L.A. Care
HEALTH PLAN
For All of L.A.

BOARD OF GOVERNORS

Executive Committee Meeting

June 26, 2024 • 2:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017

AGENDA
Executive Committee Meeting
Board of Governors

DRAFT

Wednesday, June 26, 2024, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m5e2a4da714c7bceab3f62e563251a8ba

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2489 624 4009 Password: lacare

For those not attending the meeting in person, public comments on Agenda items can be submitted prior to the start of the meeting in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Due to time constraints, we are not able to transcribe and read public comment received by voice mail during the meeting. Public comment submitted by voice messages after the start of the meeting will be included in writing at the end of the meeting minutes.

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome		Alvaro Ballesteros, MBA *Chair*
1.	Approve today's Agenda	*Chair*
2.	Public Comment *(Please read instructions above.)*	*Chair*
3.	Approve the May 22, 2024 Meeting Minutes p.5	*Chair*
4.	Chairperson's Report	*Chair*
5.	Chief Executive Officer Report	John Baackes *Chief Executive Officer*
	• Government Affairs Update	Cherie Compartore *Senior Directors, Government Affairs*
Committee Issues		
6.	Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS) **(EXE 100)** p.15	Augustavia J. Haydel, Esq. *General Counsel*

DRAFT

7. Approve the revisions to the Operating Rules of the Consumer Advisory Committee, and related changes, in accordance to the delegated authority from the Board of Governors as outlined in Motion BOG 104.0624 **(EXE A)** p.120 — John Baackes, Francisco Oaxaca, *Chief of Communications and Community Outreach & Education*

8. Discussion/Recommendation on Temporary Transitional Executive Community Advisory Committee's tabled motions from May 2, 2024 Board of Governors meeting

- Motion TTECA 100.0524: To request the Board of Governors' to consider returning the BOG monthly meetings to the first Thursday 1 pm – 4 PM BOG "public" session meetings which would cause the BOG "closed" sessions to begin before or after the "public" session meetings designated hours. — *Chair*

- Motion TTECA 101.0524: L.A. Care Board of Governors to consider the placement of push door buttons on any door accessible to the public at any site used by L.A. Care for public meetings. — Terry Brown, *Chief Human Resources Officer* p.144

9. Approve Human Resources Policies HR 306 (Equal Employment Opportunity) and HR 603 (Overtime Pay) **(EXE B)** p.148 — Terry Brown

10. Approve the list of items that will be considered on a Consent Agenda for July 25, 2024 Board of Governors Meeting. — *Chair*
- June 6, 2024 meeting minutes
- Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS)

11. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

ADJOURN TO CLOSED SESSION (Est. time: 60 mins.) — *Chair*

12. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Technology, Business Plan
Estimated date of public disclosure: *June 2026*

13. CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
- Plan Partner Rates
- Provider Rates
- DHCS Rates

14. THREAT TO PUBLIC SERVICES OR FACILITIES
Government Code Section 54957
Consultation with: Tom MacDougall, *Chief Information & Technology Officer*, and Gene Magerr, *Chief Information Security Officer*

15. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
Three Potential Cases

DRAFT

16. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
Department of Health Care Services (Case No. Unavailable)

17. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
- Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

18. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: Chief Executive Officer
Agency Designated Representative: Alvaro Ballesteros, MBA
Unrepresented Employee: John Baackes

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

There is no Executive Committee Meeting in July 2024.
The next Executive Committee meeting is scheduled on Wednesday, August 28, 2024 at 2:00 p.m.
and may be conducted as a teleconference meeting.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE EXECUTIVE COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.
ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH TUESDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings **and by email request to** BoardServices@lacare.org

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings **and can be requested by email to** BoardServices@lacare.org.

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats - i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – May 22, 2024
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Members
Alvaro Ballesteros, MBA, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson*
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary**
*Absent

Management/Staff
John Baackes, *Chief Executive Officer**
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Products Officer*
Alex Li, MD, *Chief Health Equity Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:10 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. He provided information on how to submit comments in-person or electronically.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously. 3 AYES (Ballesteros, Booth and Shapiro)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the April 24, 2024 meeting were approved.	**Approved unanimously. 3 AYES**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer,* reported that California's Governor released the May Revision to the 2024-25 State Budget, which will be reviewed by the legislature for approval. Disappointingly, the revision eliminates Medi-Cal funding from the managed care organization (MCO) tax adopted a year ago, directing tax revenue to the general fund instead to help close the budget gap. The MCO tax revenue was expected to be	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	\$2.6 billion this year, more next year and most of the funding was pushed to later years. Funding from the 2024 tax to improve Medi-Cal reimbursement to 87.5% of Medicare reimbursement is secure for about 760 aid codes. There will be an initiative on the November 2024 ballot to secure proceeds to improve Medi-Cal reimbursement. The action by the Governor to divert proceeds exemplifies the need for the ballot initiative to secure the tax proceeds for the intended purpose of increasing Medi-Cal reimbursement to providers. There will be 17 propositions on the November ballot. When it was agreed to adopt the MCO tax with a portion going to the general fund the Governor did not oppose or endorse the ballot initiative. The initiative becomes even more important going forward to secure funding. At the end of December 2023, L.A. Care was notified that an adjustment would be made to 2023 Medi-Cal rates based on the acuity of the members. It was a long and complicated explanation. Regulators also noted that all health plans reported surplus revenue last year. The amount originally proposed for retroactive reduction was \$81 million, a portion of which L.A. Care will pass on to plan partners. The balance of \$50 million plus loss was reported in L.A. Care's 2024 financial report. Late last week L.A. Care was informed that they have expanded the categories of Medicaid subject to the acuity adjustment, and the retroactive negative adjustment will now be more than \$199 million, representing more than 40% of 2023 operating income. The adjustment will be reflected in L.A. Care's FY 2023-24 financial statements. A main motivation can be interpreted as helping California solve the state budget shortfall. This illustrates that a health plan can never actually close the books because regulators can retroactively adjust reimbursement. The funding subject to the retroactive adjustment is under the 1.5% approval limit for Centers for Medicare and Medicaid Services (CMS). Every state has the ability to make retroactive adjustments up to 1.5% under CMS rules. Board Member Booth asked about the effect on the ballot initiative if the Governor opposes. Mr. Baackes responded that if the Governor opposes the ballot initiative, it could influence voters. It would be best if the Governor remains neutral. Board Member Shapiro asked about alternatives to the disbursement of the MCO tax. He is hearing from providers that the MCO tax would benefit the community. Mr. Baackes responded that the coalition is sticking together. The California Hospital Association, the Medical Associations, the California Primary Care Association, Planned Parenthood California, California Association of Health Plans, Local Health Plans of	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	California and SEIU are main groups in the coalition for the ballot initiative. The Governor's office previewed the planned Budget Revise and asked the coalition to withdraw the ballot initiative, offering funding in 2026. The coalition declined the offer. There is now pressure being applied on individual constituencies in the coalition by the Governor's office, to peel them away from the ballot initiative. At a meeting of the Hospital Association of Southern California, Carmela Coyle, President of California Hospital Association was explaining this. A small portion of the MCO tax went to the hospitals, but members of that industry know that it is important for the whole system to have more funding, to attract more doctors to participate particularly at the primary care level, because the safety net hospitals and emergency rooms are overrun if there are insufficient primary care doctors in the community. The coalition is together and will stay together through the ballot initiative process.	
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: <u>California State Budget May Revise</u> • A new children's hospital directed payment program was included in the May Revise to be funded through the MCO tax proceeds. • The equity and practice transformation (EPT) payments for providers was defunded from $700 million to $140 million. This was a five-year program in which L.A. Care participated and L.A. Care has 46 enrolled practices in the EPT program. L.A. Care is exploring options with trade associations to oppose the cut and working with the California Department of Health Care Services (DHCS) on alternative funding. • The budget revise proposes to eliminate adult Medi-Cal acupuncture benefit. • In Home Supportive Services (IHSS) workers receive Medi-Cal benefits. California's undocumented population is eligible for Medi Cal, and also was supposed to receive IHSS services. The Budget Revise pulls back the IHSS services for the undocumented. • The budget proposes to eliminate the Backup Provider System for IHSS which allows a Medi-Cal member access to alternate providers if the primary provider is unavailable to work. In Los Angeles County, providers can access a register and arrange coverage for up to 80 backup provider hours per year. • The May Revise significantly reduces local public health funding for counties. This was enacted during the pandemic. Funding supports local and statewide emergency preparedness. For Los Angeles County alone, it would be about a $47 million loss in funding.	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>• There is a proposal to increase directed payments to public hospitals, but the amount of funding is not clear. L.A. Care will continue to monitor this proposal, which appears to use an administrative fee that goes into the general fund.

A main budget bill is expected to pass the legislature by June 15 and will be sent to the Governor for signature. Over the summer and even the fall months, it is likely that details will be negotiated for various budget legislation.</td><td></td></tr>
<tr><td>COMMITTEE ISSUES</td><td></td><td></td></tr>
<tr><td>Approve Revisions to Human Resources Policies: (EXE A)
• HR-112 (Leave of Absence)
• HR-125 (Sick Leave for Per Diem, Part-Time, and Non-Regular Employees)
• HR-301 (Background Checks)
• HR-312 (Recruitment)</td><td>Terry Brown, Chief of Human Resources, summarized a motion to approve human resource policies.
• Leave of absence policy is revised to include reproductive loss leave, which was enacted by the legislature at the beginning of this year. In conversation with Board Member Booth, it became evident that a statement that the leave would be prorated for the number of hours that an employee is actually working should be added.
• Sick leave policy was revised to equalize the benefits under section 4.1 and 3.8 to reflect that 80 hours can be accrued, as required by law.
• Background check policy has been moved into the new template. Specific positions have been identified for background checks every three years for key positions with the organization. L.A. Care will make sure that there's no intervening activity that would have been reported in the background check upon hire. In conversation with Board Member Booth regarding the background check policy it was noticed that the internal reporting statement was inadvertently omitted and will be reinserted.
• Recruitment policy was revised to include diversity equity and inclusion statements suggested by our NCQA health equity consultant to help better achieve health equity certification.
<table>
<tr><th>Policy Number</th><th>Policy</th><th>Section</th><th>Description of Modification</th></tr>
<tr><td>HR-112</td><td>Leave of Absence</td><td>Employee Relations</td><td>Revisions to include Reproductive Loss Leave section 3.3.6</td></tr>
<tr><td>HR-125</td><td>Sick Leave for Per Diem, Part-Time, and</td><td>Benefits</td><td>Expanded 4.1 on how sick leave may be used; Updated</td></tr>
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<tr><td></td><td>Non-Regular Employees</td><td></td><td>3.1 to reflect 80 hours to be consistent with 3.4</td></tr>
<tr><td>HR-301</td><td>Background Checks</td><td>Employment</td><td>Transferred policy into new template and changes to section 4.4.1</td></tr>
<tr><td>HR-312</td><td>Recruitment</td><td>Employment</td><td>Revisions to include diversity, equity, and inclusion (DE&I) updates in section 4.4.3</td></tr>
</table>
<u>Motion EXE A.0524</u>
To approve the Human Resources Policies HR-112 (Leave of Absence), HR-125 (Sick Leave for Per Diem, Part-Time, and Non-Regular Employees), HR-301 (Background Checks), HR-312 (Recruitment), <s>presented</s> as amended.
</td><td>Approved unanimously as amended. 3 AYES</td></tr>
<tr><td>Proposal for Meeting State Requirements for Community Advisory Committees (CAC), Approval of motion to begin 30-day posting of revised CAC Operating Rules (EXE 100)</td><td>Mr. Baackes reported that L.A. Care has been working with the consumer advisory committee members to comply with provisions in the new Medi-Cal contract. Mr. Baackes and Sameer Amin, Chief Medical Officer, met with all eleven of the Regional Community Advisory Committees (RCACs) in the first four months of 2024. Based on those meetings, the proposal for restructuring the advisory committees was refreshed.

The members of the Temporary Transitional Executive Community Advisory Committee (TTECAC) approved the restructure concepts at the May 14 meeting.

Based on the TTECAC approval, new Operating Rules have been drafted. The Executive Committee is requested to review the proposed amendments to the Operating Rules and approve the launch of a 30-day review period. If the Committee approves the motion today, a final approval could be placed on the June 26 Executive Committee agenda.

The refreshed proposal includes requirement in the contract to have a selection committee for determining the members of the RCACs. RCAC members would elect a chair, and the chair becomes a member of the Executive Community Advisory Committee (ECAC). The selection committee will have six members, three chosen by the ECAC, two community representatives from various community-based organizations, and Alex Li, MD, L.A. Care's Chief Health Equity Officer.</td><td></td></tr>
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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	There will be eight RCAC geographic areas, based on the Los Angeles County Service Planning Areas (SPAs) which have been used for decades to track important health informatics. The data generated for the SPAs will help inform L.A. Care's RCACs about health conditions and issues in the communities they represent. There are currently 140 RCAC members. The proposal includes eight committees with 25 members each, for a total of 200 community advisory committee members, an increase of 60 members. The proposal includes doubling the amount of meeting stipend, with six meetings annually for each RCAC. RCAC members will serve a maximum of two four-year terms, to assure there is some turnover in the committee members. The proposal does not include community round table meetings. The community round tables originally proposed would have been comprised of RCAC members, and meetings would have had less structure than RCAC meetings. To open RCAC meetings for informal discussion, the agenda for RCAC meetings will be revised to include more time for open discussion or topic driven discussion. TTECAC approved this in a vote of ten supporting with one opposing vote. If the motion is approved today, the revised Operating Rules will be posted for a 30-day public comment period and then brought back to this Committee for review of the comments and final approval of the Operating Rules, which could be revised based on input during the 30-day posting. Board Member Booth suggested rewording the section on Function and Role to clarify that the consumer advisory committees assist in the development of L.A. Care's services by providing input on the topics listed, to ensure a realistic expectation of the consumer member role. Board Member Booth also noted inconsistency in the maximum number of members in two sections, on page 6 and page 9. Chairperson Ballesteros encouraged Board members to provide comments to Francisco Oaxaca, *Chief of Communications and Community Relations*, so input can be considered on June 26. **<u>Motion EXE 100.0624</u>** **To authorize staff to publicly post proposed revisions to the Consumer Advisory Committee Operating Rules with information that the Executive Committee will**	**Approved unanimously.** **3 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	consider and take action on such amendments on June 26, 2024, and with information on how feedback can be sent to L.A. Care during the 30-day posting period, and direct staff to report all feedback to the Board and Temporary Transitional Executive Community Advisory Committee (TTECAC). At the June 6 Board Meeting, Board Members Gonzalez and Vazquez will report about the May 14 TTECAC meeting and the action taken on the refreshed proposal. Francisco Oaxaca, *Chief of Communications and Community Outreach & Engagement,* responded to a question about RCAC meetings, that the RCACs met in March and April to discuss the proposed changes. The TTECAC has been meeting monthly, and for the past several months members have discussed these changes. There will be a pause in RCAC meetings for the approval of the proposed changes and the RCAC member selection process to reach as close as possible to the 200 member target. The current 140 active members will transition into the new RCACs and there is a waiting list of about 90 potential members already recruited who have completed applications and are just waiting for the selection committee process. Mr. Baackes had guaranteed that all existing RCAC members will be placed in a RCAC and will start their first four-year term. There should be no delay in scheduling RCAC meetings because every RCAC will have members. All current 140 members have been placed in a new RCAC. One RCAC will begin with 32 members, the maximum number of members is 35 in the redlined operating rules. This process will enable a timely implementation of the restructure after many months of discussions with RCAC members, with final approval by the Executive Committee at the June 26 meeting. RCAC meetings are held in alternating months. RCACs will begin meeting in August and by the end of September each new RCAC will have met. TTECAC will review the same redlined version of the revised operating rules. The 30-day comment period is not just for the public at large to comment but also for Board member comments. Mr. Oaxaca noted that the support from the TTECAC members was almost unanimous. Consumer board members are also supportive. L.A. Care has been very responsive to the comments received from RCAC and TTECAC members. Mr. Baackes noted that Board Member Vazquez attended the opening of the new Community Resource Center in Panorama City last week.	

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	Chairperson Ballesteros suggested that L.A. Care consider doing a relaunch party or gathering. Mr. Oaxaca noted that in the past there has been an annual gathering, the team is already working on how to bring that back. The annual gathering included all the RCAC members in one place for an event. Mr. Oaxaca will provide more information at future Board meetings. Dr. Amin commented that during the May TTECAC meeting, one of the biggest voices as a proponent was a RCAC Chair. She was speaking the praises of L.A. Care for acknowledging their input and that the proposal was updated and everybody can support it. She was a key facilitator of the entire group, and we appreciated her support. Mr. Oaxaca noted that her comments that stuck with him were those reminding TTECAC Members the reasons they are there and the right reasons to be there, and it is not about stipends or other benefits to each person, but they are there to represent the members and contribute to the health plan and make it better. It was compelling for Mr. Oaxaca because TTECAC members do not speak out that way very often, and it was nice to hear. Chairperson Ballesteros thanked Mr. Oaxaca for all the hard work.	
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for June 6, 2024 Board of Governors Meeting. • May 2, 2024 meeting minutes • Quarterly Investment Report	**Approved unanimously.** **3 AYES**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:52 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:53 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *May 2026*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Information & Technology Officer*, and Gene Magerr, *Chief Information Security Officer* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Three Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act Jones v. L.A. Care Health Plan, L.A. Superior Court Case No. 23STCV04081 PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: Chief Executive Officer Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:57 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:57 pm	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

_____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: _____

Board of Governors
MOTION SUMMARY

Date: June 26, 2024

Motion No. EXE 100.0724

Committee: Executive

Chairperson: Alvaro Ballesteros, MBA

Requesting Department: Legal Services Department

Issue: Request to ratify execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP contract (contract number 22-20236) with the Department of Health Care Services (DHCS).

