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# EXHIBIT A
# SCOPE OF WORK

## I. INTRODUCTION

### A. Act and Regulation

This Agreement is in accord with and pursuant to Section 12693 et. seq., Part 6.2 of Division 2 of the California Insurance Code, which establishes the Healthy Families Program (hereinafter the Program). The Agreement is also in accord and pursuant to Title XXI of the Social Security Act and its implementing federal regulations, which establish the State Children's Health Insurance Program and provide authorization and federal funding for the Healthy Families Program, and Title 10, Chapter 5.8 of the California Code of Regulations (hereinafter Program Regulations). Terms and conditions used in the Program Regulations shall have the same and identical meanings in this Agreement.

### B. Health Care Service Plan **(HMO)**

This Agreement is entered into by the Contractor and the State for the purpose of providing health coverage for subscribers determined to be eligible by the State. The method of delivery of the insured health benefits shall be a health maintenance organization. The Contractor agrees to provide and maintain the health maintenance organization.

**OR**

### B. Exclusive Provider Organization **(EPO)**

This Agreement is entered into by the Contractor and the State for the purpose of providing health coverage for subscribers determined to be eligible by the State. The method of delivery of the insured health benefits shall be an exclusive provider organization. The Contractor agrees to provide and maintain the exclusive provider organization.

### C. Geographic Areas Covered

1. The Contractor's participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's licensed service area accepted by the State. These geographic areas are described in Attachment I: Plan Coverage Area.

2. Geographic coverage in the Program may be changed only upon written approval by the State. ~~If the change request is to withdraw from an area due to Plan initiated license change or removal, the Contractor shall request such approval at least ninety (90) days prior to the date the change will take place. For all other change requests,~~ The Contractor shall request such approval in

writing at least sixty (60) days prior to the date the change will take place. ~~For all change requests,~~ The Contractor shall include documentation from the State licensing agency that approved the changes to the Contractor's licensed service area. The Contractor may not make any changes to its geographic coverage area within the first ninety (90) days of the commencement of the benefit year.

3. If the change requested is to withdraw from an area due to a plan initiated licensure change or removal, the State shall cease new enrollment of subscribers in the area and the Contractor shall continue to maintain and provide services to subscribers in the area until the end of the benefit year. [*For plans in AIM only:* The Contractor shall continue to maintain and provide services to AIM-linked subscribers in the area until the end of the second month after birth, which may go beyond the end of the benefit year.]

4. If the change requested is to withdraw from an area due to a plan- initiated licensure change or removal for a date that is not concurrent with the Program's open enrollment, then the Program will hold a special open enrollment pursuant to Exhibit B, Item I.C.

D. Provider Networks

1. The Contractor's organization shall consist of the list of health care providers to be provided to the State. These providers (institutional and professional) are listed in the Contractor's Provider Directory. The Contractor agrees to provide copies of the Provider Directory to the State upon request, and to annotate, on a quarterly basis, the information required in Item II.K. with a notation that indicates whether the providers are accepting or not accepting new Program subscribers.

2. Health care providers shall be deemed added to or deleted from the Contractor's Provider Directory as contracts between the Contractor and health care providers begin or end.

   a. If such contract activity between the Contractor and health care providers opens a new zip code to the coverage contemplated by this Agreement, the Contractor shall give at least sixty (60) days written notice to the State and, at the time of submission to the State licensing agency, shall provide the State a copy of the documentation referenced in Section I.C.2 and shall implement the change only upon written approval by the State.

   b. If such contract activity between the Contractor and health care providers would materially impair the Contractor's capacity to perform under this Agreement, the Contractor shall give at least sixty (60) days written notice to the State and, at the time of submission to the State

licensing agency, shall provide the State a copy of the documentation referenced in Section I.C.2.

3. In addition to any other rights the subscriber may have under existing law including paying providers fee-for-service in conformance with Health & Safety Code section 1373.96(d)(2), at the State's option, and in consultation with the Contractor, the Contractor agrees to maintain the availability of those providers listed at any time during the benefit year in the Contractor's Provider Directory until the end of the benefit year, if elimination of the provider would impact twenty-five (25) or more subscribers enrolled with the Contractor through the Program. For the purpose of this section, the term "provider" may refer to a solo practitioner, a medical group or a clinic.

4. Item I.D.3 above shall not apply if the withdrawal of a provider from the Contractor's network was done at the request of the provider or is part of the Contractor's activities to obtain or retain National Committee for Quality Assurance/Joint Commission on the Accreditation of Healthcare Organizations (NCQA/JCAHO) accreditation, or is initiated by the Contractor for cause.

E. Term of Agreement

The term of this Agreement shall be from July 1, 2005, through September 30, 2012 ~~2011~~. Any renewal or extension of the Agreement is at the State's sole discretion and is contingent upon successful performance by the Contractor, as solely determined by the State.

## II. ENROLLMENT

### A. Eligibility

All subscribers who are determined eligible by the State in accordance with the Act and Program regulations are eligible to enroll in a program health plan. The State certifies that its enrollment process will not be prejudicial to the Contractor or other participating health plans. The Contractor agrees that the State conducts all eligibility determinations and shall not attempt to conduct its own eligibility investigations or inquiries.

### B. Enrollment of Infants Born to Women Enrolled in the Access for Infants and Mothers (AIM) Program (only for health plans that are also AIM contractors)

1. The Contractor shall notify any woman enrolled in the AIM program with the Contractor that her newborn may be eligible for automatic enrollment in the Healthy Families Program from birth, provided the State receives the information and required family child contribution specified in the Program regulations by the end of the eleventh month following the month of birth. The Contractor shall provide services to the AIM-linked subscribers until the

end of the second month after birth in areas that the Contract or has withdrawn from in accordance with Section I.C.3.

2. Within five (5) calendar days of the Contractor's being notified of the birth of an infant born to a woman enrolled in the AIM Program with the Contractor, the Contractor shall provide the State with the following information: infant's name, infant's date of birth, infant's address, infant's gender, mother's name and identification number, infant's birth weight, and, if known, infant's primary care provider. This information shall be provided in a manner and format to be specified by the State.

3. If an infant is in need of immediate health care services and the Contractor has knowledge of this need at any time up to 5:00 p.m. on the tenth day of the second full calendar month of the infant's life, the Contractor shall notify the State of the infant's need for services in accordance with the requirements of Article 2, Section 2699.6608, subsection (f) of the Program regulations, and shall provide the information specified in Section 2699.6608, subsection (a) within the time frame specified in Section 2699.6608, subsection (f).

C. Conditions of Enrollment

1. The Contractor agrees to enroll all subscribers referred by the State, in writing and electronically when appropriate, on the date specified by the State.

2. The State shall notify the applicant of enrollment with the Contractor and the effective date of coverage by the Contractor. Except for infants born to women enrolled in the AIM Program with the Contractor and as specified in Item II.C.3, the State shall notify the Contractor of new enrollees no later than ten (10) days prior to the subscriber's effective date of coverage.

