definition of Medical Necessity in Section 2.4;
 - A.1.5.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
 - A.1.5.5. Evidence-based, if practicable; and

A.1.5.6. Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components must, at a minimum, be submitted to DHCS annually for approval no later than 60 days prior to the start of a new Contract Year, and no later than 60 days prior to any change.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received CMS and DHCS approval.

A.2 Covered Services. Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All standard Medi-Cal fee-for-service benefits excluding:

A.2.1.1. ICF/MR services;

A.2.1.2. County-administered Medi-Cal Specialty Mental Health Services and substance use disorder services. This does not include Behavioral Health services that become Medi-Cal managed care benefits on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, which will be Covered Services under this contract;

A.2.1.3. State and County activities to administer IHSS, including determining eligibility, assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, enrolling providers, conducting provider orientation, and retaining enrollment documentation, conducting criminal background checks on all potential providers, providing assistance to IHSS recipients in finding eligible providers through an established provider registry;

A.2.1.3.1 For dates of service on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97);

A.2.1.4. Medi-Cal Dental Services, known as Denti-Cal

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Particular pharmacy products that are covered by Medi-Cal and may not be covered under Medicare Part D.

- Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.3 In addition, Contractor agrees to provide the following:

A.3.1 Vision Benefit

A.3.1.1. \$0 copay for one (1) routine eye exam every year

A.3.1.2. Every two years, \$100 for eyeglasses (frames and lenses) or up to \$100 for contact lenses

A.3.2 Non-Medical Transportation and Non-Emergency Medical Transportation Benefits

A.3.2.1. Contractors must provide transportation services to beneficiaries for Medically Necessary Services.

A.3.2.2. Contractors must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs.

A.3.3 Care Transitions Assistance provided across facility and community settings. Care coordination shall be provided for transitions among levels of care and between service locations. Such services facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for Enrollees who have experienced or are expecting an inpatient stay.

A.4 Cost-sharing for Covered Services

A.4.1 Except as described below, cost-sharing of any kind is not permitted in Cal MediConnect.

A.4.1.1. Co-pays charged by Demonstration Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.4.1.2. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.4.1.3. Co-pays charged by Demonstration Plans for supplemental dental benefits.

A.5 Limitations on Covered Services.

A.5.1 - Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.5.2 -Sterilization services may be provided only as allowed by state and federal law (see 42 C.F.R. Part 441, Subpart F).

Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

- A. The right to be treated with dignity and respect.
- B. The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
- C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
- D. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
- E. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
- F. Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
- G. The right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
- H. The right to participate in all aspects of care and to exercise all rights of appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
 - a. Receive a comprehensive health risk assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination of Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
 - b. Receive complete and accurate information on his or her health and

Functional Status by the interdisciplinary team.

- c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
 - i. Before enrollment.
 - ii. At enrollment.
 - iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
- d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
- e. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
- f. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.
- I. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
- J. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- K. Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the DHCS treat the Enrollee.
- L. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and, the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.
- M. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
- N. The right not to be charged any cost sharing for Medicare Parts A and B services.
- O. The unconditional and exclusive right to hire, fire, and supervise his or her IHSS provider.
- P. The right to receive their Medicare and Medi-Cal appeals rights in a format and language understandable and accessible to them.
- Q. The right to opt out of Cal MediConnect at any time, beginning at the first of the

following month.

Appendix C: Relationship with First Tier, Downstream, and Related Entities

- A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, and 438.3(k).
- B. Contractor shall specifically ensure:
 - 1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
 - 2. HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
 - 1. Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
 - 2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and DHCS; including the requirements at 42 CFR 438.414 in relation to the grievance system.
 - 3. Language that specifies the delegated activities and reporting requirements;
 - 4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DHCS or the Contractor determine that such parties have not performed satisfactorily;
 - 5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
 - 6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and
 - 7. Language that specifies the First Tier, Downstream and Related Entities must comply with all federal and state laws, regulations and CMS instructions.
- D. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
 - 1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or
 - 2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.
- E. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must

include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

- F. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.
- G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:
 - 1. Language that the Contractor is obligated to pay contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;
 - 2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
 - 3. Language that medical providers abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
 - 4. Language that medical providers ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas;
 - 5. Language that medical providers maintain Enrollee records and information in an accurate and timely manner;
 - 6. Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and
 - 7. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.
 - 8. Language that clearly states the medical providers' EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
 - 9. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.
 - 10. Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
 - (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or
 - (b) Communicated with one or more of his or her prospective, current or former

- patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.
11. Language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.
 12. Language that specifies the term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
 13. Full disclosure of the method and amount of compensation or other consideration to be received from the Contractor.
 14. Language that requires the medical provider to assist Contractor in the transfer of care.
 15. Language that requires the medical provider to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.
 16. Notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
 17. Assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
 18. Timely gather, preserve and provide to DHCS, any records in the subcontractor's possession.
 19. Provide interpreter services for Enrollees at all provider sites.
 20. Right to submit a grievance and Contractor's formal process to resolve Provider Grievances.
 21. To participate and cooperate in the Contractor's Quality Improvement System.
 22. If Contractor delegates Quality Improvement activities, Subcontract shall include provisions as specified by DHCS.