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** <<year>>

Background: L.A. Care received Amendment A04 to the EAE D-SNP contract on June 13, 2024. DHCS required that the Plan submit the executed Amendment on or before June 20, 2024 and did not approve an extension to submit. Amendment A04 extends the contract term to December 31, 2025. This amendment allows for the continuation of the services identified in the original agreement.

Member Impact: The Plan's D-SNP Members are positively impacted by extending the Plan's contract applicable to the D-SNP line of business.

Budget Impact: Finance has reviewed for impact on relevant budgets.

Motion: **To ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS).**

Exhibit A
SCOPE OF WORK

Exclusively Aligned Enrollment D-SNP

1. Service Overview

A. This Contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP), Local Initiative Health Authority for LA County, that will be referred to in this Contract as D-SNP Contractor. The Medicare Advantage organization offering the D-SNP, D-SNP Contractor's parent organization, or another entity that is owned and controlled by the D-SNP Contractor's parent organization L.A. Care Health Plan must also hold a Medi-Cal Managed Care Health Plan (MCP) Contract with California Department of Health Care Services (DHCS), or must be a subcontracted delegate health plan as defined in Welfare and Institutions Code (W&I) section 14184.208(h)(6), also referred to as an Exclusively Aligned Enrollment (EAE) D-SNP. D-SNP Contractor must have a Medicare Advantage Contract (H-Contract) that only includes D-SNPs within California in accordance with 42 CFR section 422.107(e). The H-Contract must include both EAE and Non-EAE plan benefit packages.

B. This D-SNP Contract is a Care Coordination and benefit coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including those benefits not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates, and the Medi-Cal benefits identified in the Exhibit H attachment to this Contract and referenced below in Provision 3 of this Exhibit A. Coordination responsibility includes coordination of those Medi-Cal Services that are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

C. This D-SNP Contract is for Applicable Integrated Plans as defined in 42 CFR section 422.561. D-SNP Contractor must limit enrollment to full-benefit Dual Eligible Members enrolled in an affiliated MCP, per 42 CFR section 422.561, that holds a capitated contract with DHCS or is a subcontracted delegate health plan as defined in W&I 14184.208(h)(6). Through the capitated MCP Contract, Medi-Cal benefits include primary care and acute care, including Medicare cost-sharing as defined in 28 Social Security Act (SSA) section 1905(p)(3)(B), (C), and (D), without regard to the

limitation of that definition to qualified Medicare beneficiaries. Members enrolled in Applicable Integrated Plans have Skilled Nursing Facility (SNF) services (with coverage for a minimum of 180 days), Home Health Services (as defined at 42 CFR section 440.70), and Durable Medical Equipment (DME) including equipment and appliances, as well as medical supplies (as defined at 42 CFR section 440.70(b)(3)) covered by the capitated MCP Contract.

2. Project Representatives

A. The project representatives during the term of this D-SNP Contract will be:

Department of Health Care Services	D-SNP Contractor
Managed Care Operations Division Attn: Procurement & Contract Development Branch Chief	Local Initiative Health Authority for LA County Attn: Todd Gower, Chief Compliance Officer
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: 213-523-1854 925-595-1021 Email: TGower@lacare.org

B. Direct all inquiries to:

Department of Health Care Services	D-SNP Contractor
Managed Care Operations Division Attn: Michelle Retke, Division Chief	Local Initiative Health Authority for LA County Attn: Todd Gower, Chief Compliance Officer
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	1200 West 7th Street Los Angeles, CA 90017
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: 213-523-1854 925-595-1021 Email: TGower@lacare.org

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

Exhibit A
SCOPE OF WORK

amendment to this D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed:

   A. Exhibit A: Scope of Work

   B. Exhibit H

Exhibit A, Attachment 1
COORDINATION OF CARE

1. Care Coordination

This D-SNP Contract is a Care Coordination and benefit coordination agreement between D-SNP Contractor and DHCS. D-SNP Contractor is responsible for coordinating the delivery of all benefits and services covered by both Medicare and Medi-Cal, including when Medi-Cal Services are delivered via Medi-Cal FFS, managed care, or other Medi-Cal delivery systems. Without limitation, when Medically Necessary for the Member, D-SNP Contractor must coordinate care with providers and other entities for the Medi-Cal Services outlined in Exhibit H. D-SNP Contractor must educate Members through Member handbook and other contacts that D-SNP Contractor, and not the Member, is responsible for coordination of the Member's Medi-Cal and Medicare Services.

A. For coordination of behavioral health services, including specialty mental health and substance use disorder services, D-SNP Contractor must establish a cooperative working relationship with the Member's MCP and/or the county behavioral agency for care coordination, information sharing, and oversight. County behavioral health plan contact information can be found at the following link: https://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx.

B. For coordination of In-Home Supportive Services (IHSS), D-SNP Contractor must establish a cooperative working relationship with the County IHSS Office for care coordination, information sharing, and oversight. County IHSS Office contact information can be found at: https://www.cdss.ca.gov/inforesources/county-ihss-offices.

C. For coordination of Medi-Cal dental benefits, D-SNP Contractor must contact the DHCS Dental Administrative Service Organization (ASO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal dental fee-for-service or contact the Medi-Cal Dental Managed Care Plan for Members enrolled in Medi-Cal Dental Managed Care. ASO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below are Medi-Cal Dental Managed Care contact information:

Liberty Dental Plan
Sacramento: (888) 703-6999 or (877) 855-8039 (TTY/TTD)

Exhibit A, Attachment 1
COORDINATION OF CARE

Los Angeles: (888) 703-6999 or (877) 855-8039 (TTY/TTD)

Health Net Dental Plan
Sacramento: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)
Los Angeles: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)

Access Dental Plan
Sacramento: (877) 821-3234 | TTY: (800) 735-2929
Los Angeles: (888) 414-4110 | TTY: (800) 735-2929

Please note: the Dental Managed Care Plans are subject to change. DHCS reserves the right to provide updated contact information for Dental Managed Care plans.

D. For coordination of Medi-Cal pharmacy benefits, D-SNP Contractor must contact Medi-Cal Rx, and contact information can be found at: https://medi-calrx.dhcs.ca.gov/home/contact.

E. If D-SNP Contractor offers Supplemental Benefits as referenced in Exhibit E, Attachment A, Definitions, of this Contract, also including Special Supplemental Benefits for the Chronically Ill (SSBCI) or Expanded Primarily Health-Related Benefits (EPHRB), those services must be coordinated as needed to ensure D-SNP Contractor tracks Member use of Supplemental Benefits and exhausts Supplemental Benefits prior to or concurrent with authorization of or referral for Medi-Cal benefits, including but not limited to Dental, Vision, Transportation, Community Supports, and Behavioral Health.

F. D-SNP Contractor must implement a Special Needs Plan Model of Care (MOC). In addition to meeting requirements detailed at 42 CFR section 422.101(f) and earning approval from the National Committee for Quality Assurance (NCQA), the Contractor must include State-specific requirements outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must additionally comply with State-specific Care Coordination requirements, which are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website and may be amended from time to time. These State-specific requirements, which are outlined fully in the 2025 CalAIM Dual Eligible Special

Exhibit A, Attachment 1
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Needs Plan (D-SNP) Policy Guide, include the following:

1) Incorporating Medi-Cal data into the D-SNP risk stratification process;

2) Incorporating Medi-Cal Services and providers, including palliative care teams as appropriate, into the development and execution of the Member's care plan and care team, including Medi-Cal Services accessed through the aligned MCP as well as Medi-Cal FFS and other Medi-Cal delivery systems (including Home and Community-Based Services programs);

3) Including a question in the Member's Health Risk Assessment (HRA) to identify any engaged Caregiver and submit the HRA tool to DHCS;

4) Assessing of Caregiver support needs, if a Member identifies a Caregiver, as part of the D-SNP assessment process;

5) Providing on at least an annual basis as feasible, and with the Member's consent, face-to-face encounters for the delivery of health care or care management or Care Coordination services;

6) Incorporating trained Dementia Care Specialists in care teams and encouraging primary care providers to leverage Dementia Care Aware resources for any primary care appointment to detect cognitive impairment;

7) Utilizing Long-Term Services and Supports (LTSS) liaisons in supporting care transitions;

8) Including four (4) or more populations of focus from the Medi-Cal Enhanced Care Management (ECM) program and demonstrating how the D-SNP Contractor's model of care includes and reflects the delivery of ECM core services;

9) Providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for Members who meet Medi-Cal criteria for palliative care; and

10) Discussing advance care planning in the annual wellness visit or other provider visits.

G. D-SNP Contractor is not responsible to provide or pay for any Medi-Cal benefits, or Medicare cost sharing obligations which are covered in full through Medi-Cal FFS or MCP Contract. Medi-Cal MCPs are responsible to pay Medicare cost sharing obligations for contracted benefits for MCP members. In addition, the MCP Contract requires the MCP to enter into a Coordination of Benefits Agreement with the Medicare program through the Centers for Medicare & Medicaid Services (CMS), and to participate in Medicare's automated claims crossover process for full-benefit Dual Eligible Members, in accordance with 42 CFR section 438.3(t). D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the DHCS website or otherwise provided by DHCS. D-SNP Contractor shall coordinate with the aligned MCP to support Medi-Cal eligibility retention efforts to the extent permitted by law, and guidance from CMS and DHCS. D-SNP Contractor shall timely coordinate Medi-Cal Services requiring referral and coordination of care as outlined in Exhibit H for its Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Services are described in Title XIX of the Social Security Act, 42 CFR parts 440 and 441; the California Medicaid State Plan; Exhibit H; the DHCS and Medi-Cal websites and other relevant materials.

2. Information Sharing

A. D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs per 42 CFR section 422.107(d)(1), for the purpose of coordinating Medicare and Medi-Cal covered services between settings of care for all Members. This State policy is in addition to federal requirements for hospitals regarding electronic notifications listed in 42 CFR section 482.24(d). The goal of the information sharing policy is for D-SNP Contractor, either directly or through contracted providers or other entities, to timely notify the Member's MCP, or hospital and SNF admissions. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal Services, including Home and Community Based Services.

1) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted hospitals and SNFs to use a secure email data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor in a timely manner of any hospital or SNF admissions for all Members.

2) D-SNP Contractor will require contracted hospitals to make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the hospital's inpatient services, if applicable.

3) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted SNFs to use a secure email, a data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will require contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require contracted SNFs to make this notification in advance, if at all possible, or at the time of, the Member's discharge or transfer from the SNF.

4) In the event that the D-SNP Contractor authorizes another entity or entities to perform these notifications, D-SNP Contractor must retain responsibility for complying with this requirement. The D-SNP Contractor ultimately retains the responsibility for the notification requirements that are delegated to its contracted hospitals and SNFs.

B. D-SNPs will coordinate care management for their Members and facilitate Member access to needed LTSS, including in community-based settings to support care transitions.

3. Integrated Materials

A. D-SNP Contractor is responsible for providing integrated Member materials to Members. The State requirements described in this

Exhibit A, Attachment 1
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Paragraph are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V, 42 CFR Part 423 Subpart V, and 42 CFR section 438.10(d)(2), and as described in the Medicare Communications and Marketing Guidelines (MCMG). Required integrated Member materials will include:

1) Annual Notice of Change (ANOC);

2) Member Handbook;

3) Summary of Benefits;

4) Member Identification (ID) Card;

5) Provider/Pharmacy directory; and

6) List of Covered Drugs (Formulary).

B. D-SNP Contractor must have a single Member services/customer service phone number for Members to contact D-SNP Contractor regarding their Medicare or Medi-Cal benefits. D-SNP Contractor must use the single Member services phone number in all integrated Member materials.

C. D-SNP Contractor will be required to make all integrated Member materials available in the threshold languages for their aligned MCP Service Area. Threshold languages include both:

1) Medicare's five percent (5%) threshold for language translation as outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V); and

2) DHCS prevalent language requirements, i.e. the DHCS threshold and concentration standard languages, as specified in APL 21-004 or subsequent iterations guidance to Contractors on specific translation requirements for their Service Areas.

D. D-SNP Contractor must have a process for ensuring that Members can make a standing request to receive materials in alternative formats and in any non-English languages, at the time of request and on an ongoing basis thereafter, in accordance with 42 CFR section 422.2267 and section 423.2267, APL 21-004 or subsequent

iterations, APL 22-002 or subsequent iterations, and the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide as applicable. The process must include how D-SNP Contractor will keep a record of the Member's information and utilize it as an ongoing standing request so the Member does not need to make a separate request for each item of material, and how a Member can change a standing request for preferred language and/or format.

E. D-SNP Contractor must identify in its provider directory those providers that accept both Medicare and Medi-Cal, i.e. providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network. D-SNP Contractor must comply with existing federal and State guidelines regulating print and online provider directories. Print and online directories for D-SNP Contractor must reflect all contracted and in-network providers for D-SNP Members. The provider directories must show the providers that are in the D-SNP Medicare and/or Medi-Cal networks in a clear manner for Members.

F. D-SNP Contractor must submit all communication and marketing materials in the Health Plan Management System (HPMS) that are required to be submitted as described here and in the MCMG under D-SNP Contractor's Medicare contract ID number. The multi-plan submission process is not applicable to D-SNP only contracts. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes Member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third-party providers to D-SNP enrollees. The material must be submitted in HPMS using a separate material ID number for the D-SNP contract and that material ID number must be included in the material. Additional guidance including the submission and review process for integrated Member materials is fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

G. D-SNP Contractor must have a single Application Programming Interface (API) for Members to access both Medicare and Medi-Cal information.

4. State-Specific Supplemental Benefits

Exhibit A, Attachment 1
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Using Medicare rebate dollars, D-SNP Contractor must provide, at a minimum, the following supplemental benefits to Members:

A. $0 copay for one (1) routine eye exam every year; and

B. Every two (2) years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses.

5. Quality and Data Reporting

A. D-SNP Contractor is responsible for reporting quality measures to DHCS. These quality measures are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. This reporting will include:

1) Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures, calculated at the plan benefit package (PBP) level for the PBPs included in this Contract;

2) State-specific Care Coordination and LTSS process measures;

3) State-specific dementia measures;

4) State-specific ECM-like care management measures;

5) State-specific palliative care measures; and

6) Integrated Appeals and Grievances data.

DHCS will add additional measures as needed, and details will be provided in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

6. Consumer Participation in Governance Boards

A. D-SNP Contractor must comply with federal requirements outlined in 42 CFR section 422.107(f) in addition to State-specific requirements outlined below. D-SNP Contractor must ensure

consumer participation in governance boards that will provide regular feedback to the D-SNP Contractor on issues of duals-related topics, including plan management and Member care. D-SNP Contractor must consider region-specific meetings based on geographic county proximity rather than one State-wide setting, and ensure that the committee completes the following:

1) Meets at least quarterly throughout the Contract Year;

2) Has at least four (4) Member seats for individuals who have knowledge and perspective of EAE D-SNP topics to facilitate a variety of Member perspectives and unique lived experiences, including those using services such as Home and Community Based Services and Long-Term Care;

3) Includes a ratio of Members on the governance board focused on duals-related topics relative to the ratio of dual eligible Members enrolled with D-SNP Contractor;

4) Includes a reasonably representative sample of the population enrolled in D-SNP including Members, Member's family members, consumer advocates, and caregivers that reflect the demographic diversity of the D-SNP population, including individuals with disabilities; and

5) Solicits input on ways to improve access to Covered Services, coordination of services (including all Medicare and Medi-Cal services), and health equity for underserved populations, among other topics.

B. D-SNP Contractor is responsible for reporting their committee charter and membership to DHCS annually by March 1, 2025, through its DHCS Contract Manager via email. D-SNP Contractor is also responsible for reporting meeting minutes and agendas to DHCS quarterly through its DHCS Contract Manager via email no later than 30 days after the end of each quarter. DHCS reserves the right to review and approve Enrollee membership. D-SNP Contractor can engage and recruit Members serving on existing committees.

7. State Guidance

A. In addition to the terms and conditions of this Contract, D-SNP Contractor must comply with State-specific departmental

guidance in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. To the extent that State guidance conflicts with Medicare requirements or regulations, D-SNP Contractor must comply with Medicare requirements and regulations. For purposes of this Provision State guidance only conflicts with Medicare requirements or regulations to the extent that the guidance requires conduct that would violate Medicare requirements or regulations.

8. Coverage Area and Eligible Beneficiaries

A. This Contract covers the Medicare H-contract and Plan Benefit Package (PBP) listed within the following table.

Plan PBPs	H-Contract	Service Area of PBP	Eligible Populations within PBP
001	H1224	Los Angeles County	QMB+, SLMB+, and other Full-Benefit Medi-Cal

B. Members covered under this Contract must include all full-benefit Dual-Eligible Beneficiaries 21 years of age or older, such as Qualified Medicare Beneficiaries Plus (QMB+), Specified Low-Income Medicare Beneficiaries Plus (SLMB+), and other full-benefit Dual-Eligible Beneficiaries who are enrolled with D-SNP Contractor and with the aligned Medi-Cal MCP. Covered Members include those who meet the following:

1) Are enrolled with D-SNP Contractor;

2) Who reside in the following county or counties to maximize the continuum of services available through both Medicare and Medi-Cal: Los Angeles County

3) Are already enrolled in the MCP affiliated with D-SNP Contractor.

C. D-SNP Contractor agrees to conduct enrollment of eligible

persons in accordance with the policies and procedures set forth in this Contract and maintain EAE for the duration of the D-SNP Contract term.

9. Certification and Enrollment Reporting

A. D-SNP Contractor must submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in D-SNP Contractor's D-SNP as of the effective date of this Contract.

B. By the fifth working day of each month during the term of this Contract, D-SNP Contractor must submit a report to DHCS, signed by the Chief Operations Officer or similar executive officer, summarizing the previous month's Enrollment numbers.

10. Member Billing Prohibitions

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Social Security Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor must not bill any Member (including full-benefit Dual Eligible Beneficiaries such as QMB+, SLMB+, and other full-benefit Dual Eligible Beneficiaries) for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act, which prohibits a Medicare provider from billing a full-benefit Dual Eligible Beneficiary for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.