3. The Contractor agrees that in special circumstances the State may provide less than ten (10) days' notice prior to a subscriber's effective date of coverage. Special circumstances shall be at the discretion of the State, but Contractor shall be notified of the special circumstance, in writing and electronically when appropriate.

D. Disenrollment

1. The Contractor agrees to disenroll subscribers when notified, in writing and electronically when appropriate, to do so by the State on the date specified by the State.

2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with State and federal law. For the purposes of this Agreement, a charge

shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

E. Commencement of Coverage

Coverage shall commence for a subscriber at 12:01 a.m. on the day designated by the State as the effective date of coverage.

F. Identification Cards, Provider Directory, and Evidence of Coverage (EOC) or Certificate of Insurance (COI) Booklet

1. Except for infants born to women enrolled with the Contractor in the AIM Program and subscribers enrolled with less than ten (10) days' notice pursuant to Item II.C.3, the Contractor shall, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, issue or offer a Provider Directory, and issue an Evidence of Coverage or Certificate of Insurance booklet setting forth a statement of the services and benefits to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services and the process for resolving a problem or filing a grievance with the plan. The information shall be in addition to the description provided in the Evidence of Coverage or Certificate of Insurance booklet. Examples of acceptable forms of information include but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage or Certificate of Insurance booklet relating to accessing services, or a magnet listing the telephone number to call to schedule an appointment with a provider. The Contractor's Evidence of Coverage or Certificate of Insurance booklet, as approved by the State, is hereby incorporated by reference, as fully set forth within.

2. For infants born to women enrolled in the AIM Program with the Contractor and subscribers enrolled with less than ten (10) days' notice pursuant to Item II.C.3, the Contractor shall provide the Identification Card, issue or offer a Provider Directory, and provide an Evidence of Coverage or Certificate of Insurance booklet and other materials described in Item II.F.1 to applicants on behalf of subscribers no later than ten (10) days from the date the Contractor is notified of the enrollment.

3. a. In addition to the instances described in Items II.F.1 through II.F.2, above, the Contractor shall, by July 1 of each year, issue or offer to each applicant on behalf of the subscribers enrolled in the Contractor's plan an updated Provider Directory, and issue either an updated Evidence of Coverage or Certificate of Insurance booklet setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year, or a letter describing any changes to

the benefits package that will go into effect at the beginning of the next benefit year.

b. In any year in which an updated Evidence of Coverage or Certificate of Insurance booklet is not issued by July 1, the Contractor shall issue an updated Evidence of Coverage or Certificate of Insurance booklet by September 15 to each applicant on behalf of the subscribers enrolled in the Contractor's plan.

c. The Contractor shall obtain written approval by the State prior to issuing the updated Evidence of Coverage or Certificate of Insurance booklet and the letter describing changes in the benefit package. The letter shall be submitted to the State by June 1 for review and approval.

d. By October 1 of each year, the Contractor shall submit to the State two (2) print copies of the updated Evidence of Coverage or Certificate of Insurance booklet, one (1) electronic copy of the final approved Evidence of Coverage or Certificate of Insurance booklet on compact disk, and one (1) print copy of the updated Provider Directory.

4. The Contractor's Provider Directory shall be updated and distributed by the Contractor to applicants on behalf of subscribers whenever there is a material change in the Contractor's provider network.

5. The Contractor's Provider Directory shall indicate the language capabilities of the providers.

6. The Contractor shall provide a copy of the Contractor's Evidence of Coverage or Certificate of Insurance booklet or a Provider Directory to any person requesting such materials, by telephone or in writing, within ten (10) days of the request.

7. Written informing material provided to subscribers shall be at a sixth grade reading level or at a level that the Contractor determines is appropriate for its subscribers and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

G. Primary Care Physician Assignment **(HMOs only)**

1. The State shall provide the Contractor with the name of each subscriber's chosen primary care physician, if the name of the primary care provider is listed on the Program application. The Contractor agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) days of the effective date of coverage in the plan, unless the effective day is after the 15th of the month, then it shall be within forty-five (45) days. If the

Contractor assigns a primary care physician to a subscriber, the Contractor shall use a fair and equitable method of assignment from the Contractor's physician network and shall promptly notify the subscriber of the selection and the opportunity to change the assigned primary care physician. Such method of assignment shall take into account the geographic accessibility and language capabilities of providers. The Contractor also agrees to notify the primary care physician promptly that he or she has been chosen by the subscriber or assigned by the Contractor.

2. Whenever the Contractor assigns a subscriber to a clinic, the Contractor shall notify the subscriber of his or her right to select a new primary care provider. If a subscriber selects a primary care provider who is affiliated with a clinic and the assignment of the subscriber is made to the clinic pursuant to Insurance Code Section 12693.515, the Contractor shall inform the subscriber that he or she has been assigned to the clinic and has a right to select a new primary care provider immediately or at any future time, including such time as the selected primary care provider is no longer affiliated with the clinic. The Contractor shall notify the subscriber of his or her rights immediately after the assignment to the clinic has been made.

H. Right to Services

Possession of the Contractor's Identification Card confers no right to services or other benefits of the Program. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the Program.

I. Open Enrollment

The Contractor agrees to participate in an annual open enrollment process during which subscribers may transfer from one health plan to another.

J. Enrollment Data

The State and the Contractor agree to the following regarding the transmission, receipt, and maintenance of enrollment data.

1. The State shall transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor using Electronic Data Interchange (EDI) each business day. The Contractor must accept this information via EDI and update its enrollment system within three (3) calendar days, excluding holidays. The Contractor shall receive the transmitted information, data and file sent through the EDI in a manner and format that comply with HIPAA standards for electronic transactions and code sets. The Contractor agrees that the State is the official record holder of subscribers' information and shall not make any changes to Contractor's copy of subscribers' records unless such changes

are transmitted by the State.

2. The Contractor agrees to accept written confirmation of enrollments from the State plan liaisons, in the event system errors cause enrollment transactions to be delayed or under circumstances set forth in Item II.C.3. The State agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor until the enrollment transaction can be generated and sent to the Contractor.

3. The State shall develop an electronic bulletin board system, available twenty-four (24) hours a day, excluding maintenance periods that usually will be held on Sundays, to provide the Contractor with enrollment reports.

4. The State shall establish and manage a plan liaison function for the purpose of enhancing the program operations through the sharing and coordination of information with the Contractor. Common or persistent problems or issues with the Contractor shall be communicated to the State. The State shall provide a separate telephone number for communication between the State and the Contractor.

5. The State shall transmit to the Contractor on a weekly basis (on Saturday or Sunday) a separate confirmation file. This shall consist of a record count of the different record types in the weekly enrollment file. The State shall also transmit to the Contractor enrollment and data files on a weekly basis (on Saturday or Sunday) reflecting the prior week's activity. The Contractor shall use the data files to reconcile and validate weekly activity.

6. The State shall complete weekly transmissions by 4:00 a.m. Pacific Time each Monday or, when Monday is an official State holiday, by 4:00 a.m. Pacific Standard Time Tuesday. If the weekly transmission is not completed by the stated time, the State shall promptly notify the Contractor of the date and time when the transmission will be completed.