Appendix D: Quality Improvement Requirements

The Contractor will undertake the following quality improvement initiatives with the goal of identifying areas in need of improvement and undertaking quality improvement activities in response to the findings related to each initiative.

1. Emergency Department utilization. The goal of this initiative is to better understand reasons for ED utilization among Cal MediConnect Enrollees, and the impact of LTSS to such usage.
 - Contractor will identify a random sample of Enrollees each year who have utilized ED services. [
 - Contractor will engage an independent quality assurance entity to conduct interviews with each Enrollee in the sample to determine background & causes for ED visits, using a semi-structured interview tool provided by DHCS.
 - Contractor will analyze results of the surveys in order to understand the underlying causes of ED utilization, including the use of and/or or failure of LTSS, or there was a lack of appropriate LTSS to adequately support the Enrollee in his or her environment. Contractor will identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency department services.
 - Contractor will report results to DHCS and to CMS.
2. Barriers to Health Access. The goal of this initiative is to better understand access issues experienced by Cal MediConnect Enrollees.
 - Contractor will identify a random representative sample size of Enrollees each year.
 - An independent quality assurance entity will conduct interviews with each Enrollee in the sample, using a semi-structured interview tool provided by DHCS, to determine if any barriers to health care were experienced and to understand the nature of those barriers. Examples of barriers include, but are not limited to, the following: inaccessible medical equipment in provider offices, inaccessible signage in provider

offices (i.e. no Braille writing on signs), inaccessible communication from the Cal MediConnect or providers (i.e. no access to ASL interpreters, no written communication in large print or plain language, or no access to someone who can explain information), inadequate access to appropriate physicians for intellectually disabled Enrollees, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

Contractor will analyze results of the surveys in order to understand the underlying causes of these barriers to health care access. Contractor will identify issues within its system of care that require improvement to promote access and ADA

3. Other topic areas to be identified through annual guidance by CMS and DHCS in accordance with 42 C.F.R. § 422.152(c) and 422.152(d).

Appendix E: Addendum to Capitated Financial Alignment Contract

**PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF
THE SOCIAL SECURITY ACT FOR THE OPERATION OF A
VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as “CMS”) and _____, the state of California, acting by and through the Department of Health Care Services (DHCS), and a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract ##### governing Contractor’s operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as “the Act”) to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Article I

Voluntary Medicare Prescription Drug Plan

- A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 [(hereinafter collectively referred to as “the addendum”). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.
- B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable federal statutes, regulations, and policies.
- C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.
- D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, DHCS, and CMS.

Article II

Functions to be Performed by Contractor

A. ENROLLMENT

- 1. Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have elected to enroll in Contractor’s Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).
2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.
2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the Contract year as provided in 42 C.F.R. §423.505(o).
3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.
2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:
 - (a) Addressing and resolving Complaints in the CMS Complaint tracking system; and
 - (b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and DHCS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, DHCS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with state Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.
2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and DHCS (as defined in Appendix I) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and DHCS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.
3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).
4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.
2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. §423.329(b)(3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.
2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.
3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND DHCS LICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and DHCS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the

Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

**Article IV
HIPAA Provisions**

- A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. §423.136.
- B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

**Article V
Addendum Term and Renewal**

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2013. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

- 1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if –
 - (a) Contractor has not provided CMS or DHCS with a notice of intention not to renew in accordance with Article VII of this addendum, and
 - (b) CMS or DHCS has not provided Contractor with a notice of intention not to renew.
- 2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and DHCS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VI

Nonrenewal of Addendum

A. NONRENEWAL BY CONTRACTOR

Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VII Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VIII Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article IX Termination of Addendum by Contractor

- A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.
- B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article X Relationship between Addendum and Capitated Financial Alignment Contract

- A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to

terminate or non-renew the Contractor's Capitated Financial Alignment Contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

- B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment Contract to which this document is an addendum.
- C. In the event that Contractor's Capitated Financial Alignment Contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, Contractor, DHCS and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

**Article XI
Intermediate Sanctions**

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

**Article XII
Severability**

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

**Article XIII
Miscellaneous**

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND DHCS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and DHCS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and DHCS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

Appendix F: Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare and Medi-Cal data obtained from CMS and DHCS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and DHCS to administer. The Contractor shall only maintain data obtained from CMS and DHCS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and DHCS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or DHCS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and DHCS.

The Contractor further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Medicare-Medicaid Enrollees information about non-health related services after obtaining consent. Second, the Contractor may provide information about health-related services without obtaining prior consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and DHCS have authorized under this agreement. A termination of this data use agreement may result in CMS or DHCS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an Integrated Care Organization (Cal MediConnect). This agreement shall remain in effect as long as the Contractor remains a Cal MediConnect sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or DHCS make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (E CRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

Appendix G: Model File & Use Certification Form

Pursuant to the Contract between the Centers for Medicare & Medicaid Services (CMS), the state of California, acting by and through the Department of Health Care Services (DHCS) and Plan hereafter referred to as the Contractor, governing the operations of the following health plan: _____, the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or DHCS to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. §§422.2260 - 422.2276 and 42 C.F.R. §422.111 for Cal MediConnect and the Medicare Marketing Guidelines.