B. Any Dual Eligible Beneficiary (including full-benefit Dual Eligible Beneficiaries such as QMB+, SLMB+, and other full-benefit Dual Eligible Beneficiaries) has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements must specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Enrollees, or to bill Medi-Cal or the Member's Medi-Cal MCP as applicable for

any additional Medicare payments that may be reimbursed by Medi-Cal. D-SNP Contractor's provider agreements must require a contracted Medicare provider to comply with Welfare and Institutions Code section 14019.4.

11. Provider Network Requirements

A. D-SNP Contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. Medi-Cal FFS Provider data can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Medi -Cal Managed Care Provider Network data can be found at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-provider-listing. Alternatively, D-SNP Contractor can obtain the file from the affiliated MCP.

B. D-SNP Contractor must comply with all applicable network guidance and network requirements outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

C. D-SNP Contractor that offers Dental Supplemental Benefits must report to DHCS on the level of overlap for their Medicare dental network and the Medi-Cal Dental network, as outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide.

12. Medicare Continuity of Care

A. D-SNP Contractor must comply with State-specific requirements for Medicare primary and specialty care provider continuity of care. D-SNP Contractor must also comply with State-specific requirements for Durable Medical Equipment continuity of care as outlined in 42 CFR section 422.100(I)(2)(iii) and APL 23-022 or subsequent iterations to the extent that this requirement applies to the D-SNP Contractor. Further guidance is outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must provide Members with the following:

1) A 12-month continuity of care period from the date of the Member's Enrollment in the D-SNP, for primary and specialty providers with whom the Member has a pre-existing relationship and who are willing to work with the D-SNP Contractor; and

2) Access to Medically Necessary Medicare-covered Durable Medical Equipment and medical supplies.

13. Medi-Cal and Medicare Eligibility Verification and MCP Enrollment Verification

A. It is the responsibility of D-SNP Contractor to verify the Medi-Cal eligibility of a Member. To facilitate this verification, D-SNP Contractor will have real-time access to the Medi-Cal eligibility verification system.

B. To obtain Medicare Advantage and Medi-Cal eligibility, D-SNP Contractor must validate eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a MCP at the time of the inquiry.

2) If the beneficiary meets the criteria for enrollment listed in Provision 8, Coverage Area and Eligible Beneficiaries, the eligible beneficiary may be enrolled with D-SNP Contractor.

C. D-SNP Contractor must ensure appropriate training of plan personnel and contracted providers regarding the use of the Medi-Cal Automated Eligibility Verification System (AEVS) interface and the appropriate interpretation of its eligibility results.

D. D-SNP Contractor's providers may use the Medicare Administrative Contractor (MAC) online provider portal to check their patient's Medicare eligibility. Additional information on checking Medicare eligibility can be found on the following link: https://www.cms.gov/MAC-info.

14. Medicare Deeming Period

Exhibit A, Attachment 1
COORDINATION OF CARE

For those Members who have lost Medi-Cal eligibility, D-SNP Contractor is required to maintain enrollment for such Members for at least a three-month deeming period following notification that the Member lost Medi-Cal eligibility. This requirement does not preclude D-SNP Contractor from offering a longer deeming period. D-SNP Contractor should inform its DHCS Contract Manager of the deeming period that it will provide.

15. Contract Term

This D-SNP Contract is effective from January 1, 2025, through December 31, 2025.

16. Termination

DHCS retains the right to terminate this D-SNP Contract at any time for cause or no cause.

17. Compensation

The State of California and DHCS must not provide any remuneration or other form of compensation for the performance of any duties or obligations provided under this D-SNP Contract.

18. CMS Documentation

A. D-SNP Contractor must submit to DHCS, after execution of this Contract but no later than September 30, 2024, a complete and accurate copy of the Medicare Advantage bid for the contract containing the PBPs covered by this Contract, as approved by CMS.

B. If not included in the approved bid, the D-SNP Contractor must also provide to DHCS the following information, in a format as specified by DHCS, after execution of this Contract but no later than September 30, 2024 to the DHCS contract manager:

1) The current approved model of care, if not already submitted to DHCS.

2) A list of approved Supplemental Benefits included in the initial annual Medicare Advantage bid submission to CMS.

3) A list of approved Supplemental Benefits, inclusive of all benefits listed in the final Plan Benefit Package.

C. D-SNP Contractor must submit to DHCS copies of CMS reporting, compliance, and audit findings.

19. Medicare Encounter Data Requirements

D-SNP Contractor must submit to DHCS electronic records of all encounters, including encounters resulting in zero Medicare claims, monthly, in a mutually agreed upon format. Each encounter record must be specific to the Member and provider, listing all the data elements required for each service. This data will provide DHCS with information on services paid for by Medicare. Additional details regarding this requirement are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

20. Integrated Appeals and Grievances

A. D-SNP Contractor must adhere to the State-specific requirements described in this Contract, in addition to all existing Medicare requirements. In addition, D-SNP Contractor must implement a unified approach to appeals and grievances per 42 CFR sections 422.629-422.634, 438.210, 438.400, and 438.402. 42 CFR section 422.629(c) allows the State, at its discretion, to implement standards for timeframes or notice requirements that are more protective for the Member than required by 42 CFR section 422.630 through 422.634.

B. D-SNP Contractor must provide information about its Integrated Appeals and Grievance system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on Integrated Appeals, Integrated Grievances, State Hearings, and Independent Medical Review (IMR) procedures and timeframes, as applicable.

C. D-SNP Contractor must maintain records of the Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations. The record of each Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations must be accurately maintained in a manner accessible to the State and available upon request to CMS. Additionally, D-SNP Contractor must establish, implement, maintain, and oversee an Integrated Grievance and Integrated Appeal system to ensure the receipt,

review, and resolution of Integrated Grievances and Appeals. D-SNP Contractor must ensure that the following requirements are met through its Integrated Grievance and Integrated Appeal system.

D. Integrated Appeals and Grievances procedures apply to all benefits offered under D-SNP Contractor including optional supplemental benefits. For benefits that are carved out, such as Medi-Cal Dental, D-SNP Contractor must also follow the regulations at 42 CFR section 422.562(a)(5) and 422.629(e) that require D-SNP Contractor to provide Members reasonable assistance completing forms and taking other procedural steps to assist Members with appeals and grievances. This includes offering to assist Members with obtaining Medi-Cal covered services and navigating Medi-Cal appeals and grievances in connection with the Member's own Medi-Cal coverage, regardless of whether such coverage is in Medi-Cal fee-for-service or a separate Medi-Cal Dental Managed Care Plan. If the Member accepts the assistance, the D-SNP Contractor should assist the Member as needed, such as identifying and reaching out to a Medi-Cal fee-for-service point of contact, providing assistance in filing an appeal or grievance, helping to obtain documentation to support a request for Medi-Cal appeal or grievance, or completing paperwork that may be needed in filing an appeal or grievance.

E. For Integrated Grievances, D-SNP Contractor must have the following:

1) Procedure to allow a Member, Member's authorized representative, or their provider to file a standard or expedited Integrated Grievance orally or in writing with D-SNP Contractor at any time.

2) Procedure to ensure D-SNP Contractor sends a written acknowledgement of an Integrated Grievance that is dated and postmarked within five (5) calendar days of receipt in accordance with Health and Safety Code (H&S) section 1368(a)(4)(A) and 28 California Code of Regulations (CCR) section 1300.68(d)(1) and 42 CFR section 422.629(g).

3) Procedure to resolve standard Integrated Grievances as expeditiously as the Member's health condition requires, but no later than 30 calendar days from receipt of the Integrated Grievances in accordance with 42 CFR section 422.630.

4) Procedure to resolve expedited Integrated Grievances within 24 hours in accordance with 42 CFR section 422.630.

5) Procedure to provide a written resolution to the Member for an Integrated Grievance within the resolution timeframe for a standard and expedited Integrated Grievance when:

   a) The Member submits an Integrated Grievance in writing;

   b) The Member requests a written response;

   c) The Integrated Grievance is related to quality of care, coverage dispute, or disputed health care service involving medical necessity or experimental or investigational treatment; or

   d) The Integrated Grievance is not resolved by the next business day, regardless of the type of Integrated Grievance or how it is filed.

6) Procedure to log and report all Integrated Grievances.

F. For Integrated Organization Determinations, D-SNP Contractor must have the following:

1) Procedure for D-SNP Contractor to consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination.

2) Procedure to provide timely notice of standard Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 14 calendar days from when it receives the request in accordance with 42 CFR section 422.631(d)(2)(i)(B).

3) Procedure to provide notice to Members of their appeal rights and State Hearing rights for all fully or partially denied Integrated Organization Determinations.

4) Procedure to include the most current State Hearing form with the Integrated Organization Determination notice when the following requirements are met:

a) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

b) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

5) For Knox-Keene licensed plans, a procedure to ensure compliance with H&S section 1367.01, including making Integrated Organization Determinations in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from D-SNP Contractor's receipt of information reasonably necessary to make the Integrated Organization Determination, and no later than 14 calendar days from the receipt of request in accordance with H&S section 1367.01(h)(1) and 42 CFR section 422.631(d)(2)(i)(B).

6) For Knox-Keene licensed plans, a procedure to inform Members of their rights to an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections 1368.03, 1370.4, and 1374.30, 28 CCR sections 1300.70.4 and 1300.74.30, and including verbatim language required by H&S section 1368.02(b), as well as the most recent IMR form, application instructions, the Department of Managed Health Care's (DMHC's) toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

a) The denied Integrated Organization Determination is for experimental or investigational therapy, or is a denial of urgent care or emergency service;

b) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

c) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

7) Procedure to provide timely notice of expedited Integrated

Organization Determinations as expeditiously as the Member's health condition requires, and no later than 72 hours from when D-SNP Contractor receives the request in accordance with 42 CFR section 422.631(d)(2)(iv).

8) Procedure to ensure deadlines for integrated organization determinations are not extended in accordance with H&S section 1367.01.

9) Procedure to ensure that prior to terminating, suspending, or reducing a previously approved item or service, D-SNP Contractor must provide Members with an integrated coverage decision letter at least ten (10) calendar days in advance of the effective date of the adverse organization determination in accordance with 42 CFR section 422.631(d)(2)(i)(A).

10) For Knox-Keene licensed plans, a procedure to ensure that D-SNP Contractor must not rescind or modify an integrated organization authorization after the Provider renders the health care service in good faith in accordance with H&S section 1371.8.

G. For Integrated Appeals, D-SNP Contractor must have the following:

1) Procedure to provide written acknowledgement of receipt of all Integrated Appeals within five (5) calendar days in accordance with 42 CFR section 422.629(g) and H&S section 1368(a)(4)(A).

2) Procedure to resolve standard Integrated Appeals as expeditiously as the Member's health condition requires but to not exceeding 30 calendar days from the date of receipt of the request in accordance with 42 CFR section 422.633(f)(1).

3) Procedure to inform Members of their rights to a State Hearing and include the most current State Hearing form when the following requirements are met:

a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

b) The Integrated Appeal relates to a denial, in whole or

in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

4) For Knox-Keene licensed plans, a procedure to ensure that the Medi-Cal External Appeals processes are in accordance with DMHC's IMR System set forth in Article 5.55 of the Knox-Keene Act and the regulations promulgated thereunder.

5) For Knox-Keene licensed plans, a procedure to inform Members of their right to request an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections1368.03 and 1374.30, and 28 CCR section 1300.74.30, and including the verbatim language required by H&S section 1368.02, as well as the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

   a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

   b) The Integrated Appeal is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

6) Procedure to resolve expedited Integrated Appeals within 72 hours of receipt of the Appeal in accordance with 42 CFR section 422.633(f)(2).

7) Procedure to ensure deadlines for Integrated Appeals of Medicare and Medi-Cal Services are not extended in accordance with APL 21-011 or any subsequent iterations of this APL.

8) Procedure to ensure D-SNP Contractor is obtaining all relevant information needed to make an Integrated Appeal decision within the required timeframes.

9) Procedure to ensure D-SNP Contractor continues the Member's benefits per 42 CFR section 422.632 while the Integrated Appeal is pending if all of the following are met:

a) The Member files a request to continue benefits within ten calendar days of notice of adverse integrated organization determination;

b) The integrated appeal involves the termination, suspension, or reduction of previously authorized services;

c) The services were ordered by an authorized provider; and

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

H. For a Reversal of Integrated Appeal Decisions, D-SNP Contractor must have the following:

1) Procedure to authorize or provide the service under dispute if D-SNP Contractor reverses its decision to deny, limit, or delay services that were not provided while the Appeal was pending within the following timeframes:

a) As expeditiously as the Member's health condition requires and no later than 72 hours from the date it reverses its determination; or

b) With the exception of a Medicare Part B drug, 30 calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal; or

c) For a Medicare Part B drug, seven (7) calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal.

2) Procedure to authorize or provide the disrupted service(s) if a State Hearing officer reverses D-SNP Contractor's Integrated Appeal decision to deny, limit, or delay services that were not provided while the Appeal was pending, as expeditiously as the Member's health condition requires but no later than 72 hours of the date it receives notice reversing the determination in accordance with 42 CFR section 422.634(d)(2).

3) Procedure to effectuate decisions made by a Part C independent review entity, an administrate law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council to reverse D-SNP Contractor's decision under the same timelines applicable to other Medicare Advantage plans as specified in 42 CFR sections 422.618,422.619, and 422.634(d)(3).

4) For Knox-Keene licensed plans, the procedure to promptly implement the decision of an IMR that a disputed health care service is medically necessary in accordance with H&S section 1374.3.

21. Additional Guidance

A. For Marketing materials, D-SNP Contractor must include information about Medi-Cal Dental benefits. Additional details regarding this requirement are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. D-SNP Contractor must include information about Medi-Cal Dental benefits in any materials that provide Member information about D-SNP Dental Supplemental Benefits. Additional details regarding this requirement are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

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Exhibit C
GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. D-SNP Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by D-SNP Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: D-SNP Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. D-SNP Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. D-SNP Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. (Government Code Section 8546.7, Public Contract Code Section 10115 et seq., and California Code of Regulations, Title 2, Section 1896).

5. INDEMNIFICATION: D-SNP Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by D-SNP Contractor in the performance of this Agreement.

6. DISPUTES: D-SNP Contractor shall continue with the responsibilities under this Agreement during any dispute.

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should D-SNP Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any

Exhibit C
GENERAL TERMS AND CONDITIONS

manner deemed proper by the State. All costs to the State shall be deducted from any sum due D-SNP Contractor under this Agreement and the balance, if any, shall be paid to D-SNP Contractor upon demand.

8. INDEPENDENT CONTRACTOR*:* D-SNP Contractor, and the agents and employees of D-SNP Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: D-SNP Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer material as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, D-SNP Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40*),* marital status, and denial of family care leave. D-SNP Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provision*s* of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 8101 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. D-SNP Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 307 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION:

Exhibit C
GENERAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

14. GOVERNING LAW: This D-SNP Contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. CHILD SUPPORT COMPLIANCE ACT:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

18. PRIORITY HIRING CONSIDERATIONS: If this D-SNP Contract includes services in excess of $200,000, D-SNP Contractor shall give priority consideration in filling vacancies in positions funded by the D-SNP Contract to qualified recipients of aid under Welfare and Institutions Code Section 11200 in accordance with Public Contract Code Section 10353.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. D-SNP Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. D-SNP Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. D-SNP Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state D-SNP Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

B. D-SNP Contractor will, in all solicitations or advancements for employees placed by or on behalf of D-SNP Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

C. D-SNP Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of D-SNP Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. D-SNP Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act

of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. D-SNP Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of D-SNP Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and D-SNP Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. D-SNP Contractor will include the Provisions of Paragraphs A through G in every purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or

(38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. D-SNP Contractor will take such action with respect to any purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event D-SNP Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, D-SNP Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. If any inspection or evaluation is made of the premises of D-SNP Contractor, D-SNP Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be

performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

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

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5:

A. Government contractors agree to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act [42 USC 1857(h)], Section 508 of the clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

13. Confidentiality of Information

A. D-SNP Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to D-SNP Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

B. D-SNP Contractor and its employees or agents shall not use such identifying information for any purpose other than carrying out D-SNP Contractor's obligations under this D-SNP Contract.

C. D-SNP Contractor and its employees, or agents shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. D-SNP Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. Human Subjects Use Requirements

By signing this D-SNP Contract, D-SNP Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such

examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

19. Debarment and Suspension Certification

A. By signing this D-SNP Contract, D-SNP Contractor agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this D-SNP Contract, D-SNP Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three-year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein;

4) Have not within a three-year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default;

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all

lower tier covered transactions and in all solicitations for lower tier covered transactions.

C. If D-SNP Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this D-SNP Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If D-SNP Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this D-SNP Contract for cause or default.

20. Smoke-Free Workplace Certification

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed.

B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

C. By signing this D-SNP Contract, D-SNP Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

21. Covenant Against Contingent Fees

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

D-SNP Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this D-SNP Contract upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by D-SNP Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this D-SNP Contract without liability or in its discretion to deduct from the D-SNP Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of D-SNP Contractor at the conclusion of this D-SNP Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

26. Prohibited Use of State Funds for Software

D-SNP Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

28. Alien Ineligibility Certification

By signing this D-SNP Contract, D-SNP Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et. seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per 31 USC Section 1352)

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or sub-grant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph B of this provision.

2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Section 1352 of Title 31, USC, provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Exhibit E, Attachment 1
DEFINITIONS

As used in this D-SNP Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this D-SNP Contract:

1. **Aligned Enrollment** means, per 42 CFR section 422.2, the Enrollment in a D-SNP of a full-benefit Dual Eligible Beneficiary whose Medi-Cal benefits are covered under a Medi-Cal managed care organization contract under section 1903(m) of the Social Security Act between California and D-SNP Contractor's MA organization, which is the parent organization, or another entity that is owned and controlled by D-SNP Contractor's parent organization.

2. **Applicable Integrated Plan** means, per 42 CFR section 422.561, the Medi-Cal managed care organization through which D-SNP Contractor, its parent organization, or another entity that is owned and controlled by its parent organization, covers Medi-Cal services for Dual Eligible Beneficiaries enrolled with D-SNP Contractor and such Medi-Cal managed care organization.