7. On a monthly basis, the State shall provide audit files for the Contractor, including, but not limited to, currently active subscribers. The audit files shall normally be provided by the third Monday of the month following the month for which data are being reported. If unexpected circumstances cause a delay in the provision of the audit files, the State, through the administrative vendor's assigned plan liaison, shall notify the Contractor.

8. The Contractor agrees to reconcile its enrollment data using the monthly data files sent by the State and the Online Eligibility Verification System (OEVS) provided by the State's administrative vendor. The Contractor shall report any enrollment discrepancies to the State, in a format approved by the State, within sixty (60) days from the date the monthly audit file is provided to the Contractor. The State shall not be liable for any discrepancies reported by

the Contractor after this sixty (60) day period. The State shall respond to discrepancies timely submitted to the State by the Contractor.

9. The State shall transmit the files described in Items II.J.1, II.J.5, and II.J.7 to the Contractor at no charge.

10. The State shall provide, at the Contractor's request, retransmission files of the data files set forth in Items II.J.5 and II.J.7 above within six (6) months of the original transmissions. The Contractor agrees to pay for assembly and transmissions costs of the files in Items II.J.5 and II.J.7 above at the rate of eighty-five dollars ($85) per hour or two cost is greater. The State shall waive the assembly and retransmission fee if the State determines that the original transmission file was corrupted or unusable.

11. With respect to Items II.J.5 and II.J.7 above, the Contractor shall utilize the State's plan liaison personnel as much as possible. There shall be no charge for the services of the State's plan liaison.

12. Prior to commencing work requested by the Contractor under Item II.J.10, the State shall provide a cost estimate to the Contractor.

13. The State shall provide EDI instructions and data mapping formats to the Contractor upon request of the Contractor. The State shall provide additional technical assistance, either by telephone or at the Contractor's site, to plans new to EDI data transmission as they establish electronic capability.

14. The State shall conduct at least one (1) meeting for the period of this Agreement for the purpose of providing training and technical assistance to the Contractor regarding EDI and transmission of enrollment data.

15. The Contractor agrees either to use the Program's unique Family Member Number (FMN) in its data base for subscriber tracking purposes or to maintain a cross reference mechanism between the Contractor's unique identifier and the Program's unique identifier.

K. Network Information Service

1. The Contractor agrees to provide, to the best of the Contractor's ability, complete and accurate data on its provider network in an electronic format to be determined by the State. The Contractor understands that the minimum data set requested by the State shall include the information on the Contractor's network outlined in Attachment II, Provider Data File Requirements. The information described in Attachment II may be expanded by the State with no less than ninety (90) days notice by the State. The Contractor agrees to provide additional data elements, as requested by the State, to the best of its ability. The Contractor understands that the State intends to use information provided pursuant to this section to assist potential

and current applicants and subscribers in selecting a health plan and providers, and that information provided to the State will be shared with the public.

2. The Contractor agrees to provide the provider network information listed in Attachment II to the State on a quarterly basis, including updated notations on providers accepting or not accepting new Program subscribers. The Contractor may update its provider network information on a monthly basis. The Contractor is required to provide data for the creation of the database to the State between the 11th and 25th of any submission month.

3. If the Contractor is unable to provide electronic files in the specified provider network formats, the State agrees to offer the Contractor data capture services at the rate of twenty-five dollars ($25) per hour.

4. If the Contractor so requests, the State agrees to offer the Contractor an unscheduled update to the provider network information at the rate of five hundred dollars ($500) per update.

~~5. The Contractor shall promptly notify the State of any providers that have been debarred, suspended, proposed for debarment, or declared ineligible or voluntarily excluded from participation in any federally funded health care program.~~

L. Traditional and Safety Net Providers

1. The Contractor agrees to establish, with traditional and safety net providers as described in Article 4 of the Program regulations, network membership and payment policies which are no less favorable than its policies with other providers.

2. The Contractor shall, on or before July 30 of each year, report to the State on the number of subscribers who selected or were assigned by the plan to traditional and safety net providers as the subscriber's primary care physician in the previous year. The format for the report shall be determined by the State.

3. No later than April 15 of each year, the Contractor shall provide the State with a list of those traditional and safety net providers (as described in Article 4 of the Program regulations) that have signed contracts with the Contractor to provide services to Program subscribers.

4. The Contractor assures the State that it has signed contracts with all providers the Contractor has listed in its Traditional and Safety Net Provider Report described in Item II.L.3 above, and shall provide the State with copies of the contracts, if requested by the State.

M. Public Awareness

1. The Contractor agrees to engage in marketing efforts designed to increase public awareness of and enrollment in the Program. The Contractor shall publicize its participation in the Program through its internal provider communications system and through its general membership communication publications. All public awareness efforts must be approved by the State before being released in public and must be in compliance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments and applicable regulations, Insurance Code Sections 12693.31, 12693.32, 12693.325 and 12693.326, as well as be in compliance with the State's marketing guidelines. In the event that the State does not notify the Contractor in writing, with the reasons the marketing materials are not approved, within sixty (60) days of receipt by the State, the materials shall be deemed approved.

2. The Contractor is prohibited from directly, indirectly, or through its agents, conducting in person, door to door, mail or telephone solicitation of applicants for enrollment.

3. By September 1, 2005, the Contractor agrees to submit to the State for its approval, in a format determined by the State, a marketing plan that covers the term of this Agreement.

    a. The marketing plan shall include the Contractor's mission statement, a written description of proposed marketing activities and locations, a listing of all proposed marketing materials to be used, and proposed locations for distribution, including ancillary components such as scripts. Upon request by the State, the Contractor shall submit other information, such as examples of previously approved marketing materials currently being used.

    b. The marketing plan shall be in compliance with all applicable statutes and regulations, as well as the Program's marketing guidelines.

4. For each benefit year, the Contractor agrees to submit to the State for its approval, in a format determined by the State, any proposed updates or amendments to its then-approved marketing plan.

5. If the Contractor chooses to provide application assistance, the plan must have an approved application assistance plan on file with the State and agrees that its designated staff must successfully complete the State's online application assistance training before beginning any application assistance activity. The Contractor's application assistance activities shall include, but not be limited to, assistance to new applicants to apply for the program; and assistance to their own program subscribers going through the Annual Eligibility Review (AER) process to maintain their coverage for another year.

The State provides the Contractor a monthly AER file that identifies the Contractor's subscribers that are within sixty (60) and thirty (30) days of their anniversary date with the program so that the Contractor may assist subscribers in retaining their program coverage.

## III. CUSTOMER SERVICE

### A. Telephone Service for Subscribers

The Contractor agrees to provide a toll free telephone number for applicant and subscriber inquiries. This telephone service shall be available on regular business days, at a minimum, from the hours of 8:30 a.m. to 5:00 p.m. Pacific Standard Time. The Contractor shall provide staff bilingual in English and Spanish during all hours of telephone service. The Contractor shall have the capability to provide telephone services via an interpretive service for all Limited English Proficient (LEP) persons.