I agree that CMS or DHCS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and DHCS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor.

Appendix H: Medicare Mark License Agreement

THIS AGREEMENT is made and entered into January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Plan (hereinafter "Licensee"),
with offices located at _____.

CMS Contract ID: _____

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning January 1, 2018.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2018, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2018, this agreement shall be renewable for

successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

Appendix I: Service Area

The Service Area outlined below is contingent upon the Contractor meeting all Readiness Review requirements in each county. CMS and DHCS reserve the right to amend Appendix I to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and DHCS.

Appendix J: Eligible Populations

Enrollment into Cal MediConnect will be available to individuals who meet all of the following criteria:

- Age 21 and older at the time of enrollment;
- Entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, or enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a state plan under title XIX of such Act or under a waiver of such plan;
- Eligible for full Medicaid (Medi-Cal), including
 - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
 - Individuals who meet the share of cost provisions described below:
 - Nursing facility residents with a share of cost,
 - MSSP Enrollees with a share of cost, and
 - IHSS recipients with a share of cost.
 - Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act as described below:
 - For those Enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, the Department or its designee shall make a Medi-Cal eligibility determination “as if” the beneficiary were in a long-term care facility. Specifically, the spousal impoverishment rule codified section 1924 of the Act will apply to Enrollees. The terms “intermediate care facility level of care” and “nursing facility level of care” and “subacute facility level of care” shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- Reside in one of the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
 - Up to 200,000 individuals in Los Angeles may be enrolled in the Demonstration. CMS and the state will monitor the enrollment and stop participation when this enrollment cap is met.
- Individuals residing in San Mateo or Orange county with a diagnosis of end stage renal disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through California’s regional centers or state developmental centers or intermediate care facilities for the developmentally

disabled in Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara counties;

- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals living in the following rural zip codes:
 - San Bernardino County - 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558
 - Los Angeles County - 90704
 - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in a separate line of business operated by the Contractor. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all Enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

Individuals that may enroll but may not be passively enrolled include (see section C.2 for a description of passive enrollment):

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in Medicare Advantage in 2014;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
 - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/ Acute hospital Waiver, HIV/ AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and
 - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Appendix K: Disputes

Contractor also agrees to the following:

1. This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues. It shall not be used with respect to any dispute regarding the actuarial soundness of the capitated rate, as provided in paragraph 4.6.2. Filing a dispute will not preclude DHCS and CMS 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 twenty-five (25) percent of the capitation payment, amounts of up to twenty-five (25) percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.
2. Disputes Resolution by Negotiation
 - a. DHCS, CMS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contract Management Team (CMT) 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.
3. Notification of Dispute
 - a. Within fifteen (15) calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the CMT in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.
 - b. The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:
 - i. That it is a dispute pursuant to this section.
 - ii. The date, nature, and circumstances of the conduct which is subject of the dispute.
 - iii. The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/state official or CMS employee involved in or knowledgeable about the conduct.
 - iv. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
 - v. The reason the Contractor is disputing the conduct.
 - vi. The cost impact to the Contractor directly attributable to the alleged conduct, if any.
 - vii. The Contractor's desired remedy.

- c. The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.
 - d. Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.
4. CMT or Alternate Dispute Officer's Decision
- a. Pursuant to a request by Contractor, the CMT may provide for a dispute to be decided by an alternate dispute officer designated by DHCS and CMS, who is not a member of the CMT and is not directly involved in Medicare or the Medi-Cal Managed Care Program, as appropriate for the issue involved. Any disputes concerning performance of this Contract shall be decided by the CMT or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) calendar days of receipt of a Notification of Dispute, the CMT or the alternate dispute officer, shall either:
 - i. Find in favor of Contractor, in which case the CMT or alternate dispute officer may:
 - A. Countermand the earlier conduct which caused Contractor to file a dispute; or
 - ii. Or,
 - A. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or
 - B. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the CMT or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the CMT or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the CMT 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.
5. Appeal of CMT or Alternate Dispute Officer's Decision
- a. Contractor shall have thirty (30) calendar days following the receipt of the decision to file an appeal of the decision to the Director and the Medicare Drug & Health Plan Contract Administration Group Director, Center for Medicare. All appeals

shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph 7, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Appendix K, Disputes, prior to initiating any other action to enforce this Contract.

6. Contractor Duty to Perform

- a. Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851(d) and proceed diligently with the performance of this Contract and in accordance with the CMT or alternate dispute officer's decision. If pursuant to an appeal under Paragraph 5, Appeal of CMT or Alternate Dispute Officer's Decision above, the CMT or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph 5. shall be retroactive to the date of the CMT or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. CMS and DHCS shall not pay interest on any amounts paid pursuant to a CMT or alternate dispute officer's decision or any appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

7. Waiver of Claims

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