3. **Care Coordination or Coordination of Care** means a process used by a person or team to assist Members in accessing Medicare and Medi-Cal Services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

4. **Care Coordinator** means a clinician or other trained individual who is employed or contracted by the Member's primary care provider or D-SNP Contractor, serves on one (1) or more Interdisciplinary Care Teams (ICT), and coordinates and facilitates meetings and other activities of those ICTs, as well as participates in the Health Risk Assessment of each Member on whose ICT they serve.

5. **Caregiver** means, per CY 2024 Physician Fee Schedule (Final Rule), an adult family member or other individual who has significant relationship with, and who provides a broad range of assistance to a Member with a chronic or other health condition, disability, or functional limitation, and a family member, friend or neighbor who provides unpaid assistance to a Member with a chronic illness or disabling condition.

6. **Centers for Medicare & Medicaid Services (CMS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

Exhibit E, Attachment 1
DEFINITIONS

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

8. **Covered Service(s)** means Care Coordination or Coordination of Care. This is the only service covered under this Contract.

9. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

10. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

11. **Dementia Care Specialists** means D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.

12. **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

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

14. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan. This Contract is only for full-benefit Dual-Eligible Beneficiaries (QMB+, SLMB+, and other full-benefit Dual-Eligible Beneficiaries).

15. **Enrollment** means the process by which a beneficiary eligible for enrollment, as contained in Exhibit A, Attachment 1, Provision 8, and becomes a Member of the D-SNP Contractor’s D-SNP.

16. **Exclusively Aligned Enrollment** means that State Policy has limited a D-SNP’s membership to individuals with Aligned

Exhibit E, Attachment 1
DEFINITIONS

Enrollment.

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

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

B. Maintained by a provider to provide services on behalf of D-SNP Contractor.

18. **Grievance** means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of D-SNP Contractor's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

19. **Integrated Appeal** means any of the procedures that deal with, or result from, adverse integrated organization determinations by D-SNP Contractor on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service. An Integrated Appeal is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Reconsiderations procedures in 42 CFR sections 422.629, 422.633, and 422.634.

20. **Integrated Grievance** means a dispute or complaint that would be defined and covered, for Grievances filed by a Member in a non-applicable integrated plan, under 42 CFR section 422.564 or 42 CFR sections 438.400 through 438.416. Integrated Grievances do not include Appeals procedures and QIO complaints, as described in 42 CFR section 422.564(b) and (c). An Integrated Grievance made a Member in an Applicable Integrated Plan is subject to the Integrated Grievance procedures in 42 CFR sections 422.629 and 422.630.

21. **Integrated Organization Determination** means an organization determination that would otherwise be defined and covered, for a non-Applicable Integrated Plan, as an organization determination under 42 CFR section 422.566, an adverse benefit determination under 42 CFR section 438.400(b), or an action under 42 CFR 431.201. An Integrated Organization Determination is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Organization

Determination procedures in 42 CFR sections 422.629, 422.631, and 422.634.

22. **Medi-Cal Managed Care Health Plan (MCP)** means a managed care health plan that contracts with DHCS for provision or arrangement of Medi-Cal benefits and services. For the purposes of this Contract, this includes Subcontracted Delegate Health Plans. A Subcontracted Delegate Health Plan is a health care service plan that is a subcontractor of a MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Dual Eligible Beneficiary that are covered under the applicable comprehensive risk contract of the MCP.

23. **Medi-Cal Fee-For-Service (FFS)** means the Med-Cal delivery system in which providers submit claims to and receive payments from DHCS for services covered under Medi-Cal and rendered to Medi-Cal recipients.

24. **Medi-Cal Services** means all services covered by the Medi-Cal program as identified in Exhibit H, which is attached to this Contract.

25. **Medically Necessary or Medical Necessity** means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and Title 22 CCR section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

26. **Member** means any Dual-Eligible Beneficiary who is enrolled in with D-SNP Contractor.

27. **Service Area** means the county or counties that D-SNP Contractor is approved to operate in under the terms of this D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D-SNP Contract.

28. **State** means the State of California.

29. **Supplemental Benefits** means all of the following under Medicare Advantage definitions: Initial and Expansion Primarily Health Related Supplemental Benefits, Special Supplemental Benefits for the Chronically Ill, and Value Based-Insurance Design Model benefits.

Exhibit E, Attachment 1
DEFINITIONS

30. **Subcontracted Delegate Health Plan** means a health care service plan that is a subcontractor of a Medi-Cal MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Member that is covered under the applicable comprehensive risk contract of the MCP.

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

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, Provision 14, Governing Law, D-SNP Contractor also agrees to the following:

A. If it is necessary to interpret this D-SNP Contract, all applicable laws may be used as aids in interpreting the D-SNP Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or D-SNP Contractor, unless such applicable laws are expressly incorporated into this D-SNP Contract in some section other than this provision, Governing Law. The parties agree that any remedies for DHCS' or D-SNP Contractor's non-compliance with laws not expressly incorporated into this D-SNP Contract, or any covenants implied to be part of this D-SNP Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This D-SNP Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this D-SNP Contract, both parties shall be deemed authors of this D-SNP Contract.

Any provision of this D-SNP Contract which is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the D-SNP Contract will be effective on the effective date of the statutes or regulations necessitating it and binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

B. Such amendment will constitute grounds for termination of this D-SNP Contract in accordance with the procedures and provisions of Provision 18, Paragraph C, Termination – D-SNP Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. All existing policy guidance issued by DHCS, including the D-SNP Policy Guide, can be viewed at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx and shall be complied with by D-SNP Contractor. All policy guidance issued by DHCS subsequent to the effective date of this D-SNP Contract must provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-

SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and DHCS policy guidance, the D-SNP Contract shall prevail.

2. Entire Agreement

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

3. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, D-SNP Contractor also agrees to the following:

Should either party, during the life of this D-SNP Contract, desire a change in this D-SNP Contract, that change shall be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change has the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this D-SNP Contract which would provide for the change. If the proposal is accepted, this D-SNP Contract will be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this D-SNP Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the D-SNP Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. D-SNP Contractor's Obligation to Implement

The D-SNP Contractor must make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, federal or State guidelines, or judicial interpretation, DHCS may direct the D-SNP Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the D-SNP Contractor must implement the required changes while discussions are taking place. DHCS may, at any time, within the general scope of the D-SNP Contract, by written notice, issue change orders to the D-SNP Contract.

5. Delegation of Authority

DHCS intends to implement this D-SNP Contract through a single administrator, called the "Contracting Officer." The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this D-SNP Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the D-SNP Contractor.

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative." The Contractor's Representative, on behalf of the D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of the D-SNP Contract, Federal and State laws and regulations. The Contractor's Representative may delegate their authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 13, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered services under the Medi-Cal program administered in this D-SNP Contract or coverage for such services, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Program resides with DHCS. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

The D-SNP Contractor may not make any limitations, exclusions, or changes in covered services; any changes in definition or interpretation of covered services; or any changes in the administration of the D-SNP Contract related to the scope of covered services, allowable coverage for those covered services, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Assignments or Delegation of D-SNP Contractor's Duties and Obligations Under this D-SNP Contract

The D-SNP Contractor must not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 17.

9. Prohibition Against Novations

D-SNP Contractor must not enter any novation agreements without prior discussion with DHCS.

10. Obtaining DHCS Approval

D-SNP Contractor must obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS must acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

B. Within 60 calendar days of receipt, DHCS must make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision must not be construed to imply DHCS approval of any material that has not received written DHCS approval.

11. Program

DHCS reserves the right to review and approve any changes to D-SNP Contractor's protocols, policies, and procedures as specified in this D-SNP Contract.

12. Certifications

D-SNP Contractor must comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, Provision 11, Certification Clauses, D-SNP Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this D-SNP Contract, the Contractor's Representative or their designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

13. Notices

All notices to be given under this D-SNP Contract will be in writing and will be deemed given when sent via certified mail or electronic mail (email). DHCS and D-SNP Contractor will designate email addresses for notices sent via email. Notices sent via certified mail must be addressed to the

following DHCS and D-SNP Contractor contacts:

California Department of Health Care Services	Local Initiative Health Authority for LA County
Managed Care Operations Division Attn: Michelle Retke, Division Chief MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	Attn:John Baackes, CEO 1200 West 7th Street Los Angeles, CA, 90017

14. Term

The D-SNP Contract is effective January 1, 2025, and continues in full force and effect through December 31, 2025.

15. Service Area

The Service Area covered under this D-SNP Contract is stated in Exhibit A, Provision 8, Coverage Area and Eligible Beneficiaries. All D-SNP Contract provisions apply separately to each county within the Service Area.

16. D-SNP Contract Extension

DHCS has the exclusive option to extend the term of this D-SNP Contract for any reason, in any county within the Service Area, with at least nine (9) months' written notice to D-SNP Contractor before the end of the D-SNP Contract term.

17. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7, Termination for Cause, D-SNP Contractor also agrees to the following:

A. DHCS-Initiated Terminations

1) DHCS will terminate this D-SNP Contract in the event that the Director determines that the health and welfare of Members is jeopardized by the continuation of the D-SNP Contract. Termination pursuant to the requirements in this Provision's Paragraph A.1) will be effective immediately upon the provision of written notice provided by DHCS to D-SNP Contractor.

2) Termination for Cause

a) DHCS may terminate this D-SNP Contract should D-SNP Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this D-SNP Contract in any manner deemed proper by DHCS.

b) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under this D-SNP Contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

c) Should DHCS terminate this D-SNP Contract for cause under this Provision's Paragraph A.2) of this D-SNP Contract, DHCS will provide D-SNP Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless potential beneficiary harm requires a shorter notice period. D-SNP Contractor agrees that this notice provision is reasonable.

d) DHCS must terminate this D-SNP Contract under this Provision and pursuant to the provisions of Welfare and Institutions Code, Section 14197.7, and California Code of Regulations, Title 22, Section 53873.

B. D-SNP Contractor-Initiated Terminations

D-SNP Contractor may only terminate this D-SNP Contract when a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the conditions under which the D-SNP Contractor entered into this D-SNP Contract, such that the D-SNP Contractor can demonstrate this to the satisfaction of DHCS.

C. Termination of Obligations

All obligations to provide services under this D-SNP Contract will

automatically terminate on the date the operations period ends.

18. Disputes

D-SNP Contractor must comply with and exhaust the requirements of this Provision when it initiates a contract dispute with DHCS. In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

A. Disputes Resolution by Negotiation

D-SNP Contractor agrees to make best efforts to resolve all contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). D-SNP Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

1) Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor must serve a written Notice of Dispute to the DHCS' Contracting Officer. D-SNP Contractor's failure to serve its Notice of Dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to D-SNP Contractor constitutes a waiver of all issues raised in D-SNP Contractor's Notice of Dispute.

2) The D-SNP Contractor's Notice of Dispute must include, based on the most accurate and substantiating information then available to the D-SNP Contractor, the following:

a) That it is a dispute subject to the procedures set forth in this Provision.

b) The date, nature, and circumstances of the conduct which is subject of the dispute.

c) The names, phone numbers, functions, and conduct of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the alleged issue that is the subject of the dispute.

d) The identification of any substantiating documents and the substances of any oral communications that are relevant to the alleged conduct. Copies of all identified documents will be attached.

e) Copies of all substantiating documentation and any other evidence.

f) The factual and legal bases supporting Contractor's Notice of Dispute.

g) The cost impact to D-SNP Contractor directly attributable to the alleged conduct, if any.

h) D-SNP Contractor's desired remedy.

3) The required documentation set forth above, in this Provision's Paragraph B.2), will serve as the basis for any subsequent appeal.

4) After D-SNP Contractor submits its Notice of Dispute with all accurate available substantiating documentation, D-SNP Contractor must comply with the requirements of Title 22, CCR, Section 53851(d) and must diligently continue performance of this D-SNP Contract, including compliance with contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute.

5) If D-SNP Contractor requests and DHCS agrees, D-SNP Contractor's Notice of Dispute may be decided by an Alternate Dispute Officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted D-SNP Contractor's Notice of Dispute.

6) Any appeal of the DHCS Contracting Officer or ADO's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court shall be limited to the issues and arguments set forth and properly documented in D-

SNP Contractor's Notice of Dispute, that were not waived or resolved.

C. The DHCS Contracting Officer's or ADO's Decision

Any disputes concerning performance of this D-SNP Contract will be decided by the DHCS Contracting Officer or the ADO in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notice of Dispute, the Contracting Officer or the ADO shall either:

1) Find in favor of D-SNP Contractor, in which case the DHCS Contracting Officer or ADO may correct the earlier conduct which caused D-SNP Contractor to file a dispute; or

2) Deny D-SNP Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under Paragraphs B.2) or C.1) above. If the DHCS Contracting Officer or ADO determines that additional substantiating information is required, they will provide D-SNP Contractor with a written request identifying the issue(s) requiring additional substantiating documentation. D-SNP Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request. Upon receipt of this additional requested substantiating information, the DHCS Contracting Officer or ADO shall have 30 calendar days to issue a decision. Failure to supply additional substantiating information requested by the DHCS Contracting Officer or ADO, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within the time period specified above shall constitutes D-SNP Contractor's waiver of issues raised in D-SNP Contractor's Notice of Dispute.

A copy of the decision shall be served on D-SNP Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

1) D-SNP Contractor will have 30 calendar days following the receipt of the DHCS Contracting Officer or ADO's decision to

appeal the decision to the Director, through the OAHA. All of D-SNP Contractor's appeals are governed by Health and Safety Code, section 100171, except Government Code section 11511 will not apply.

2) All of D-SNP Contractor's appeals must be in writing and be filed with the OAHA and a copy sent to the Chief Counsel of DHCS and the DHCS Contract Manager. D-SNP Contactor's appeal shall be deemed filed on the date it is received by the OAHA. D-SNP Contractor's appeal will be known as Statement of Disputed Issues and must specifically set forth the unresolved issue(s) that remain in dispute and issues that have not been waived because of D-SNP Contractor's failure to provide all substantiating documentation to DHCS, as specified in Paragraph C of this Provision, and include D-SNP Contractor's contentions as to those issues. Additionally, D- SNP Contractor's appeal will be limited to those issues raised in its Notice of Dispute filed pursuant to Paragraph B, Notification of Dispute that have not been resolved or waived.

3) D-SNP Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) D-SNP Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the Notice of Dispute that were not waived by the untimely filing of the Notice of Dispute or Statement of Disputed Issues, by D-SNP's Contractor's failure to provide all requested substantiating documentation requested by the DHCS Contracting Officer or ADO, or by D-SNP's Contractor failure to notify the DHCS Contracting Officer or ADO that no additional documents exist within the required timeframe as required in Paragraph C(3), or otherwise resolved by D-SNP Contractor and DHCS.

E. No Obligation to Pay Interest

If D-SNP Contractor prevails on its Notice of Dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by the Sacramento County Superior Court or any California court of appeal, DHCS will not be required to pay interest on any amounts found to be due or owing to D-SNP Contractor arising out of the Notice of Dispute or any subsequent litigation.

F. D-SNP Contractor Duty to Perform

D-SNP Contractor must comply with all requirements of 22 CCR section 53851(d) and continue to perform all obligations under this D-SNP Contract, including continuing D-SNP Contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court or any California Court of Appeal or the California Supreme Court.

G. Waiver of Claims

D-SNP Contractor waives all claims or issues if it fails to timely submit a Notice of Dispute with all substantiating documents within the timeframes set forth in Paragraph B of this Provision. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days at the DHCS Contracting Officer or ADO's request, or if it fails to notify the DHCS Contracting Officer or ADO, within 30 calendar days of DHCS Contracting Officer's or ADO's request, that no additional documents exist. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely appeal the DHCS Contracting Officer or ADO's decision in the manner and within the time specified in this Provision 18. D-SNP Contractor's waiver includes all damages whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, Provision 4, Audit, D-SNP Contractor agrees to the following:

The D-SNP Contractor must maintain such books and records necessary to disclose how the D-SNP Contractor discharged its obligations under

this D- SNP Contract. These books and records will disclose the quantity of Covered Services provided under this D-SNP Contract, the quality of those services, the manner for those services, the persons eligible to receive Covered Services, and the manner in which the Contractor administered its daily business.

A. Books and Records

These books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this D- SNP Contract including working papers; reports submitted to DHCS; all medical records, medical charts and prescription files; and other documentation pertaining to Covered Services rendered to Members.

B. Records Retention

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

20. Inspection Rights

In addition to Exhibit D(F), Provision 8, Site Inspection, D-SNP Contractor also agrees to the following:

A. Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor must allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this

D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers, or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies have the right to monitor all aspects of the D-SNP Contractor's operation for compliance with the provisions of this D-SNP Contract and applicable federal and State laws and regulations. Such monitoring activities include, but are not limited to, inspection and auditing of D-SNP Contractor and provider management systems and procedures, and books and records as the Director deems appropriate, at any time during the D-SNP Contractor's normal business hours. The monitoring activities may be announced or unannounced.

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 13, Confidentiality of Information, D-SNP Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this D-SNP Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder. For the purpose of this D-SNP Contract, all information, records, data, and data elements collected and maintained for the operation of the D-SNP Contract and pertaining to Members shall be protected by the D-SNP Contractor from unauthorized disclosure.

D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for medical records made in accordance with applicable law. Exhibit G is hereby incorporated into this Contract by reference.

B. With respect to any identifiable information concerning a Member under this D-SNP Contract that is obtained by the D-SNP Contractor, the D-SNP Contractor:

1) Will not use any such information for any purpose other than carrying out the express terms of this D-SNP Contract;

2) Will promptly transmit to DHCS all requests for disclosure of such information, except requests for medical records in accordance with applicable law;

3) Will not disclose, except as otherwise specifically permitted by this D-SNP Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder; and

4) Will, at the termination of this D-SNP Contract, return all such information to DHCS or maintain such information according to written procedures sent to the D-SNP Contractor by DHCS for this purpose.