### B. Grievance Procedure **(DMHC)**

Department of Managed Health Care Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between the Contractor and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by Contractor's licensing statute, and the Knox-Keene Health Care Service Plan Act, of 1975, as amended. These procedures shall be described in the Contractor's Evidence of Coverage booklet.

2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of grievances filed by Program subscribers and by applicants on behalf of subscribers for the previous calendar year. "Grievance" means a written or oral expression of dissatisfaction regarding the plan or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Grievances include, but are not limited to, complaints about waiting times for appointments, timely assignment to a provider, issues related to cultural or linguistic access or sensitivity, difficulty with accessing specialists or other services including those related to mental health services, substance abuse treatment services, and prescription drugs, delays and denials of care, and the administration and delivery of medical benefits in the Program.

**OR**

B. Grievance Procedure **(CDI)**

Department of Insurance Licensees:

1. The Contractor shall establish a grievance procedure to resolve issues arising between the Contractor and subscribers or applicants acting on behalf of subscribers. The Contractor's process shall include all features required for health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of, 1975, as amended, and shall provide a written response to subscriber grievances and resolution of subscriber grievances as required by the Knox-Keene Act. These procedures shall be described in the Contractor's Certificate of Insurance booklet.

2. The Contractor shall report to the State by February 1 of each year, in a format determined by the State, the number and types of grievances filed by Program subscribers and by applicants on behalf of subscribers for the previous calendar year. "Grievance" means a written or oral expression of dissatisfaction regarding the plan or provider, including quality of care concerns, and shall include a complaint, dispute, and request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. Grievances include, but are not limited to, complaints about waiting times for appointments, timely assignment to a provider, issues related to cultural or linguistic access or sensitivity, difficulty with accessing specialists or other services including those related to mental health services, substance abuse treatment services, and prescription drugs, delays and denials of care, and the administration and delivery of medical benefits in the Program.

C. Cultural and Linguistic Services

1. Linguistic Services

a. The Contractor shall ensure compliance with Title 6 of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a Limited English Proficient (LEP) individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.

b. The Contractor shall also ensure compliance with Health & Safety Code, Section 1367.04 and Title 28, California Code of Regulations, Section 1300.67.04 et seq. related to Language Assistance Programs.

c. The Contractor shall provide information to its network providers on the language needs of subscribers.

d. The Contractor shall provide twenty-four (24) hour access to interpreter services for all LEP subscribers seeking health services from providers within the Contractor's network. The Contractor shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor may use telephone language lines for interpreter services.

e. The Contractor shall develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor's procedures shall ensure subcontracted providers comply with these requirements.

f. When the need for an interpreter has been identified by a provider or requested by a subscriber, the Contractor agrees to provide a competent interpreter for scheduled appointments. The Contractor shall ensure timely delivery of language assistance services for emergency, urgent, and routine health care to persons of Limited English Proficiency. The Contractor shall instruct the providers within its network to record the language needs of subscribers in the medical record.

g. The Contractor shall use qualified interpreters. The Contractor agrees that subscribers shall not be required or encouraged to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the Contractor, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor agrees that minors shall not be used as interpreters except for only the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the request or refusal of language or interpreter services is documented in the medical records of providers in the Contractor's network.

h. The Contractor shall inform subscribers and its network providers of the availability of, and how to access linguistic services. Information provided to subscribers and providers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right of a subscriber to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers; the subscriber's right to receive materials as described in Item III.C.2 of

this Exhibit; and the subscriber's right to file a complaint or grievance if linguistic needs are not met.

i. The Contractor shall ensure that there is appropriate bilingual proficiency at medical and non-medical points of contact for providers who list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to members. Non-medical points of contact include member/customer service, plan or provider office reception, appointment services, and member orientation sessions.

j. The Contractor shall identify and report the on-site linguistic capability of providers and provider office staff through the reporting required for the Network Information Service described in Item II.K of this Exhibit.

k. If the State finds that the Contractor is deficient in meeting the Cultural and Linguistic requirements specified in Section C, Cultural and Linguistic Services, the Contractor shall submit a corrective action plan that corrects the deficiency within a time period satisfactory to the State.

2. Translation of Written Materials

a. The Contractor shall translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage or Certificate of Insurance booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; grievance forms; notices pertaining to the right to seek Independent Medical Review; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written informing materials for subscribers shall be provided at a sixth grade reading level or as determined appropriate through the Contractor's Cultural and Linguistic Needs Assessment and approved by the State, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements.

b. Translation of subscriber materials shall be in the following languages: Spanish~~,~~ and any language representing the preferred mode of communication for either five percent (5%) or more of the Contractor's enrollment or three thousand (3,000) or more subscribers of the Contractor's enrollment in the Program as of December 1 of the previous year. In addition, if the State includes the subscriber's

preferred written language in the enrollment file sent to the Contractor, and that language is Spanish or the preferred mode of communication for either five percent (5%) or more of the Contractor's enrollment or three thousand (3,000) or more subscribers of the Contractor's enrollment in the Program, the Contractor shall provide materials in that language. If the Contractor serves both Medi-Cal and Program subscribers, the Contractor is encouraged to translate Program member materials into additional Medi-Cal threshold languages not required by the Program. The Contractor shall ensure that members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials.

c. The Contractor shall ensure the quality of the translated material. The Contractor is encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor agrees that the translation process shall include the use of qualified translators for translating, editing, proofreading and professional review.

d. By December 31 of each year, the Contractor shall submit to the State one copy of only those materials that, pursuant to Item II.F., are routinely provided to new subscribers for each language in which the materials are translated.

3. Cultural and Linguistic Competency

a. The Contractor shall develop internal systems that meet the cultural and linguistic needs of the Contractor's subscribers in the Program. The Contractor shall provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, interpreters, providers, and encounter/claims data.

b. The Contractor shall report, on or before March 10 of each year, the linguistically and culturally appropriate services provided in the prior benefit year and proposed to be provided during the subsequent benefit year to meet the needs of Limited-English Proficient applicants and subscribers in the Program.

i. This report shall include information about the number and types of services provided by Contractor including, but not limited to, linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, referrals to culturally and

linguistically appropriate community services and programs, and training and education activities for providers.

ii. The report shall include a description of the Contractor's efforts to evaluate cultural and linguistic services and outcomes of cultural and linguistic activities as part of the Contractor's ongoing quality improvement efforts. Reported information shall include member complaints and grievances, results from membership satisfaction surveys, and utilization and other clinical data that may reveal health disparities as a result of cultural and linguistic barriers.

iii. The report shall also address activities undertaken by the Contractor to develop internal systems, as required in Item V.F.1 of this Exhibit. The Contractor shall also report on the status of the Contractor's cultural and linguistic activities identified in the Group Needs Assessment. The format for this report shall be determined by the State.

## IV. COVERED SERVICES AND BENEFITS

### A. Covered and Excluded Benefits

1. Except as required by any provision of applicable law, the benefits described in Article 3, Sections 2699.6700 through 2699.6707~~,~~ of the Program regulations, shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the Program regulations shall not be covered benefits. The Contractor shall describe all covered and excluded benefits as well as any limitations in benefits in an Evidence of Coverage or Certificate of Insurance booklet.

2. The parties understand that terms of coverage under this Agreement are set forth in the attached Evidence of Coverage or Certificate of Insurance booklet, hereby incorporated by reference, as fully set forth within. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage or Certificate of Insurance booklet shall be binding notwithstanding any provisions in this Agreement which are less favorable to the subscriber.

3. The Contractor shall make benefit and coverage determinations. All such determinations shall be subject to the Contractor's grievance procedures.

4. State Supported Services as defined in the program regulations are not covered under this Agreement.

B. California Children's Services (CCS)

1. Medically necessary services that are authorized and provided by the CCS Program to treat a subscriber for CCS eligible conditions, once CCS eligibility is determined as defined in Title 22, CCR, Section 41515.1 ~~41518~~, are not covered under this Agreement.

2. The Contractor shall identify subscribers with suspected CCS eligible conditions and shall refer them to the local CCS Program office for determination of medical eligibility by the CCS Program. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber with a ~~CCS~~ one-page (double-sided) CCS informational flyer. The State agrees to provide the Contractor with a camera-ready copy of the CCS informational flyer.

3. The Contractor shall implement written policies and procedures for identifying and referring subscribers with suspected CCS eligible conditions to the local CCS Program office. Upon request, the Contractor shall provide the policies and procedures to the State. ~~The policies and procedures will address early identification and referral.~~ The policies and procedures shall include, but not be limited to:

   a. Procedures for ensuring that the Contractor's providers are informed of the identity of CCS paneled providers and CCS approved hospitals within the Contractor's entire network.

   b. Policies and operational controls that ensure that the Contractor's providers perform appropriate baseline health assessment and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a subscriber has a CCS eligible medical condition.

   c. Policies and procedures for ensuring ~~to assure~~ that the Contractor's providers refer potentially eligible children to the CCS Program.

   d. Policies and procedures that ensure continuity of care between the Contractor's providers and CCS providers.

4. The Contractor shall report to the State the subscribers who were referred to the local CCS Program and the subscribers who received services from CCS in the previous benefit year. The report shall include information about the referrals that were accepted, denied and pending with the local CCS Program. The report is due by October 31 of each year. The format for the report shall be determined by the State.

5. The Contractor, to the extent feasible, shall enter into a Memorandum of Understanding (MOU) with each local CCS Program in the Contractor's service area. The Program shall provide a MOU template to the Contractor.

6. The Contractor shall consult and coordinate CCS referral activities with the local CCS Program in accordance with the required MOU between the Contractor and the local CCS Program.

7. Until eligibility for the CCS Program is established by the local CCS Program, and to the extent that otherwise-covered services are not provided by the CCS program once eligibility is established, the Contractor shall be responsible for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Payments paid to the Contractor by the CCS Program shall be made pursuant to the policies contained in the Department of Health Care Services N.L. 02-0203, dated July 11, 2003 and any modification to such policies.

8. Once eligibility for CCS is established by the CCS Program for a subscriber and the CCS program is providing services to treat the eligible condition:

   a. The Contractor shall continue to provide covered primary care and all other medically necessary covered services other than those provided through the CCS Program for the CCS eligible condition.

   b. The Contractor shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.

   c. The CCS Program shall authorize and pay for the delivery of medically necessary health care services to treat a subscriber's CCS eligible condition. The CCS authorization, on determination of medical eligibility, shall be to CCS paneled providers and approved facilities, some of which may also be members of the Contractor's network. Authorization normally cannot predate the initial referral to the local CCS Program in accordance with Title 22, CCR, Section 41770 ~~42180~~. Claims for authorized services shall be submitted to the appropriate CCS office for approval of payment.

   d. For the purposes of Item IV.B.6.c, above, initial referral means referral by a Contractor's network physician, or by any other entity permissible under CCS regulations.

~~9. In the event the CCS Program does not provide the services to treat a CCS-eligible condition, the Contractor shall provide all medically necessary covered services to treat the condition.~~

C. Mental Health and Substance Abuse Services

1. The Contractor agrees to involve family members in the treatment of mental health and/or substance abuse conditions for a subscriber who has experienced family dysfunction and/or trauma to the extent such involvement is required as part of the course of treatment for the health and recovery of the child.

2. The Contractor shall educate ~~support~~ the parents and guardians of children with mental health and substance abuse conditions. ~~in connection with the child's treatment.~~ The Contractor shall submit to the State, by a date and in a format determined by the State, a plan and timeframe as to how the Contractor will educate ~~support~~ such parents and guardians. The plan shall be developed in consultation with the State, be implemented by the Contractor, and may include, but not be limited to, the following:

   a. Parent and guardian orientation regarding how to seek mental health-related services.

   b. The process for making an appointment with a mental health or behavioral health provider.

   c. What to expect when attending the first session with a mental health or behavioral health provider.

   d. Explanation of the standard procedures for obtaining the mental health assessment and the information the parent will be expected to provide.

   e. The roles and responsibilities of the mental health or behavioral health professional, the Contractor, and the parent(s) or guardian(s).

   f. A description of the program benefits available for assessment and treatment of a mental health or behavioral health condition.

   g. Definitions and explanations of medical terminology and diagnoses.

3. The Contractor shall track and report to the State the length of time from the date a subscriber was referred for plan-provided mental health services to the actual date mental health services were provided to the subscriber. The report shall be due by February 1 of each year for the prior benefit year. The format for the report shall be determined by the State.

D. Mental Health: Services for Subscriber Children with Serious Emotional Disturbance or Serious Mental Disorder

1. The Contractor, to the extent feasible, shall enter into a Memorandum of Understanding (MOU) with each local County Mental Health Department in

the Contractor's service area. The Program shall provide the MOU template to the Contractor.

a. The Contractor shall notify the Program if any local County Mental Health Department refuses to enter into a MOU with the Contractor or if the Contractor determines not to enter into a MOU with a local County Mental Health Department.

b. The Contractor shall cooperate with the local County Mental Health Department in establishing policies and procedures that will successfully develop the interface between the Contractor and the local County Mental Health Department.

c. The MOU shall provide specific time frames for the County Mental Health Department to notify the Contractor about the assessment and determination of whether a subscriber child has a serious emotional disturbance or serious mental disorder.

d. The MOU entered into by the Contractor and the local County Mental Health Department shall include a mediation process to ensure that disputes concerning referral or coverage questions and any other areas of dispute between the Contractor and the County Mental Health Department are mediated and resolved.

2. The Contractor shall identify subscriber children who potentially have a serious emotional disturbance or serious mental disorder and shall refer them to the local County Mental Health Department for determination of medical eligibility. Upon referral, the Contractor shall provide the applicant on behalf of the subscriber child, an informational flyer. The State agrees to provide the Contractor with a camera-ready copy of the County Mental Health informational flyer.