22. Third-Party Tort and Workers' Compensation Liability

D-SNP Contractor must identify and notify DHCS' Third Party Liability and Recovery Division of all instances or cases in which D-SNP Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, D-SNP Contractor shall make no claim for recovery of the value of case management rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability and Recovery Division within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, D-SNP Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of reports for Covered Services to an individual Member, D-SNP Contractor must deliver the requested information within 30 calendar days of the request.

B. Information to be delivered must contain the following data items:

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Diagnosis code and description of illness/injury (if known).

6) Procedure code and/or description of services rendered (if known).

C. D-SNP Contractor must identify to DHCS' Third Party Liability and Recovery Division the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor must refer the request to the Third Party Liability and Recovery Division with the information contained in Paragraph B above, and provide the name, address and telephone number of the requesting party.

E. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding D-SNP Contractor's service and utilization information, and paid invoices and claims submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the secure file transfer protocol folders.

23. Records Related To Recovery for Litigation

A. Upon request by DHCS, D-SNP Contractor must timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful

privileges, in D-SNP Contractor's possession, relating to threatened or pending litigation by or against DHCS.

B. If D-SNP Contractor asserts that any requested documents are covered by a privilege, D-SNP Contractor must:

1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) State the privilege being claimed that supports withholding production of the document.

C. Such a request must include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. D-SNP Contractor acknowledges that time may be of the essence in responding to such request. D-SNP Contractor must use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by D-SNP Contractor related to this D-SNP Contract.

24. Equal Opportunity Employer

D-SNP Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the D-SNP Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the D-SNP Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor must not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor’s D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information marital status, gender, gender identity, marital status, gender, gender

identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with the statutes identified in Exhibit E, Attachment 2, Provision 26 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination includes, but is not limited to, the following:

1) Denying any Member case any Covered Services;

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

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

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability;

7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and potential enrollees.

8) D-SNP Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

9) For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related to Health Status

D-SNP Contractor must not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during Enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the Enrollment of an eligible individual based on an adverse change in the Member's health.

26. Federal and State Nondiscrimination Requirements

D-SNP Contractor must comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. D-SNP Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

27. Discrimination Grievances

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

D-SNP Contractor must process a grievance for discrimination as required by APL 21-004 or subsequent iterations, and in accordance with federal and State nondiscrimination law as stated in 45 CFR section 84.7; 34 CFR section 106.8; 28 CFR section 35.107; and W&I Code section 14029.91(e)(4).

A. D-SNP Contractor must designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. D-SNP Contractor must adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor will not require a Member or potential enrollee to file a discrimination grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor must submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

    1) The original discrimination grievance;

    2) The provider's or other accused party's response to the discrimination grievance;

    3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on behalf of D-SNP Contractor;

    4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

    5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the

discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

28. Nondiscrimination Notice and Language Taglines

A. D-SNP Contractor must post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in a conspicuously visible font size in English, the threshold languages, and at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted in the Member Services Guide/Evidence of Coverage, and in all Member information, informational notices, and materials critical to obtaining services targeted to Members, potential Members, applicants, and members of the public, in accordance with APL 21-004 and APL 22-002 or subsequent iterations, 42 CFR section 438.10(d)(2)-(3), and W&I Code section 14029.91(f) and 14029.92(c).

B. D-SNP Contractor's nondiscrimination notice must include all information required by W&I Code section 14029.91(e) and APL 21-004 or subsequent iterations, any additional information required by DHCS, and must provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation or identification with any other persons or groups defined in Penal Code 422.56. (W&I Code section 14029.91(e); H&S Code section 11135; and

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (W&I Code section 14029.91(e)).

29. Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements

A. D-SNP Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract Code section 10230.

B. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve small business participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract report to DHCS the actual percentage of small business participation that was achieved per Government Code section 14841.

C. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve DVBE participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract certify in a report to DHCS the following:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved, per Mil. & Vets. Code section 999.5(d), and Government Code section 14841.

30. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers is deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may"

is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

31. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor must comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor must demonstrate compliance with this provision, which may include providing DHCS with copies of D-SNP Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. D-SNP Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

   7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

   8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

      8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

      8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

   8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

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18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

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BUSINESS ASSOCIATE ADDENDUM

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, D-SNP Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

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DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work Exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. **Responsibility of DHCS.** DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. **Audits, Inspection and Enforcement**

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. **Termination**

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

January 1, 2022 – December 31, 2026[i]
Updated May 22, 2024

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	**X**	
Audiological Services	Audiology Services	Audiological services are covered when provided by persons who meet the appropriate requirements	**X**	
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan.	**X**[ii]	
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
California Children Services (CCS)	EPSDT	California Children Services (CCS) are services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.	X[iii]	
Certified Family Nurse Practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioner who provides services within the scope of their practice.	X	
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	EPSDT	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 15 µg/dL, or two BLLs equal to or greater than 10 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services are limited to treatment of the spine by means of manual manipulation.	X[iv]	
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The “cleaned” blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Community Health Workers	Preventive Services	Preventive services by unlicensed community health workers, promotores, and community health representatives to prevent disease, disability, and other health conditions or their progression.	X[v]	
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided during pregnancy and up to 12 months following the last day of pregnancy.	X	
Dental Services (Covered under Medi-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws, and associated structures; the use of drugs administered in-office, anesthetics, and physical evaluation; consultations; home, office, and institutional calls.	X[vi]	
Dyadic Services		Integrated physical and behavioral health screening and services for child, caregiver, and family.	X[5]	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Doula Services		Personal support by unlicensed providers to pregnant beneficiaries and their families throughout pregnancy, labor, and in the post-partum period.	X[5]	
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	EPSDT	Medicaid program's benefit for children and adolescents, providing a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.	X	
Erectile and/or Sexual Dysfunction Drugs		Drugs for which the only FDA-approved indication is the treatment of sexual dysfunction or erectile dysfunction are not a benefit of the program. Drugs that are FDA-approved for the treatment of sexual dysfunction or erectile dysfunction in addition to one or more other indications, are a benefit only if the drug has is used for a FDA-approved indication outside of the treatment of sexual dysfunction or erectile dysfunction.		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Expanded Alpha-Fetoprotein Testing (Administered by Genetic Disease Branch of CDPH)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.		X
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the valid prescription of a physician or optometrist.	X[vii]	
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	Services described in 42 U.S.C. Section 1396d(a)(2)(C) furnished by an entity defined in 42 U.S.C. Section 1396d(l)(2)(B)).	X	
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		performed by or under the supervision of the above physician or by a licensed audiologist.		
1915(c) Home and Community- Based Waiver Services (Does not include EPSDT Services)		Provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.		X
Home Health Agency Services	Home Health Services- Home Health Agency	Covered as specified below when prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	
Home Health Aide Services	Home Health Services- Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Home Health Pharmacy Services-Total Parenteral and Enteral Nutrition under Medi-Cal Rx.	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed by a pharmacy on a pharmacy claim, including formula, pumps, tubing, and general sub-categories, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		**X**
Home Health Other Pharmacy Services-Total Parenteral and Enteral Nutrition	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed on medical and institutional claims as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL2	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		0-020.pdf).		
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation, and minor treatment.	X	
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual		X

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	X	
Indian Health Services (Medi- Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services,	X	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.		
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner.	X[viii]	
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	When provided by a licensed midwife, the following are covered Medi-Cal services: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		appropriate to age and health status, consisting of non- classroom health education and anticipatory guidance based on age and developmentally appropriate health education.		
Long Term Care (LTC) Facility Services		Medically necessary care in a LTC facility or setting, including the following: • Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital; • Intermediate Care Facility (ICF); • Intermediate Care Facility for Developmentally Disabled (ICF/DD); • Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH); • Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN); • Subacute facility; • Pediatric Subacute Facility.	*Prior to 1/1/2023:* **X**[ix,x,xi] *After 1/1/2023 for SNF (in all counties):* **X** *After 1/1/2024 for ICF/DD, ICF/DDH, ICF/DDN, Subacute, and Pediatric Subacute*: **X**	**X**[15]
Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries includes: counseling services and behavioral therapy related to the drugs and biologicals covered under the		**X**

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		SUPPORT Act.		
Medical Supplies	Medical Supplies	Supplies are medically necessary when prescribed by a licensed practitioner. Does not include medical supplies carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including medical supplies described in the Medi-Cal Rx All Plan Letter (ALP 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Medical & Non-Medical (NMT) Transportation Services	Transportation - Medical & Non-Medical Transportation (NMT) Services	Covers ambulance, litter van and wheelchair van medical transportation services when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. NMT is transportation by private or public vehicle for beneficiaries who do not have another way to get to their appointment.	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses.	X	
Organ and Bone Marrow Transplant Surgeries	Transplant	Medically necessary donor and recipient organ and bone marrow transplant surgeries for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Preventive mental health services for potential mental health disorders not yet diagnosed • Behavioral health screenings and interventions • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements	X[xii]	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		• Mental health services for beneficiaries 21 years and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders • Mental health services for beneficiaries under age 21 regardless of level of distress or impairment or the presence of a diagnosis, unless the recipient meets the criteria for Specialty Mental Health Services		
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in- home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover various medications and treatments, allowing for day-to-day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.		X
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.		X
Personal Care Services	Personal Care Services	Services for categorically needy beneficiaries with a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. Benefit known as In Home Supportive Services (IHSS).	X[14]	X[14]

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Pharmaceutical Services and Prescribed Drugs under Medi-Cal Rx	Pharmaceutical Services and Prescribed Drugs	Pharmacy benefits carved-out to Medi-Cal Rx, which are pharmacy benefits that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		**X**
Other Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers Pharmacy benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Pharmacist Services	Pharmacist Services	Pharmacists in a community pharmacy setting furnishing specified categories of drugs (furnishing of naloxone, self-administered hormonal contraceptives, nicotine replacement therapy, HIV pre-exposure and post-exposure prophylaxis, and initiating and administrating	**X**	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		immunizations).		
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	X	
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Medically necessary Office visits are covered. All other outpatient services are subject to the same prior authorization procedures that govern physicians, and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X	
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	
Physical Therapy and Occupational Therapy	Physical Therapy and Occupational Therapy	Physical therapy and occupational therapy are covered when provided by persons who meet the appropriate requirements	X	
Private Duty Nursing	EPSDT	Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse for individuals under 21 years of age.	X[2]	
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation on an outpatient basis. The center may offer occupational therapy, physical therapy, vocational training, and special training.	X	
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	
Respiratory Care	Physician	A provider trained and licensed for respiratory	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Services	Services	care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.		
Rural Health Clinic Services	Rural Health Clinic Services	Services described in 42 U.S.C. Section 1396d(a)(2)(B) furnished by a rural health clinic as defined in 42 U.S.C. Section 1396d(l)(1).	**X**	
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	**X**	
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.		**X**
Specialty Mental Health Services		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.		**X**[xiii]

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services are covered. Such service must include the medically necessary continuation of treatment services initiated in the hospital or short-term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self- care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[9]	
Speech Pathology	Speech Pathology	Services are covered when provided by persons who meet the appropriate requirements.	X	
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	
Targeted Case Management Services (provided by Local Governmental Agencies)	Targeted Case Management	Persons who are eligible to receive targeted case management services must consist of the following Medi-Cal beneficiary groups: (1) high risk children under the age of 21, (2) medically fragile individuals; (3) children with an Individualized Education Plan or Individualized Family Service Plan; (4) individuals at risk of institutionalization; (5) individuals in jeopardy of		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		negative health or psycho-social outcomes; and (6) individuals with a communicable disease. Targeted case management services must include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.		

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focuses on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	
Tuberculosis (TB) Related Services (Provided by the Local County Health Departments)	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.		X

[i] Coverage and reimbursement of COVID-19 vaccines and administration are carved out of Medi-Cal managed care for all eligible populations and are exclusively covered and reimbursed through the State's fee-for-service delivery system by all applicable providers.
[ii] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT requirements.
[iii] California Children Services (CCS) covered in COHS counties with the exception of Ventura County (Gold Coast Health Plan). CCS not covered in Non-COHS counties and Ventura County.
[iv] Chiropractic coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; 5) beneficiaries enrolled in the PACE; 6) beneficiaries who receive services at an FQHC or RHC; and 7) beneficiaries in hospital outpatient settings. Chiropractic services are not available at Indian Health Clinics except for those in the exempt groups.
[v] Coverage of benefit subject to federal approval in the Medi-Cal State Plan.
[vi] Dental services are carved in to managed care for Health Plan of San Mateo.
[vii] The fabrication of eyeglasses lenses are carved out statewide to FFS Medi-Cal contracted optical laboratories, with the exception of specialty

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

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lenses (including lenses that exceed contract lab ranges), which remain the responsibility of the managed care plan.
[viii] Coverage and reimbursement of COVID-19 testing in school settings, to be carved out of managed care, covered and reimbursed through the state's Fee For Service delivery system.
[ix] Only covered for the month of admission and the following month in Non-COHS. Services covered in COHS.
[x] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. IHSS benefits are not part of this covered service.
[xi] ICF-DD residents are exempt from managed care plan enrollment in Coordinated Care Initiative Counties.
[xii] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.
[xiii] Kaiser members in Solano and Sacramento counties carved into managed care until 7/1/2023.
[14] Personal care services benefit carved-in to SCAN Connections and SCAN Connections at Home, and members of those plans are not eligible for In Home Supportive Services (IHSS). For all other plans, the IHSS personal care services benefit is carved-out of Medi-Cal managed care and is administered and authorized by county agencies.
[15] Intermediate Care Facility for Developmentally Disabled (ICF/DD) – Continuous Nursing Care (ICF/DD-CN) Homes are not subject to the LTC Carve-In Policy

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT - AMENDMENT

SCO ID:

STD 213A (Rev. 4/2020)

☒ CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED 102 PAGES

AGREEMENT NUMBER	AMENDMENT NUMBER	Purchasing Authority Number
22-20236	A04	

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

CONTRACTING AGENCY NAME
Department of Health Care Services

CONTRACTOR NAME
Local Initiative Health Authority for LA County

2. The term of this Agreement is:

START DATE
January 1, 2023

THROUGH END DATE
December 31, 2025

3. The maximum amount of this Agreement after this Amendment is:
Budget Act Line Items 4260-601-0912 and 4260-601-0555

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. Amendment effective date: December 31, 2024 or until approved by DGS (if DGS approval is needed).

II. Purpose of amendment: It extends the contract term to December 31, 2025. DHCS is obtaining a continuation of the services identified in the original agreement.

III. Paragraph 2 (term) on the face of the original STD 213 is amended to read: January 1, 2023 through December 31, 2025. All references to the former contract term of January 1, 2023 through December 31, 2024 in any exhibit incorporated into this agreement are hereinafter deemed to read January 1, 2023 through December 31, 2025.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
Local Initiative Health Authority for LA County

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
1055 West 7th Street	Los Angeles	CA	90017

PRINTED NAME OF PERSON SIGNING	TITLE
John Baackes	Chief Executive Officer

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT - AMENDMENT

STD 213A (Rev. 4/2020)

SCO ID:

CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED ____ PAGES	AGREEMENT NUMBER	AMENDMENT NUMBER	Purchasing Authority Number
	22-20236	A04	

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME			
Department of Health Care Services			
CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
1501 Capitol Avenue, MS 4415, P.O. Box 997413	Sacramento	CA	95899
PRINTED NAME OF PERSON SIGNING	TITLE		
Michelle Retke	Chief, Managed Care Operations Division		
CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED		
CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)		
	Welfare & Institutions Code section 14087.55(c)		

Board of Governors
MOTION SUMMARY

Date: June 26, 2024 **Motion No. EXE A.0624**

Committee: Executive Committee **Chairperson:** Alvaro Ballesteros, MBA

Issue: Revisions to the Operating Rules for the Consumer Advisory Committees of L.A. Care Health Plan.

Background: A proposal to make certain revisions to the Operating Rules for the Consumer Advisory Committees (CAC) was presented at the June 12, 2024 Temporary Transitional Executive Community Advisory Committee (TTECAC) meeting. The members of the TTECAC endorsed the revisions to the Operating Rules that covered changes to CAC operations previously approved by the TTECAC at its meeting of May 12, 2024. The most substantive revisions to the Operating Rules are summarized below:

1. Section II – Function and Role – Additional subject areas added to align with new language in L.A. Care's contract with the Department of Health Care Services (DHCS) to provide Medi-Cal services.
2. Section III – Membership, Paragraph A – Selection Committee – A new section added describing the structure and role of a new CAC Member Selection Committee. The section also adds language referring to the submission of an Annual CAC Membership Demographic report by April 1 of each year.
3. Section III – Membership, Paragraph F – CAC Member Term – Language added describing term limits for CAC members (a maximum of two, four-year terms) and the setting of a target membership of 25 members for each CAC.
4. Section III – Membership, Paragraph H – Replacement of Members – Language added to specify that L.A. Care intends to replace CAC members who resign or are removed within 60 days.
5. Section VII – CAC Meetings, Paragraph D - Additional Meeting Guidelines – Additional language referring to posting of CAC meeting summaries, the deadline for submission of meeting summaries to DHCS and the length of the meeting summary record retention period.

At its meeting of June 12, 2024, the TTECAC requested an additional revision to the Operating Rules:

1. Section V – Role and Term of ECAC Leadership – Sections A and B – In subparagraph e in each section, the TTECAC has requested that only unexcused absences be considered when determining if an ECAC Chairperson or Vice-Chairperson is considered to have resigned from their position due to missed meetings. In addition, the TTECAC asked that language that staff would consider each situation of this type on a case-by-case basis be added.

Staff is in agreement with these additional revisions to the Operating Rules.

Other non-substantive edits to the Operating Rules to remove mention of the CCI Council CAC that no longer exists and several minor corrections are also noted.

Member Impact: The approval of the proposed revisions to the Operating Rules will document changes to operationalize new requirements for CACs in L.A. Care's contract with DHCS.