3. The Contractor shall implement the written policies and procedures it has developed in cooperation with County Mental Health Department Programs pursuant to the MOU for identifying and referring children who potentially have a serious emotional disturbance or serious mental disorder to the County Mental Health Department for determination of medical eligibility. These policies and procedures shall include, but not be limited to:

a. Identification of a specific screening tool for identifying and referring subscriber children who potentially have a serious emotional disturbance or serious mental disorder. The County Mental Health Department shall make the final determination of whether the subscriber child has a serious emotional disturbance or serious mental disorder.

b. Procedures to ensure that the Contractor and the Contractor's providers use the screening tool and specific referral protocols ~~as described in the MOU~~ to govern referral of subscriber children who potentially have a serious emotional disturbance or serious mental disorder to the County Mental Health Department. Referral protocols should ensure that a referral is made at the earliest recognition by the Contractor or the Contractor's providers that the subscriber child may have a serious emotional disturbance or serious mental disorder.

c. A procedure to ensure that pertinent health and mental health information about the subscriber child is shared between the Contractor, the County Mental Health Department and any County Contract Providers.

d. Procedures that provide for continuity of care ~~as described in the MOU~~ between the Contractor and the Contractor's providers and the County Mental Health Department and any County Contract Providers.

e. Procedures that maintain continuity of care for the subscriber child when the subscriber child is a new subscriber child with the Contractor and has an ongoing treatment plan with the County Mental Health Department. This procedure shall include an automatic referral for a new subscriber child who has a treatment plan for serious emotional disturbance or serious mental disorder with the County Mental Health Department.

f. Designation of at least one of the Contractor's or subcontractor's employees as Mental Health Services Liaison who shall, as one of his or her primary functions, coordinate and collaborate with each County Mental Health Department in which Contractor serves Program subscribers. The liaison's primary functions shall be identified in the Memorandum of Understanding. The name and contact information of this liaison, including changes, shall be provided to the State on a quarterly basis and as part of the annual report identified in Item IV.D.4.

4. The Contractor ~~shall notify the State of the screening tools used and~~ shall report to the State ~~the number of subscribers screened for mental health conditions by age, and~~ the number of subscribers referred ~~referred~~ by the Contractor or the Contractor's subcontracted behavioral health organization to the local County Mental Health Departments for an evaluation to determine if the subscriber has a serious emotional disturbance or serious mental disorder. The report shall include information about the referrals that were accepted, denied and pending with each local County Mental Health Department. The report shall be ~~is~~ due by February 1 ~~October 31~~ of each year for the prior benefit year. The format for the report shall be determined by the State.

5. Unless and until the County Mental Health Department determines that a subscriber child has a serious emotional disturbance or serious mental disorder and the County Mental Health Department provides the medically necessary services to treat the serious emotional disturbance or serious mental disorder, the Contractor shall continue to provide all covered medically necessary health and mental health care and case management services for a subscriber child referred to the County Mental Health Department including development of a treatment plan for the serious emotional disturbance or serious mental disorder.

6. Once the County Mental Health Department establishes eligibility for a subscriber child with a serious emotional disturbance or serious mental disorder and is providing the medically necessary services to treat the serious emotional disturbance or serious mental disorder:

   a. The County Mental Health Department will notify the Contractor of the serious emotional disturbance determination, in a time frame consistent with the MOU.

   b. The Contractor shall continue to provide all other covered services, including, but not limited to, primary care and any medically necessary covered drugs, laboratory, ~~and~~ inpatient ~~care,~~ and outpatient care. ~~consistent with the Contractor's mechanism for subscriber conversion of an inpatient day for other less intensive treatment services.~~

   c. The Contractor shall work with the County Mental Health Department to ensure the coordination of services between the Contractor's primary care providers and the County Mental Health Department and its specialty providers.

   d. The County Mental Health Department will authorize the delivery of medically necessary services to treat a subscriber child's serious emotional disturbance or serious mental disorder.

   ~~e. The Contractor shall work with the County Mental Health Department to coordinate inpatient care.~~

7. The Contractor is not responsible for providing or reimbursing a county for services to treat a subscriber child's serious emotional disturbance or serious mental disorder that are authorized and provided ~~or authorized~~ by a County Mental Health Department as defined in Welfare and Institutions Code Section 5600.3.

8. Nothing in this section shall be construed to relieve the Contractor of the responsibility to provide mental health care, set forth in Article 3 of the

Program regulations, for subscriber children who are referred to the County with a serious emotional disturbance or serious mental disorder.

E. Other Public Linkages

The Contractor shall, to the extent feasible, create viable protocols for screening and referring subscribers needing supplemental services outside of the Scope of Benefits described in Article 3 of the Program regulations to public programs providing such supplemental services for which they may be eligible, as well as for coordination of care between the Contractor and the public programs. Public programs may include but not be limited to: regional centers, programs administered by the Department of Alcohol and Drug Programs, Women, Infants and Children Supplemental Food Program (WIC), lead poisoning prevention and programs administered by local education agencies, including schools.

F. Pre-existing Condition Coverage Exclusion Prohibition

No pre-existing condition exclusion period or post-enrollment waiting period shall be required of subscribers.

G. Exercise of Cost Control

The Contractor shall enforce all contractual agreements for price and administer all existing utilization control mechanisms for the purpose of containing and reducing costs.

H. Copayments

1. The Contractor shall impose copayments for subscribers as described in Article 3 of the Program regulations. The Contractor agrees that copayment maximums as described in Article 3 of the Program regulations shall be applied for each benefit year and shall be renewed on October 1 of each year. The Contractor's Evidence of Coverage or Certificate of Insurance booklet shall describe the process to be used by applicants on behalf of subscribers to document that the annual two hundred and fifty dollar ($250) family maximum has been reached.

2. The Contractor shall work with its network providers to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are required. The Contractor shall instruct its network providers to offer extended payment plans whenever a family's copayments exceed twenty-five dollar ($25) in one month.

3. The Contractor shall report the number of subscribers who meet the copayment maximum for covered services in the previous benefit year by January 1 of each year. The format for the report shall be determined by the State. ~~The Contractor shall annually report the number of subscribers who~~

~~meet the copayment maximum for covered services in the previous benefit year by January 1 of each year. The format for the report shall be determined by the State. copayments paid by subscriber households for covered services in the previous benefit year by February 1 of each year. The format for the report shall be determined by the State.~~

4. The Contractor shall implement an administrative process that ensures that the Contractor waives all copayments for American Indian and Alaska Native subscribers in the Program, if the State identifies such subscribers as qualifying for the waiver.

~~5. Contractor shall monitor subscriber family copayments on a quarterly basis to determine if any subscriber household has reached the two hundred and fifty dollar ($250) annual copayment maximum.~~

6. The Contractor shall, no less than twice annually, notify all subscriber families of the annual copayment maximum and the process for informing the Contractor when a subscriber family reaches the maximum. The first notice shall be prominently included in the materials provided by the Contractor to subscribers pursuant to Item II.F.1. The second notice shall be provided in the third quarter of the benefit year via a mailed notice or e-mail message and shall be provided in English and Spanish.