Budget Impact: None

Motion: **To authorize the Executive Committee of the Board of Governors to approve revisions to the Operating Rules for the Consumer Advisory Committees of L.A. Care Health Plan as presented during the June 12, 2024 meeting of the Temporary Transitional Executive Community Advisory Committee.**

OPERATING RULES FOR THE
CONSUMER ADVISORY COMMITTEES
OF L.A. CARE HEALTH PLAN

~~*(Revised on February 8, 2018 through Motion ECA 102.0218, with effective date of April 5, 2018)*~~

I. Authority and Purpose

The Consumer Advisory Committees (CACs), which include the Executive Community Advisory Committee (ECAC) and the Regional Community Advisory Committees (RCACs) ~~and the Coordinated Care Initiative Councils (CCI Councils)~~(collectively referred to as Consumer Advisory Committees or CACs) of L.A. Care Health Plan (L.A. Care) were established to ensure community involvement in implementation of Medi-Cal managed care in Los Angeles County, as mandated by California Welfare and Institutions Code §14087.966, and as clarified in the Medi-Cal Managed Care Division Policy Letter 99-01 of April 2, 1999 from the California State Department of Health Services, *et seq*. Rules for the CACs are subject to the Bylaws of the Board of Governors of L.A. Care.

The purposes of the Consumer Advisory Committees are to:

1. Provide a vehicle for L.A. Care's member population to be represented in its actual geographic, ethnic, linguistic and disability diversity, with a special focus on those who are monolingual and/or disabled;
2. Provide advice and guidance to the Board of Governors and management regarding the direction, approach and response of L.A. Care to regional and cultural issues that have implications on member satisfaction, new product lines, health promotion and education efforts, marketing, and outreach;
3. Inform and empower L.A. Care members to become advocates for themselves and their communities through leadership in responding to pertinent issues raised among members and in the community by partnering with L.A. Care to implement CAC-initiated projects, policy initiatives, programs supporting L.A. Care strategic health initiatives and legislative campaigns;
4. Provide information on regional community health issues that impact large numbers of L.A. Care members or the community at large to the Board of Governors through the Executive Community Advisory Committee, (ECAC), where joint planning and development of policy recommendations for the Board of Governors should occur, and
5. Create, promote and sustain positive and cooperative relationships among health plan members, providers, and advocates who serve the L.A. Care population.

II. Function and Role

CACs shall serve in an advisory capacity and may be given opportunities by the Board of Governors and/or the management of L.A. Care to have input into and evaluate the operation of Medi-Cal managed care and other L.A. Care product lines in Los Angeles County. CAC input is considered in annual reviews and updates to relevant policies and procedures including that which is relevant to those affecting quality of services and health equity. Areas where community and especially L.A. Care member input may be requested include:

- Improving member satisfaction with L.A. Care's provision of services;
- Improving access to care;
- Ensuring the provision of culturally and linguistically appropriate services and programs including those related to Quality Improvement education and operational and cultural competency issue affecting groups who speak a primary language other than English;
- Identifying emerging needs in the community and establish programmatic responses; Member or provider targeted services, programs or trainings;
- Population Needs Assessments (PNA) findings with an emphasis on Health Equity and Social Drivers of Health
- Determining and prioritize health education and outreach programs: and
- Addressing community health concerns collaboratively.
- Plan marketing materials and campaigns
- Needs for network development and assessment
- Community resources and information
- Population Health Management
- Health delivery systems reforms to improve health outcomes
- Carved out services
- Health equity

To ensure community involvement, L.A. Care staff from various departments and functions will periodically attend meetings of the CACs to create a meaningful and productive dialogue with CAC members and provide educational information. Such dialogues will seek feedback and input from the CAC members as well as input from the public in each region through the public comment portions of each CAC meeting. These will also serve as a feedback loop to regularly inform CAC members how their input has been incorporated by the health plan.

L.A. Care will also ensure sufficient resources are provided for the CAC to support the activities outlined above including support for additional CAC engagement opportunities such as roundtables, consumer listening sessions focus groups and/or surveys.

The CACs also have a responsibility to support the gathering of information about issues and concerns that are pertinent to the health and well-being of L.A. Care members in the region. This information will be used by the CACs, the ECAC, and L.A. Care staff to plan, implement, and evaluate activities to address identified concerns.

Each CAC brings together L.A. Care members, and in the case of the Regional Community Advisory Committees (RCACs) and ECAC, community-based member advocates and health care providers from the regions that have been approved to serve on a CAC by the Board of Governors. The committee format should assure equal participation by all CAC members as they discuss relevant health, managed care and access to care issues. The Chairperson of each CAC shall represent the region on the ECAC and shall carry issues between the CAC and ECAC.

When the ECAC reaches consensus on specific items appropriate for action by the Board of Governors, it shall make recommendations to the Board in the form of motions and report on its activities to the governing body, and shall be able to place matters on the governing body's agenda for consideration. In addition, the L.A. Care consumer members of the CACs are responsible for electing the Consumer Member and Member Advocate representatives to the L.A. Care Board of Governors.

Within a standard meeting framework for all CACs as described below, each CAC shall establish its meeting agenda. ECAC can place items on each CAC agenda if the ECAC determines that the issue needs to be addressed by all the CACs.

CAC activities are based on an annual work plan developed by the membership of each CAC and approved by L.A. Care management. The work plan identifies key projects, timelines, and evaluation measures. At the beginning of each fiscal year, ECAC will establish a common theme for each CACs' work plans.

III. Membership

Composition of the CAC and criteria for membership shall be approved by the Board of Governors of L.A. Care, and shall be in accordance with applicable law, regulations, and L.A. Care Bylaws. Initial selection of members for the restructured CAC as of January 1, 2024 shall be completed by the Selection

Committee within 60~~180~~ days of the effective date of the ~~latest health plan contract with DHCS for provision of Medi-Cal services or by June 30, 2024, whichever comes first~~revised Operating Rules for Consumer Advisory Committees of L.A. Care Health Plan.. L.A. Care will also complete an Annual CAC Membership Demographic Report and submit it to DHCS by April 1 of each year.

A. ~~A.~~ Selection Committee

a. L.A. Care will convene a CAC member selection committee of six (6) members tasked with selecting the members of the CAC. L.A. Care will demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC:

i. Three (3) L.A. Care Medi-Cal beneficiaries who are chairpersons of their respective Regional Community Advisory Committees (RCACs) and serve on the Executive Community Advisory Committee (ECAC); and

ii. Two (2) from community based organizations who are representatives within the L.A. Care Health Plan Service Area (the County of Los Angeles) adjusting for changes in membership diversity.

iii. L.A. Care Health Plan's Chief Health Equity Officer or designee.

b. The CAC Selection Committee must ensure the CAC membership reflects the general Medi-Cal Member population within the L.A. Care Service Area, including representatives from IHSS Providers, and adolescents and/or parents and/or caregivers of children, including foster youth, as appropriate and modified as the population changes to ensure that the L.A. Care member community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or servicing populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

~~A.~~B. CAC Membership Voluntary Status and Member Categories

All participants in the CACs serve on a voluntary basis, regardless of category. CAC membership is not a form of employment with L.A. Care, nor is any permanent relationship or right to serve implied or established by such membership.

1. RCAC Member Categories

a. Consumer Member

A "Member" as defined by these Rules is an L.A. Care member; or a parent, legal guardian or conservator of a L.A. Care member. L.A. Care membership is determined by reviewing L.A. Care's member records. Proof of legal guardian or conservator status will be requested, when applicable.

b. Provider

A "Provider" as defined by these Rules is a person or a representative of an entity contracted with either L.A. Care or its plan partners to offer health care services to L.A. Care members. L.A. Care's Provider Network Operations Department may assist in confirming a provider applicant's contractual status. Only p~~P~~roviders contracted with ~~both~~ L.A. Care ~~and Health Net~~ are permitted to serve as RCAC members in this category.

c. Member Advocate

A "Member Advocate" as defined by these Rules must comply with at least one of the following criteria:

i. A person who, while employed by a community-based organization[1], represents the interests and brings forward the issues and concerns of the population served by L.A. Care; or

ii. A volunteer of a community-based organization who is recommended by that organization as its representative to L.A. Care's CAC's. ~~CCI Councils~~

a. ~~All of the membership of the CCI Councils shall consist of consumer members enrolled in L.A. Care's Cal MediConnect Plan, or meet the criteria set by the California Department of Health Care Services for being a senior and/or a person with a disability and be receiving health insurance through L.A. Care.~~ A "consumer member" as defined by these Rules is an L.A. Care member; or a parent, legal guardian or conservator of a L.A. Care member. L.A. Care membership is determined by reviewing L.A. Care's member records. Proof of legal guardian or conservator status will be requested, when applicable.

~~B~~. Committee Composition

A person can only be a member of one L.A. Care Consumer Advisory Committee at any given time. ~~As such, a person cannot be a RCAC member and a CCI Council member at the same time.~~ If a person is eligible for more than one Consumer Advisory Committee, he or she must choose one Consumer Advisory Committee for application. If a person is eligible to represent both themselves

[1] *A "community-based organization" as defined by these Rules is a non-profit corporation, a public benefit agency or other public entity.*

and another individual, he or she must only choose one Consumer Advisory Committee for application.

RCACs

Each RCAC shall have at least eight and no more than 35 members with a target membership of ~~20~~25, and at least one-third of who shall be Members, as defined above.

One-third of the membership of each RCAC shall consist of Consumer Members; however, a RCAC may also include both Providers and Member Advocates in its membership. To maintain the one-third Member composition, new Provider or Member Advocate applicants may be placed on a waiting list and ranked according to the date their applications were verified. Waiting list applicants shall be added to the RCAC membership according to their ranking as new Provider or Members Advocates.

The membership of each RCAC may include up to one-third Provider members; however, a RCAC need not have any Provider members.

If a RCAC falls below the minimum membership of eight persons, the RCAC must shift its energies to recruitment to achieve the minimum number of members. The RCAC must refrain from implementing any Work Plan activities until the minimum membership number is met.

The RCACs' membership shall seek to be representative of ethnic, cultural, linguistic, age, sexual orientation, disability and special medical needs of the Member population in the designated region. Diversity is a desired goal for recruitment of Members to be approved by the Board of Governors and shall not dictate any specific membership approval decision.

~~CCI Councils~~

~~Each CCI Council shall have at least 5 members and no more than 11 members with a target membership of 10. Every Council should work to maintain its regular membership at a minimum of 8 members. If a CCI Council falls below the minimum membership of 5 persons, the CCI Council must shift its energies to recruitment to achieve the minimum number of members. The CCI Council must refrain from implementing any Work Plan activities, or selecting a chair or vice-chair, until the minimum membership number is met.~~

D~~C~~. Application for CAC Membership

Applications for CAC membership are accepted by the Community Outreach and Engagement (CO&E) Department ~~and the CCI Unit~~ at any time. A CAC candidate's application, and for RCACs category of eligibility (Consumer Member, Provider or Member Advocate, as applicable), shall be verified by L.A. Care staff. Applicants will be subject to an initial eligibility check and debarment check with the federal Office of the Inspector General (OIG) and the General Services Administration (GSA). If the submitted information cannot be verified or the applicant appears on the debarment list, the applicant shall not be eligible for consideration. Once the application has been verified by L.A. Care staff, ~~a sub-~~the Selection C~~c~~ommittee will be ~~established~~ convened to review the new CAC member application. ~~The sub-committee will consist of the Chair, Vice-Chair of the CAC for which member application is submitted and L.A. Care Staff.~~ The Selection ~~sub-C~~ommittee will schedule a meeting with the new applicant. If the new applicant does not ~~show up~~appear to the scheduled meeting this will automatically ~~forfeit~~ invalidate the applicant's application. Once the Selection ~~sub-C~~ommittee has met with the new applicant, if selected for membership, their application will be submitted to ECAC for review and consent to forward to the Board of Governors for approval.

Upon approval by the Board of Governors, a new Committee member will serve as a "Provisional" member for a period of six (6) months. Provisional members are not eligible to receive a meeting stipend until completion of the six (6) month but are able to receive reimbursements for eligible and approved transportation and ~~child care~~childcare expenses incurred to attend Committee meetings and other required activities as of the date of their approval as a Committee member. The stipend is not retroactive to time of Board of Governors membership approval. They are eligible to vote on Committee actions and recommendations but not to run for election as a Committee Chairperson or Vice-Chairperson. To achieve full Committee member status, the Provisional member must complete the following during the six (6) month provisional membership period:

1. Successfully complete a new member orientation within Ninety (90) days of approval of provisional membership
2. Attendance at one ECAC or BOG meeting
3. Attend all his or her regularly scheduled RCAC ~~or CCI Council~~ meetings and work plan activities.

At the end of the six (6) month provisional membership period, L.A. Care staff will evaluate the member's status and recommend full CAC membership or removal of the member based on a

failure to fulfill the provisional membership requirements. Staff may extend the member's provisional status in extenuating circumstance a maximum three (3) additional months.

Any applicant who disagrees with a decision concerning their application may appeal to CO&E ~~or CCI~~ Unit management, if the applicant disagrees with CO&E's decision the applicant may then appeal to the Governance Committee if applicant disagrees with the Governance Committee they may appeal within sixty (60) calendar days to the Executive Committee of the Board of Governors. The decision of the Executive Committee is final in all cases.

E~~D~~. Re-certification

CAC member re-certification by L.A. Care staff shall occur bi-monthly. The purpose of recertification shall be to confirm that CAC members remain eligible to continue participating in the CAC. Re-certification consists of confirming that the individual is receiving health care coverage under one of L.A. Care's product lines, or is a legal guardian or conservator of an individual receiving health care coverage under one of L.A. Care's product lines; and a monthly eligibility and debarment check with the federal Office of the Inspector General (OIG) and the General Services Administration (GSA). If the above cannot be verified or the individual appears on the debarment list, the individual's CAC membership will be terminated immediately.

F~~E~~. CAC Member Term

Since CAC member applications are received on an on-going basis, a CAC member's term of eligible service extends between the dates of his or her application until the next recertification period. Bi - monthly recertification checks and monthly eligibility and debarment checks with the federal Office of the Inspector General (OIG) and the General Services Administration (GSA) will be conducted throughout the member's term, including the initial provisional membership period.

Members will serve for an initial four-year period after which, the Selection Committee will review the member's suitability for continued membership for up to one additional four-year term. The maximum term of service for a CAC member is 8 years (two, 4-year terms). A Consumer Member's membership on a CAC will end if she/he loses eligibility for L.A. Care's benefits program. The Consumer Member may be removed within thirty (30) days from the date of loss of eligibility unless L.A. Care membership eligibility has been re-established and/or debarment by the federal OIG and/or GSA is rescinded. During the time the member is not eligible all of his or her CAC membership rights are suspended and he or she shall not receive a stipend for meeting attendance, nor will the stipend be provided retroactively once the member has re-establish his or her eligibility.

No more than two persons age eighteen (18) or older from the same household may serve on a CAC at the same time in the same region.

For RCACs only one Provider or Member Advocate member employed by or volunteering with a particular community based organization (CBO) or provider agency may serve on a given RCAC. In cases where the CBO or provider agency is supporting multiple programs or projects in a specific RCAC region or in multiple RCAC regions, an exception may be made to allow for more than one CBO or provider agency representative to participate in the RCAC(s).

For RCACs, Providers or Member Advocates must retain their respective eligibility status during their term on the RCAC. If the Provider or Member Advocate member is no longer associated with an L.A. Care provider or community based organization, a new representative must be assigned by the respective entity.

If a CAC Consumer Member moves to another region, he or she can become a member of the CAC of their new residence. The Consumer Member shall either be added to the new CAC's roster, or be placed on the waiting list if the new CAC's membership is at the target membership of twenty-five (25) ~~maximum of thirty-five (35)~~ for a RCAC with a maximum membership of thirty-five (35) ~~and eleven (11) for a CCI Council~~.

A Consumer Member's membership in a CAC, or any of the privileges associated with membership, is non-transferable. Each Member of the CAC is chosen, in part, for his or her unique ability to bring valuable input to the group's discussions, deliberations and decisions. Therefore, substitute representatives may not vote and may not participate in discussion, except as a member of the public.

New CAC members must complete a formal new member orientation as provided by L.A. Care staff within ninety (90) days of being approved as a CAC member by the Board of Governors. Such orientations may occur during regularly scheduled CAC meetings, or at other designated times and locations.

G~~F~~. Resignation and Removal

Resignation: A member may resign from the CAC upon giving written notice to the CAC Chairperson and/or the assigned CO&E ~~or CCI~~ Unit staff person. A resignation is effective immediately, unless stated otherwise in the letter of resignation.

Removal:

a. Absences

Consistent with the Consumer Advisory Committee Operating Rules, an absence is excused when a member notifies the CAC Chairperson or assigned CO&E or CCI Unit staff person of his or her impending absence prior to the meeting or event. Notice must be in the form of a written, verbal, telephonic or electronic communication and received no less than two business days prior to the scheduled meeting.

CAC members who have two absences (excused or unexcused) and one medically excused absence (with doctor's note) from CAC meetings, CAC work plan events, or other L.A. Care sponsored events in a fiscal year, will be considered having voluntarily resigned from the CAC, effective the date of the last meeting or event missed.

If a CAC member is deemed to have voluntarily resigned due to absences as described above, he or she will be ineligible to re-apply to the CAC for a period of one (1) calendar year from the loss of CAC membership. Members who leave the CAC because of personal reasons that are communicated to CO&E or CCI Unit staff are excluded from the one (1) calendar year ineligibility period. These members will be allowed to reapply and will follow the new member application process.

b. Non-Compliance with the Code of Conduct or CAC Member Standards of Behavior

A CAC member shall be removed from the CAC if the member substantially violates L.A. Care's Code of Conduct or the CAC Member Standards of Behavior. CAC members shall receive annual training on the Code of Conduct and Standards of Behavior and are required to sign an acknowledgement stating that the member has read and understood both the Code of Conduct and the CAC Member Standards of Behavior. Failure to sign the acknowledgement of receipt and understanding of the Code of Conduct and the CAC Member Standards of Behavior upon sixty (60) days of receipt may lead to termination of CAC membership.