7. a. The Contractor shall inform its providers to stop collecting copayments when a subscriber household reaches the two hundred and fifty dollar ($250) household maximum in a benefit year.

b. If a subscriber household provides the Contractor with information that the subscriber household has paid more than two hundred and fifty dollars ($250) in copayments, the Contractor shall reimburse the subscriber household that amount which exceeds two hundred and fifty dollars ($250) within ninety (90) days of the Contractor's determination that an overpayment occurred.

~~c. The Contractor shall not rely solely on the subscriber household to notify the Contractor when the subscriber household reaches the two hundred and fifty dollar ($250) maximum.~~

I. Coordination of Benefits

1. The Contractor agrees to coordinate benefits with other group health plans or insurance policies for subscribers in the Program. The Contractor agrees to work with other plans or insurers to provide no more than one-hundred percent (100%) of subscribers' covered medical expenses. The Contractor shall coordinate such that coverage provided pursuant to this Agreement is secondary to all other coverage except for Medicaid (Medi-Cal) and Access for Infants and Mothers (AIM).

2. The Contractor shall designate at least one of the Contractor's employees as a Dental Plan Liaison who shall, as one of his or her ~~primary~~ functions, coordinate benefits and services and resolve issues with a subscriber's Dental plan. The Contractor shall provide the State with the name and contact information of its Dental Plan Liaison no later than thirty (30) days prior to the start of the benefit year and within fifteen (15) days if the liaison changes.

J. Acts of Third Parties

If a subscriber is injured through the wrongful act or omission of another person, the Contractor shall provide the benefits of this Agreement and the subscriber or applicant on behalf of a subscriber shall be deemed:

1. To have agreed to reimburse the Contractor to the extent of the reasonable value of services allowed by Civil Code Section 3040, immediately upon collection of damages by him or her, whether by action at law, settlement or otherwise, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement; and

2. To have provided the Contractor with a lien to the extent of the reasonable value of services provided by the Contractor and allowable under Civil Code Section 3040, provided that the subscriber is made whole for all other damages resulting from the wrongful act or omission before the Contractor is entitled to reimbursement. The lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

K. Workers' Compensation Insurance

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Contractor, then the Contractor shall provide the benefits of this Agreement and the subscriber shall be deemed to have provided the Contractor with a lien on such Workers' Compensation medical benefits to the extent of the reasonable value of the services provided by the Contractor. The lien may be filed with the responsible third party, his or her agency, or the court. For purposes of this subsection, reasonable value shall be determined to be the usual, customary or reasonable charge for services in the geographic area where the services are rendered.

L. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Items IV.J. and IV.K of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. The

State understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise liens as may be reasonable and appropriately consistent with normal business practices.

M. Health Insurance Portability and Accountability Act of 1996 Conformity

The State and the Contractor understand that the coverage provided pursuant to this Agreement constitutes creditable coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996. The State shall issue the Certificates of Creditable Coverage for disenrolled subscribers.

N. Interpretation of Coverage

The Contractor, in its Evidence of Coverage or Certificate of Insurance booklet (Attachment VII), shall provide clear and complete notice of terms of coverage to subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

## V. CLINICAL QUALITY MEASURES AND MANAGEMENT PRACTICES

### A. Measuring Clinical Quality

1. The Contractor agrees to provide the State annually with audited clinical quality measures as outlined in Attachment III, Performance Measures. The measures to be provided include selected measures from the most recent version of the Healthcare Effectiveness Data and Information Set (HEDIS®) released by the National Committee for Quality Assurance (NCQA) and are attached as Attachment III. ~~may be modified to include core quality measures as required by the Centers for Medicare and Medicaid Services (CMS) and are attached as Attachment III.~~

2. Data on the measures described in Item V.A.1 above shall include data on subscribers enrolled in the Contractor's plan through the Program and shall cover the experience of the previous calendar year. The report shall be submitted by June 15 of each year in a format determined by the State. The State hereby notifies the Contractor that compliance with Item V.A.1 and the information received by the State will significantly influence the State's willingness to extend or renew this or subsequent Agreements for provision of service to Program subscribers.

3. All data reported to the State pursuant to Item V.A.1 above shall be audited by a certified NCQA HEDIS® auditor.

4. The Contractor understands that the State may include the results of any of the data included in the reports submitted pursuant to this Item in its annual open enrollment or Program application materials.

5. The Contractor understands that the State will annually evaluate the plan's performance on clinical quality measures and will take appropriate action if the State determines that the Contractor's continued participation in the Healthy Families Program is not in the best interest of its subscribers.

B. Measuring Consumer Satisfaction

1. The Contractor understands that the State shall conduct a consumer satisfaction survey of Program participants no more often than annually using the most recent release of NCQA's version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The Contractor further understands that the State will conduct an adolescent survey using the Young Adult Health Care Survey (YAHCS), as released by the Child and Adolescent Health Measurement Initiative.

2. The Contractor understands that the State will conduct annual CAHPS® and YAHCS surveys, if funding is made available to the State for this purpose, using the services of a vendor selected by the State, hereafter referred to as the CAHPS® Vendor, to collect and analyze CAHPS® and YAHCS data.

3. The Contractor understands that the State will release the CAHPS® and YAHCS data to applicants, subscribers and other interested parties. The Contractor understands that the final decision regarding the release of information collected from the CAHPS® and YAHCS surveys shall be made by the State.

4. The Contractor shall provide the State with a camera-ready and electronic copy of the Contractor's logo and a signature of a high level Contractor official. The State assures the Contractor that the items listed in this section shall ~~only~~ be used only in the conduct of the CAHPS® and YAHCS Surveys.

5. The Contractor understands that the State will evaluate the plan's customer satisfaction survey results annually and will take appropriate action if the State determines that the Contractor's continued participation in the Healthy Families Program is not in the best interest of Program subscribers.

C. Health Care Services

1. The Contractor assures the State that its providers shall use, and the Contractor shall monitor the most recent recommendations of the American

Academy of Pediatrics (AAP) with regard to Recommendations for Preventative
Pediatric Health Care and the most recent version of the Recommended Childhood Immunization Schedule/United State's, adopted by the Advisory Committee on Immunization Practices (ACIP).

2. The Contractor shall notify the applicants associated with all subscriber children enrolled in Contractor's plan through the Program, on an annual basis, of the recommended schedule of preventive care visits. The first notice shall be included in the materials provided by the Contractor to new members pursuant to Item II.F.1. Such notification shall be provided via a mailed notice or brochure and shall be provided in English and Spanish. As soon as five percent (5%) of subscribers or more enrolled with the Contractor or 3,000 subscribers or more enrolled with the Contractor in the Program who are identified as primarily speaking a language other than English or Spanish, the Contractor shall provide the notice in the language primarily spoken by the subscriber.

3. The Contractor shall increase the awareness among its providers of the importance of screening for:

   a. Overweight and obese children. The Contractor shall increase the awareness among applicants and subscribers of the health risks associated with being overweight and obese, as well as the importance of good nutrition and physical activity. The Contractor shall report to the State ~~by March 10 of~~ each year on current and planned activities to comply with these requirements in a format determined by the State. ~~The Contractor shall collect and report to the State information on overweight and obese childrens' Body Mass Index score.~~

   b. Behavioral health and developmental issues in subscriber children ages 0-5. The Contractor shall inform ~~make available to~~ its providers of the availability of standardized screening tools at a discounted rate. The State will provide the Contractor information on ordering the screening tools. ~~which may include but are not limited to: Ages and Stages Questionnaires®, Third Edition (ASQ-3™); Parents' Evaluation of Developmental Status (PEDS); PEDS: Developmental Milestones (PEDS:DM); or the Child Health Disability Prevention (CHDP) Program Health Assessment Guidelines on "Developmental and Socio-Emotional/Behavioral Surveillance, Screening and Anticipatory Guidance."~~ The Contractor shall report to the State each year on current and planned activities to increase screening of young children in a format determined by the State.

   c. Routine pediatric dental care. The Contractor shall encourage pediatricians to educate parents about oral health and the need to visit a dentist for check-ups during well-baby visits.

D. Encounter and Claims Data

1. The terms "Protected Health Information," "Health Care Operations" and "Minimum Necessary" shall have the same meanings as the terms are defined in the Health Insurance Portability and Accountability Act, of 1996 (HIPAA). The term "Medical Information" shall have the same meaning as the term defined in the Confidentiality of Medical Information Act, California Civil Code Section 56 et seq. (CMIA).

2. ~~As~~ No later than sixty (60) ~~thirty (30)~~ days after requested by the State, the Contractor shall provide such encounter and claims data as described in the most current version of the Healthy Families Program Health Care Claim Companion Guides (Institutional, Professional and Pharmacy) for each file format (837 and DHCS) including, but not limited to, Protected Health Information and Medical Information, to such third party vendor that the State shall designate (hereinafter "Encounter Data Vendor) for the purposes of the State conducting Health Care Operations. The encounter and claims data shall be provided in a manner consistent with the most current version of the Healthy Families Program Claim and Encounter Processing Guide and shall be submitted no later than one hundred and eighty (180) days after the end of the month in which a service was rendered. The Contractor agrees that data provided to the State shall be owned by the State.

3. The Contractor shall provide encounter and claims data retroactively to January 1, 2008. ~~2006~~

4.~~3~~ The Contractor shall disclose Protected Health Information and Medical Information to the Encounter Data Vendor for the sole purposes of:

a. Encoding, encrypting or otherwise anonymizing the encounter and claims data so that the data is not individually identifiable health information; and

b. Permitting the State to conduct Health Care Operations consistent with the Minimum Necessary standard.

5.~~4~~ The Contractor and State agree that, unless required by law, the Encounter Data Vendor, in performing any data analysis and reporting obligations to the State, shall not provide the State with information that is individually identifiable as to any subscriber or applicant.

6.~~5~~ Notwithstanding any obligation of the Contractor or the Encounter Data Vendor in any agreements with the State, the Contractor shall be obligated to provide the State or the Encounter Data Vendor with access to such information to the extent that access to such information is required or permitted by applicable federal and State law and regulation, including, but

not limited to, State or federal law or regulation related to confidential or private information.

7.~~6~~ The Contractor acknowledges and agrees that all encounter and claims data and reports generated by the Encounter Data Vendor shall be the sole property of the State.

8.~~7~~ The Contractor shall take all reasonable actions to enter into any appropriate agreements with the Encounter Data Vendor which are required to accomplish the purposes of this section.

9.~~8~~ The Contractor represents and warrants that the receipt, use and disclosure of the Protected Health Information and Medical Information to the State's Encounter Data Vendor is compliant with all applicable federal and s~~S~~tate laws and regulations.

E. Quality Performance

1. The Contractor shall maintain a system of accountability for quality improvement in accordance with all applicable statutes and regulations. The Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf in any setting.

   a. Activities shall include the participation of the governing body of the Contractor's organization, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of Quality Improvement development and performance. Evidence of such activities shall be provided to the State upon request.

   b. The Contractor shall ~~will~~ collaborate with the State to develop and implement a Quality Assessment and Improvement Strategy as required by Section 403 of the Children's Health Insurance Program Reauthorization Act of, 2009. ~~In addition, the Contractor is on notice that the State will contract with an External Quality Review Organization (EQRO) to review the quality of care provided by the Contractor. The Contractor shall cooperate with the EQRO designated by the State.~~

   c. The Contractor shall cooperate with the State and an external quality review organization (EQRO) contracted by the State, in compliance with Title XXI of the Social Security Act, Section 1932(c)(2) and with Section 403 of The Children's Health Insurance Program Reauthorization Act (CHIPRA), of 2009. The State will set methodology and standards for quality improvement (QI) with advice from the EQRO.

i. The Contractor shall provide all information requested by the EQRO, including but not limited to, quality outcomes concerning timeliness of, and enrollee access to, covered services.

ii. The Contractor shall cooperate with the EQRO during the external quality review activities, which may include independent review of medical records.

iii. If the State determines that the Contractor fails to meet any QI standard, the State may require the Contractor to submit a corrective action plan.

2. The Contractor represents that its Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), or the California Department of Managed Health Care.

3. The State will ~~intends to~~ track the Contractor's performance on the measures that are listed in Item V.A.1 and V.B.1. The State's analysis of the Contractor's performance shall include, but not be limited to, the Contractor's performance for the most recent reporting period, a comparison of the Contractor's performance over time, and a comparison of the Contractor's performance with national benchmarks. The Contractor agrees to submit a quality improvement ~~corrective action~~ plan to improve its performance upon request by the State.

F. Group Needs Assessment

The Contractor shall submit an update to the 2011 Group Needs Assessment to the State no later than September 30, 2012 in a format determined by the State.

~~1. The Contractor shall complete a Group Needs Assessment and submit a report to the State by September 30, 2011. The purpose of the Group Needs Assessment is to assess services provided to the Contractor's diverse enrollee population based on race, ethnicity, spoken language, and health status. The Group Needs Assessment report shall include the Contractor's plan to address any disparities identified as a result of the assessment findings, with special attention to addressing cultural and linguistic barriers and reducing health disparities among different racial, ethnic, and Limited-English Proficient groups. The State will coordinate the report content and format with the Department of Health Care Services.~~

G. Pay-for-Performance System

The Contractor understands that the State may implement a pay-for-performance system for plans participating in the Program. Details of the pay-for-performance system shall be developed with input from participating plans. The State shall give the Contractor an opportunity to participate in a work group to determine the specific terms and conditions for payment, as well as the feasibility of such a program. Specific terms and conditions shall be implemented via an amendment to this Agreement.

## VI. COMPLIANCE WITH THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

The State and Contractor recognize that, as guidance is issued and as regulations are promulgated and become effective under the Children's Health Insurance Program Reauthorization Act, of 2009 (CHIPRA), the State may add one or more additional provisions to this Agreement in order for the State to achieve compliance with all applicable CHIPRA requirements. The State may, by written notice to Contractor, amend this Agreement to comply with such new regulations. If Contractor agrees with any such amendment, it shall so notify the State in writing within thirty (30) days of the written notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, the State may terminate this Agreement for cause as provided in Exhibit C, Section VII.