The removal process shall consist of a petition from L.A. Care staff or a motion recommending removal "for cause" by a majority of CAC members, which will be reviewed by the Legal Services Department and forwarded to the Governance Committee of the Board of Governors for a disposition.

A member removed as a result of an action by the Governance Committee may appeal to the Executive Committee[2] of the Board of Governors, within 60 calendar days of the Governance Committee action, whose decision shall be final in all cases.

Any CAC member removed for substantial violation of the Code of Conduct or CAC Member Standards of Behavior shall be ineligible to reapply for CAC membership. The following, while not intended to be an exhaustive list are examples of the kind of conduct which are not permitted and which will subject any CAC member to termination from Consumer Advisory Committee membership:

- Unlawful sexual harassment or other unlawful harassment, whether verbal, physical or visual.
- Actual or threatened violence.
- Falsifying or making material omission on CAC applications, request for stipend and reimbursement forms.
- Misusing, destroying or damaging property belonging to L.A. Care, a L.A. Care employee, a member or visitor.
- Fighting on L.A. Care property or at L.A. Care sponsored events.
- Gross misconduct (including, but not limited to stealing, conflict of interest and other forms of misrepresentation)

No disciplinary or retaliatory actions will be taken against anyone who reports potential fraud or abuse in good faith.

H. Replacement of Members

L.A. Care will make its best effort to replace members who resign or are removed for any reason within 60 days of their departure from their CAC.

IV. Role and Term of CAC Chairperson and Vice-Chairperson

A. CAC Leadership

The elected leadership of each CAC shall be a Chairperson and a Vice-Chairperson. At any time, the CAC Chairperson and Vice-Chairperson may not be related by blood, marriage or belong to the same "household" as defined in the Consumer Advisory Member Handbook and Guidelines and Procedures.

[2] *Members serving jointly on the Executive and Governance Committee and who participated in the initial proceedings shall recuse themselves from consideration of a subsequent removal appeal.*

B. Duties of CAC Chairpersons

The Chairperson shall preside at all meetings of his or her CAC. In the absence of the Chairperson, the Vice-Chairperson shall preside.

In partnership with the assigned CO&E ~~or CCI~~ Unit staff person, the Chairperson shall develop CAC meeting agendas, moderate business meetings and other discussions, provide guidance and oversight for CAC work plan projects, maintain a respectful and productive environment during meetings for discussion, and ensure inclusion of all CAC members in CAC events and activities.

The Chairperson of each CAC shall be the official representative of that CAC to the ECAC. In the absence of the Chairperson, the CAC's Vice-Chairperson will represent the CAC at ECAC.

The CAC Chairperson is responsible for reporting to ECAC the issues presented by his or her CAC and to share information gathered at ECAC with his or her CAC members.

C. CAC Chairperson Term and Election

The CAC Chairperson's and Vice-Chairperson's term shall be two years. The Chairperson or Vice-Chairperson may be re-elected for one additional two-year term for a maximum of four consecutive years.

CAC Chairperson and Vice-Chairperson regular elections shall be held in September. Only Consumer Members and Member Advocates are eligible to be Chairpersons or Vice-Chairpersons.

If a CAC is unable to elect a Chairperson and/or a Vice-Chairperson in September, the current Chairperson and/or Vice-Chairperson in good standing may retain their position beyond the conclusion of their current term for a maximum of three additional months or until a Chairperson and/or a Vice-Chairperson is elected, whichever is shorter. After three months, the Chairperson and/or the Vice-Chairperson positions will automatically become vacant and remain so until a new Chairperson and/or Vice-Chairperson is elected.

The outgoing Chairperson will be encouraged to mentor the incoming Chairperson for two months following the Chairperson election.

The Vice-Chairperson replacing a CAC Chairperson who was removed or resigned prior to end of their elected term, will complete the remaining term of the departing Chairperson with all the rights and privileges of the Chairperson as described in the L.A. Care Bylaws, PAC Operating Rules and

these CAC Operating Rules. The CAC shall have the ability to have a Vice-Chairperson election to fill the vacancy left by former Vice-Chairperson.

CAC Chairpersons or Vice-Chairpersons may resign by giving written notice to the assigned CO&E staff person responsible for that region.

A CAC Chairperson or Vice-Chairperson can be removed for any one of the following reasons:

a.) For consumer members, if he or she no longer resides in the CAC geographic area;

b.) For advocate members, as applicable, if he or she is no longer employed in the CAC geographic area;

c.) He or she has been convicted of a crime involving corruption, fraud or any felony;

d.) He or she fails to follow L.A. Care's Code of Conduct or CAC Member Standards of Behaviors;

e.) He or she has two absences (excused or unexcused) and one medically excused absence (with doctor's note) from CAC or ECAC meetings, CAC Work Plan events, ECAC Leadership Trainings or other L.A. Care-sponsored events; or has failed to attend a majority of CAC or ECAC meetings, CAC Work Plan events, ECAC Leadership Trainings or other L.A. Care-sponsored events in a fiscal year, will be considered having voluntarily resigned from the CAC, effective the date of the last meeting, training or event missed.

f.) A request for removal has been voted on by CAC members at a scheduled meeting and submitted by the CAC to L.A. Care for disposition.

g.) A request for removal has been voted by the ECAC members at a scheduled meeting and submitted by the ECAC for L.A. Care disposition.

h.) A request for removal has been submitted by L.A. Care staff to the L.A. Care Board of Governors, and it is approved by the Governance Committee where a quorum is present.

The CACs shall have the ability to have a CAC Chairperson and/or Vice-Chairperson election at least once every two years, or as needed when:

- A Chairperson or Vice-Chairperson resigns;
- The CAC calls for the removal of a Chairperson or a Vice-Chairperson;
- Other circumstances considered appropriate by the ECAC.

V. Role and Term of ECAC Leadership

The elected leadership of ECAC shall be a Chairperson and a Vice-Chairperson. At any time, the ECAC Chairperson and Vice-Chairperson may not be related by blood, marriage or belong to the same "household" as define in the Consumer Advisory Member Handbook and Guidelines and Procedures.

A. ECAC Chairperson and Vice Chairperson Terms

The Chairperson and Vice Chairperson for ECAC will be elected by the members of ECAC, in November of each year, to complete a one-year term with the possibility of re-election for a second one-year term.

In order to be eligible for election to Chairperson or Vice Chairperson of ECAC, the individual must have served on the ECAC for at least one year and have actively participated in leadership development training during their tenure on the ECAC.

ECAC Chairpersons or Vice-Chairpersons may resign by giving written notice to the assigned CO&E ~~or CCI~~ Unit staff person responsible for that region.

A Chairperson or Vice-Chairperson can be removed for any one of the following reasons:

a.) For consumer members, if he or she no longer resides in the CAC geographic area;

b.) For advocate members, as applicable, if he or she is no longer employed in the CAC geographic area

c.) He or she has been convicted of a crime involving corruption, fraud or any felony;

d.) He or she fails to follow L.A. Care's Code of Conduct or Consumer Advisory Member Standards of Behaviors;

e.) He or she has two absences (~~excused or~~ unexcused) and one medically excused absence (with doctor's note) for a total of three from RCAC~~, Coordinated Care Initiative (CCI)~~ or ECAC meetings, RCAC~~/CCI Council~~ Work Plan events, ECAC Leadership Trainings or other L.A. Care-sponsored events; in a fiscal year, will be considered having voluntarily resigned from the ECAC, effective the date of the last meeting, training or event missed. Staff will evaluate each situation on a case-by-case basis.

f.) A request for removal has been voted on by RCAC or CCI Council members, as applicable, at a scheduled meeting and submitted by the RCAC/CCI Council to L.A. Care for disposition.

g.) A request for removal has been voted by the ECAC members at a scheduled meeting and submitted by the ECAC for L.A. Care disposition.

h.) A request for removal has been submitted by L.A. Care staff to the L.A. Care Board of Governors, and it is approved by the Governance Committee where a quorum is present.

B. ECAC At-Large Member Terms

The two ECAC At-Large Members, one At-Large member will represent the RCACs and the other At-Large Member will represent the L.A. Care member population of seniors and persons with disabilities~~CCI Councils~~, will be selected by the members of ECAC, in November of each year, to complete a two-year term with the possibility of re-selection to a second two-year term.
Only RCAC/CCI Consumer Members or Member Advocates in good standings are eligible for selection for the two At-Large Members to the ECAC.

In addition to the CAC Chairpersons, the two At-Large Members shall comprise the ECAC.
At-Large Members may resign by giving written notice to the assigned CO&E ~~or CCI~~ Unit staff person responsible.

At-Large Members can be removed for any one of the following reasons:

a.) For consumer members, if he or she no longer resides in the CAC geographic area;

b.) For advocate members, as applicable, if he or she is no longer employed in the CAC geographic area

c.) He or she has been convicted of a crime involving corruption, or any felony;

d.) He or she fails to follow L.A. Care's Code of Conduct or Consumer Advisory Committee Member Standards of Behaviors;

e.) He or she has two absences (~~excused or~~ unexcused) and one medically excused absence (with doctor's note) for a total of three from RCAC~~, CCI Council~~ or ECAC meetings, RCAC~~/CCI Council~~ Work Plan events, ECAC Leadership Trainings or other L.A. Care-sponsored events, in a fiscal year, will be considered having voluntarily resigned from the ECAC, effective the date of the last meeting, training or event missed. Staff will evaluate each situation on a case-by-case basis.

f.) A request for removal has been voted on by RCAC~~/CCI Council~~ members at a scheduled meeting and submitted by the RCAC~~/CCI Council~~ to ECAC for disposition.

g.) A request for removal has been voted on by the ECAC members at a scheduled meeting and submitted by the ECAC for L.A. Care disposition.

h.) A request for removal has been submitted by L.A. Care staff to the L.A. Care Board of Governors, and it is approved by the Governance Committee where a quorum is present.

Guidelines and procedures for role and responsibility for the ECAC and At-Large Members can be found in the Consumer Advisory Member Handbook and Guidelines and Procedures.

VI. Code of Conduct

L.A. Care's Code of Conduct and the Consumer Advisory Member Standards of Behavior shall govern the behavior of CAC members when they are acting on behalf of L.A. Care. As part of L.A. Care's Public

Advisory Committee structure, each CAC member shall receive; review and acknowledge receipt of copy of the Code of Conduct and CAC Member Standards of Behavior annually. Failure to sign the acknowledgement of receipt and understanding of the L.A. Care Code of Conduct and CAC Member Standard of Behavior upon sixty (60) days of receipt may lead to termination of CAC membership.

VII. CAC Meetings

A. Public Meeting

Notice of CAC meetings is posted seventy-two (72) hours in advance of the meeting or in accordance with the "Ralph M. Brown Act." All CAC meetings are open to the public.

B. Meeting Schedule and Location

CACs will meet every other month on a schedule and location to be determined jointly by L.A. Care staff and the CAC members. L.A. Care will provide a location for all CAC meetings and all necessary tools and materials to run meetings, including, but not limited to:

- Ensuring that all meeting locations are accessible to all participants;
- Providing accommodations to allow all individuals to attend;
- Participating in the meetings

With guidance from the assigned CO&E ~~or CCI~~ Unit staff person, CAC members shall set the date and time of each meeting. CACs shall meet at a convenient location within its regional boundaries with appropriate meeting facilities and access to public transportation and/or parking.

C. Quorum and Voting

A majority of ~~that~~ each ~~month's~~ meeting's official CAC membership must be present in person to have an official CAC meeting. All official acts of the CAC require a majority vote of the members present. No vote or election shall be by secret ballot.

D. Additional Meeting Guidelines

CAC meetings will be conducted as informal discussion forums, in such a way that all members have input and the opportunity to reach consensus on issues. Use of formal communications systems such as parliamentary procedures based on the most recent edition of "Robert's Rules of Order Newly Revised" may be used to supplement the informal conversation and provide structure, especially to the disposition of motions from the members.

All official CAC business (i.e., votes, consensus items, election of Chairperson and Vice-Chairperson, recommendations to the ECAC, CAC Work Plan project, etc.) shall occur at a designated time and location every other month and entered into the public record through the meeting summary written by the assigned CO&E ~~or CCI~~ Unit staff person and then reviewed and approved at a subsequent CAC meeting. Each written meeting summary will be posted on the L.A. Care website and submitted to DHCS no later than 45 calendar days after each meeting. Meeting summaries will be retained for no less than 10 years and available upon request.

Decisions concerning work plans, events and other issues will be made by the CAC as a whole. Reports from the work groups shall be a regular part of the CAC meeting structure and shall include recommendations for consideration by the CAC as a whole.

The CAC meeting will be conducted in accordance with the official meeting agenda. CAC members will be mailed the agenda by L.A. Care at least seven days prior to the meeting or as soon as practical thereafter. The Chairperson of the CAC with the assistance of the assigned CO&E ~~or CCI~~ Unit staff person will prepare the agenda for each general meeting based on the input of the CAC as a whole. Agendas will be reviewed and approved by the CAC members at the beginning of every meeting. Only CAC members may participate in votes on an issue and the election of a Chairperson and Vice-Chairperson. L.A. Care staff and the public may participate in discussion when recognized by the CAC Chairperson. The public shall be encouraged to share its comments during the public comment portions of the meeting.

CAC requests for information and materials should be made through the CAC Chairperson to the assigned CO&E or CCI Unit staff person, who will forward the request(s) to any appropriate departments. L.A. Care staff will make every effort to respond to these requests in a timely manner. Copies of L.A. Care's public documents are available to individuals by request through L.A. Care's Board Services or Legal Departments.

Any written communication(s) the CAC decides to send or distribute outside of L.A. Care must first be reviewed and approved by the ~~Senior Director~~Chief of Communications and Community Relations (or his or her designate). Certain outreach materials intended for wide distribution (brochures, posters, etc.) may also require approval from the California Department of Health Services.

Funding for support of the CACs and ECAC is determined by the Board of Governors each year in the annual L.A. Care budget. Completed project plan and budget request forms shall be submitted and

reviewed by the ~~Community Outreach and Engagement or CCI~~CO&E Unit staff prior to expenditure of funds. Unspent CAC Work Plan funds cannot be donated or carried over into the next fiscal year. Unused Work Plan funds will be returned to L.A. Care's general fund.

CAC approved recommendations may be forwarded to the ECAC by the CAC Chairperson. In addition, the ECAC may request the CACs to review and comment on issues ECAC identifies.

The CAC Chairperson is responsible for ensuring that all issues or concerns carried to the ECAC for discussion and consideration reflect a true CAC consensus and diversity of opinion.

VIII. Regional Boundaries

CACs shall be established within each of the regional areas as defined by L.A. Care's Board of Governors.

CAC members are assigned to a specific CAC based on their zip code of residence (Consumer Members), area of community service (Member Advocates), or place of work (Providers). Regional boundaries are for CAC purposes only and do not affect a L.A. Care member's ability to access care in different regions.

~~I~~X. CAC and ECAC Member Stipends and Reimbursement

CAC members serve as volunteers and shall not be compensated for their services or reimbursed for their out-of-pocket expenses except as provided by L.A. Care's Policy AFS-004 (Expense Reimbursement) or as indicated below, subject to approval by L.A. Care's Board of Governors. Eligible CAC Consumer Members who attend at least 80% of their scheduled CAC meetings or CO&E~~/CCI~~ Unit staff approved L.A. Care, ECAC or CAC special meetings or events may receive a cash stipend or grocery gift card for participating in the meeting. The stipend amount is determined by the Governance Committee of the Board of Governors.

Eligible CAC and ECAC members may receive a cash stipend or grocery gift card for participating in CO&E/CCI Unit staff approved L.A. Care, ECAC or CAC special meetings or events.

ECAC Chairpersons or Vice Chairpersons assuming the leadership role at the ECAC monthly meeting may be eligible to receive a cash stipend or grocery gift card for leading the ECAC meeting. CAC Chairpersons or Vice-Chairpersons assuming the leadership role at their CAC Meeting may be eligible to receive a cash stipend or grocery gift card, for leading their CAC meeting.

At-Large Members assuming the work of the ECAC may be eligible to receive a cash stipend or grocery gift card.

Details specific to CAC and ECAC member eligibility and for determining which meetings, events or special functions are eligible for possible receipt of a cash stipend or grocery gift card and amount of the stipend can be found in the CAC Member Handbook and Guidelines and Procedures.

Only consumer members are eligible to receive a cash stipend (or grocery gift card).

Both consumer members and consumer advocate ECAC members who serve as a CAC chair are eligible to receive a cash stipend for conducting their CAC meetings and ECAC attendance. Vice-Chairs are eligible to receive a cash stipend, if they conduct their CAC meeting or represent their CAC at the ECAC meeting in the absence of their chair. Advocate members invited to attend an ECAC meeting are eligible to receive a mileage reimbursement. In all cases, stipends paid shall be deemed taxable income and reported to the relevant tax authorities in accordance with applicable law and regulations.

CAC Consumer and RCAC Advocate members may be eligible for certain reimbursements to attend other approved L.A. Care, ECAC or CAC special meetings or events.

In addition, in order to be eligible to receive a stipend and/or reimbursement, each CAC member or ECAC member must successfully complete New Member Orientation and an ethics training provided by CO&E~~/ CCI~~ Unit staff.

X. Election of Member and Member Advocate to the Board of Governors

The Board approved Consumer Members in each CAC shall vote for one Member and one Member Advocate to represent the interest of Members on the Board of Governors. The two representatives' names shall be forwarded to the Los Angeles County Board of Supervisors, the official appointing body for the Board of Governors of L.A. Care.

XI. Amendments to the CAC and ECAC Operating Rules

These CAC and ECAC Operating Rules are duly adopted by L A. Care's Board of Governors and may be amended by the Board of Governors according to L.A. Care Bylaws Article XI. The CAC and ECAC Operating Rules were revised on February 8, 2018 through Motion ECA 102.0218. The effective date of this Operating Rule is ~~April 5~~June 26, 202~~418~~.

ATTESTED BY:

_____

~~G. Michael Roybal, MD~~

Secretary, Board of Governors

Date Signed: _____

Board of Governors
MOTION SUMMARY

Date: May 2, 2024

Motion No. TTECA 100.0524

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC)

Chairperson: Ana Rodriquez

Requesting Department:

Issue: Consumer input to L.A. Care's Board of Governors is essential to decisions affecting L.A. Care Medicaid members. For the last three Board meetings in 2024, closed session have been at the beginning of the Board meeting making it difficult for consumer members, who want to attend and provide public comment. Consumer members now have to wait to speak. TTECAC is asking the Board of Governors (BOG) to consider returning the "public" session to start at the beginning of monthly BOG meetings and "closed" session to occur before or after the "public" session.

This will greatly increase participation of community advisory members as well as other public members who desire to express concerns to L.A. Care's Board of Governors.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** <<year>>

Background: During the April 2024 TTECAC meeting, it was discussed and determined that a motion be forwarded to the Board of Governors to consider returning the BOG monthly meetings for the "public" sessions to start 1:00 p.m. to 4:00 p.m. and the "closed" session to occur before or after the "public" session.

Member Impact: Reduced consumer in-person participation and lessened feedback to board members on issues affecting L.A. Care monthly BOG meetings.

Budget Impact: None

Motion: **To request the Board of Governors' to consider returning the BOG monthly meetings to the first Thursday 1P-4P BOG "public" session meetings which would cause the BOG "closed" sessions to begin before or after the "public" session meetings designated hours.**

Board of Governors
MOTION SUMMARY

Date: May 2, 2024

Motion No. TTECA 101.0524

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC)

Chairperson: Ana Rodriguez

Requesting Department:

Issue: Including push-door buttons in the design of all L.A. Care facilities where appropriate for persons with disabilities is essential for ensuring accessibility and independence. These buttons allow individuals with mobility impairments to easily enter and exit buildings without assistance, promoting inclusivity and equal access to public spaces. Additionally, push-door buttons can also benefit those with temporary disabilities, parents with strollers, and individuals carrying heavy loads, making them a practical and inclusive design feature for all.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** <<year>>

Background: During the April 2024 Temporary Transitional Executive Community Advisory Committee (TTECAC) meeting, the committee discussed and determined that a motion be forwarded to the Board of Governors to consider the placement of push door buttons on any door accessible to the public on any site used by L.A. Care Health Plan for public meetings.

Member Impact:

Budget Impact: Staff will return with an estimate cost and budget impact once a response to the attached motion is developed.

Motion: **L.A. Care Board of Governors to consider the placement of push door buttons on any door accessible to the public at any site used by L.A. Care for public meetings. This action will greatly support seniors and persons with disabilities who utilize restrooms for business and access the building for public business.**

Automatic Door / Board Summary

L.A. Care HEALTH PLAN

For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Automatic Door Update

- The current swinging entry doors at our Community Resource Centers (CRCs) comply with all state and federal laws and regulations.
- Currently, there are no automatic doors installed at any of our 13 CRCs.
- Since construction has not yet begun at our Lincoln Heights CRC we could install an automatic door for an additional $25,000.
- The 13 other CRC locations would require a retrofit with an estimated cost of $37,600 per location for a total of over $488,000.
- In terms of industry standards, we did not find examples of buildings with automatic doors on restrooms. Doing so also creates privacy issues as the doors swing all the way open and stay open longer than they otherwise would. And, while open they block the adjacent hallway. As such, we do not recommend adding them to any of our restrooms.

Below are pro's and con's of automatic swinging door openers:

Pros:

- Improves access for those who may have difficulty opening a traditional door.
- Reduces physical contact with door handles (must still push button).
- After the hold open period, the door automatically returns to the closed position.

Cons:

- Door can be harder to operate manually when out of service (e.g., power outage).
- Not suitable for locations requiring security because they open for anyone.
- Installation and ongoing maintenance costs.

Automatic Door Staff Recommendation

- All our buildings are compliant with applicable law and industry standards. As such, the recommendation is not to make any changes at this time.
- Should the Board desire to add automatic doors to the entrance of our buildings going forward staff recommends doing so on all new facilities and retrofitting those with at least eight years left on the lease so the costs may be fully amortized.

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Current CRC Lease End Dates

Site	RSF	Lease Expiration
Pacoima (RCAC 2)	5,006	6/9/2024
Palmdale (RCAC 1)	7,000	10/26/2026
East L.A. (RCAC 10)	8,344	7/31/2028
Lynwood (RCAC 6)	7,537	8/31/2028
Pomona (RCAC 11)	12,173	6/30/2029
*Metro LA (RCAC 4)	9,900	1/31/2030
Wilmington (RCAC 8)	13,246	6/3/2031
El Monte (RCAC 3)	12,000	7/12/2031
Norwalk (RCAC 7)	10,000	8/12/2031
Inglewood (RCAC 6)	9,000	2/24/2032
Long Beach (RCAC 9)	12,350	8/7/2032
Westside (RCAC 5)	7,810	12/1/2032
South Los Angeles	9,085	7/1/2034
Lincoln Heights (RCAC 10)	9,000	Approx. 11/1/2034

Board of Governors
MOTION SUMMARY

Date: June 26, 2024 **Motion No. EXE B.0624**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Issue: L.A. Care Policy HR-501 requires that the Executive Committee annually review substantial changes to the Human Resources Policies.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: The revised policy is written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care's practices.

Policy Number	Policy	Section	Description of Modification
HR-306	Equal Employment Opportunity	Employment	Including recommended verbiage to meet NCQA Health Equity HE1A Factor 1
HR-603	Overtime Pay	Benefits	Transferred Policy to new template and made minor changes

Member Impact: L.A. Care members will benefit from this motion by receiving more efficient service from L.A. Care staff members, who will be thoroughly versed on L.A. Care Human Resource policies

Budget Impact: None

Motion: **To approve the Human Resources Policies HR 306 (Equal Employment Opportunity) and HR 603 (Overtime Pay), as presented.**

	EQUAL EMPLOYMENT OPPORTUNITY	HR-306
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)		

DATES					
Effective Date	5/30/1996	Review Date	~~4/17/2024~~6/17/2024	Next Annual Review Date	~~4/17/2025~~6/17/2025
Legal Review Date	4/15/2024	Committee Review Date	4/24/2024		

LINES OF BUSINESS			
Cal MediConnect	L.A. Care Covered	L.A. Care Covered Direct	MCLA
PASC-SEIU Plan	Internal Operations		

DELEGATED ENTITIES / EXTERNAL APPLICABILITY			
PP – Mandated	PP – Non-Mandated	PPGs/IPA	Hospitals
Specialty Health Plans	Directly Contracted Providers	Ancillaries	Other External Entities

ACCOUNTABILITY MATRIX			

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Terry Brown	Michelle Li
DEPARTMENT	Human Resources	Talent Strategy & HR Technology
TITLE	Chief Human Resources Officer	Senior Director, Talent Strategy and Human Resources Technology

AUTHORITIES

- HR-501, "Executive Committee of the Board: HR Roles and Responsibilities"
- California Welfare & Institutions Code §14087.9605
- Title VII of the Civil Right Act of 1964
- Americans with Disabilities Act (ADA)
- California Fair Employment and Housing Commission (FEHC)
- Age Discrimination in Employment Act (ADEA)
- Rehabilitation Act of 1973
- Division of Labor Standards Enforcement (DLSE)

REFERENCES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
12/2/1996	Revision
4/1/2014	Review
1/25/2017	Revision
8/22/2018	Revision: protected classes expanded and updated. Means for reporting policy violations broadened.
4/17/2024	Review, DEI statement and Cannabis use protection added
6/17/2024	Revision to include recommended verbiage to meet NCQA Health Equity HE1A Factor 1

DEFINITIONS

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) is an equal opportunity employer under applicable laws and is committed to valuing diversity, equity, and inclusion. In accordance with L.A. Care's Mission, Vision and Values, L.A. Care believes that all persons are entitled to equal employment opportunity in accordance with applicable federal, state, and local laws and is dedicated to ensuring that all terms, conditions and privileges of employment are in accordance with its principles of equal employment opportunity.

2.0 DEFINITIONS:

N/A

3.0 POLICY:

3.1 L.A. Care believes that all persons are entitled to equal employment opportunity and does not discriminate against qualified employees or applicants because of race (including traits historically associated with race, such as hair texture and protective hairstyles, including braids, locks, and twists), ethnicity, color, religion, religious creed (including religious dress and grooming practices), religious affiliation, national origin (including language restrictions), ancestry, sex, pregnancy, child birth, breastfeeding and medical conditions related to pregnancy, child birth, and breastfeeding, maternity, caring responsibilities, marital status, civil partnership status, physical or mental disability, (including HIV and AIDS), medical condition (including cancer and genetic characteristics), age, citizenship status, sexual orientation, sex/gender, gender identity, genetic information, gender expression, military or veteran status, family care or medical leave status (including denial of family and medical care leave), domestic violence victim status, political affiliation, use of cannabis off the job and away from the workplace, or any other protected category as identified by applicable local, state or federal law, rule, ordinance or regulation.

3.2 Equal employment opportunity will be extended to all persons in all aspects of the employment relationship, including without limitation recruitment, hiring, training, promotions, transfer, discipline, layoff, recall, or termination, to the extent permitted by law.

3.3 It is L.A. Care's policy to recruit, employ, retain, promote, terminate, and otherwise treat all employees and job applicants on the basis of merit, qualifications and competence.

3.4 All job postings will include the applicable paygrade and the pay range L.A. Care reasonably expects to pay for the position.

3.5 All L.A. Care job descriptions are developed in a manner that they are gender neutral**.**

3.6 Consistent with Government Code section 11139.6: Engage in general recruitment and outreach programs to all individuals, including persons who are economically disadvantaged.

3.7 Engage in inclusive public sector outreach and recruitment programs that, as a component of general recruitment, may include, but not be limited to, focused outreach and recruitment of minority groups (defined by race, ethnicity, and/or sexual orientation) and women if any such group is determined to be significantly underutilized at any level of position at the County. Such focused outreach and recruitment may include, but is not limited to, placement of job announcements through:

3.7.1 General circulation publications, and general market radio and television stations, including electronic media.

3.7.2 Local and regional community newspapers.

3.7.3 Newspapers, publications, and radio and television stations that provide information in languages other than English and whose primary audience is residents of minority and low-income communities.

3.7.4 Publications, including electronic media, that are distributed to the general market and to newspapers, publications, and radio and television stations whose primary audience is comprised of minority groups or women.

~~3.5~~3.7.5 Recruitment booths at job fairs or conferences oriented to both the general market and the economically disadvantaged as well as those events drawing a significant participation by minorities or women.

~~3.6~~3.8 L.A. CARE MISSION STATEMENT:

~~3.6.1~~3.8.1 L.A. Care's mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents and to support the safety net required to achieve that purpose.

~~3.7~~3.9 L.A. CARE VISION:

~~3.7.1~~3.9.1 A healthy community in which all have access to the health care they need.

~~3.8~~3.10 L.A. CARE VALUES:

~~3.8.1~~3.10.1 We are committed to the promotion of accessible, high quality health care that:

~~3.8.1.1~~3.10.1.1 Is accountable and responsive to the communities we serve and focuses on making a difference;

~~3.8.1.2~~3.10.1.2 Fosters and honors strong relationships with our health care providers and the safety net;

~~3.8.1.3~~3.10.1.3 Is driven by continuous improvement and innovation and aims for excellence and integrity;

~~3.8.1.4~~3.10.1.4 Reflects a commitment to cultural diversity and the knowledge necessary to serve our members with respect and competence;

~~3.8.1.5~~3.10.1.5 Empowers our members by providing health care choices and education and by encouraging their input as partners in improving their health;

~~3.8.1.6~~3.10.1.6 Demonstrates L.A. Care's leadership by active engagement in community, statewide and national collaborations and initiatives aimed at improving the lives of vulnerable low income individuals and families; and

~~3.8.1.7~~3.10.1.7 Puts people first, recognizing the centrality of our members and the staff who serve them.

4.0 PROCEDURES:

4.1 N/A

5.0 MONITORING:

5.1 Human Resources reviews its policies routinely to ensure they are updated appropriately and has processes in place to ensure the appropriate required steps are taken under this policy.

6.0 REPORTING:

6.1 Any suspected violations to this policy should be reported to any member of the management or Leadership Team, any of L.A Care's Human Resources Business Partners, Compliance Officer or Compliance Department, or anonymously through Compliance Helpline at (800) 400-4889 or online portal at lacare.ethicspoint.com.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time with or without notice.

	OVERTIME PAY	**HR-603**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6504

DATES					
Effective Date	7/6/1998	Review Date	~~12/5/2023~~6/26/2024	Next Annual Review Date	~~12/5/2024~~6/26/2025
Legal Review Date	~~10/10/2018~~3/27/2024	Committee Review Date	~~5/27/2019~~6/26/2024		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, HR Total Rewards

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities" ➢ California Welfare & Institutions Code §14087.9605

REFERENCES

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
~~8/29/2006~~	~~Revision~~
~~April 2014~~	~~Review~~
~~11/28/2024~~12/~~15/2024~~6/26/2024	~~Revision~~transferred policy to new template and minor changes made ~~Review~~

~~DEFINITIONS~~
~~Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures~~

1.0 OVERVIEW:

1.1 Due to the nature of L.A. Care Health Plan's ("L.A. Care")~~'s~~ business and to ensure that our members are provided with the best possible service, overtime work is recognized as a necessary responsibility for all employees.

~~2.0 DEFINITIONS:~~

~~Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.~~

~~**2.1** N/A~~

~~3.0~~2.0 POLICY:

~~3.1~~2.1 L.A. Care pays overtime pay to all non-exempt employees in accordance with specific applicable Federal and State wage and hour laws and regulation.

~~3.2~~2.2 L.A. Care reserves the right to assign employees, with or without notice, to work overtime based on the business needs. Failure to work assigned overtime may result in disciplinary action, up to and including ~~immediate employee~~ termination of employment.

~~3.3~~2.3 Only actual time worked is considered Overtime in the computation of overtime pay. Paid Time Off ("PTO"), Leave of Absence, Bereavement, Volunteer time, Holidays ~~(see procedure #2)~~, or Jury Duty are not considered time worked for the computation of overtime hours.

~~3.4~~2.4 Only Supervisors and above may authorize ~~the use of~~ overtime work. Employees who work overtime but have not obtained prior approval from their Supervisor~~/Manager~~ may be subject to disciplinary ~~corrective~~ action, up to and including termination of employment.

~~3.5~~2.5 Compensatory time off in ~~-~~ lieu of overtime pay is not permitted.

~~3.6~~2.6 Pyramiding or stacking of overtime, daily and weekly, for the same hours of work is not allowed. L.A. Care is responsible for determining the appropriate overtime calculation which provides the most lucrative overtime payment to eligible non-exempt employees.

~~3.7~~2.7 Exempt employees are not eligible for overtime pay.

~~4.0~~3.0 PROCEDURES:

~~4.1~~3.1 Overtime is ~~normally~~ paid at a rate of 1.5 times the employee's regular rate of pay for any time worked over 8 hours in a workday and any time worked over 40 hours in a workweek. Double time is paid at two times the employee's regular rate of pay for all hours worked over 12 hours in a single workday.

~~4.2 Employees who are required to work additional weekend hours during a week with a company recognized holiday may be eligible for a special payment of overtime for additional hours worked.~~

~~4.3~~3.2 Employees working a seventh day will be paid at 1.5 times the employee's regular rate of pay ~~receive time and one half~~ for the first 8 hours of work and two times the employee's regular rate of pay ~~double time~~ for hours worked in excess of 8 hours.

~~4.4~~3.3 ~~Overtime is paid in quarter-hour~~ tenth-hour (.10hrs) ~~increments and is rounded to the nearest quarter-hour~~ tenth-hour (.10hrs)~~.~~ Non-exempt staff must accurately enter all hours worked, including overtime into L.A. Care's timekeeping system (HR-216 Recording of Time). Management is responsible for reviewing and approving assigned non-exempt staff's timesheets on a bi-weekly basis to ensure accuracy of hours reported for payment. ~~All hours worked for non-exempt staff, including overtime, must be accurately entered in L.A. Care's timekeeping system.~~

~~4.5~~3.4 Make Up Time:

~~4.5.1~~3.4.1 If a non-exempt employee misses work as a result of personal obligations, the employee may make up the missed time at the straight-time rate, only if prior supervisor approval has been obtained, and only if the makeup time will not involve overtime work or cause overtime pay;

~~4.5.2~~3.4.2 The request for make-up time must be in writing; Manager must enter "make up time" in timesheet accordingly.

~~4.5.3~~3.4.3 The hours of make-up time, if approved, must be worked in the same workweek in which the time was lost;

~~4.5.4 The hours of make-up time must not extend the work day past eleven total hours worked, nor must not extend the workweek past forty (40) hours worked.~~.

~~4.6~~3.5 Exempt Employees:

~~4.6.1~~3.5.1 Employees working in exempt positions, ~~especially those in management~~ are ~~normally~~ typically scheduled on a five-day workweek. These employees are expected to work as many hours as is necessary to complete their duties.

~~4.6.2~~3.5.2 Because such employees are exempt from ~~the~~ overtime ~~laws~~, they are not entitled to additional compensation for extra hours of work or for time off in ~~-~~ lieu of additional compensation. L.A. Care does not maintain any compensatory time off plan or arrangement.

~~4.6.3~~3.5.3 ~~Any~~ All time off which is provided to ~~an~~ exempt employees must be entered in L.A. Care's timekeeping system~~is done on an informal basis~~. Neither extra compensation nor compensatory time off will, under any

circumstances, be owed or payable to an exempt employee upon separation from employment for any reason.

~~4.7~~3.6 For purposes of this policy, the workday begins at 12:00 a.m. and ends at 11:59 p.m. The workweek begins on Monday and ends on ~~the following~~ Sunday.

~~5.0~~4.0 MONITORING:

4.1 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy.

~~**5.1** Human Resources reviews its policies routinely to ensure that they are updated appropriately and has processes in place to ensure that the appropriate required steps are taken under this policy.~~

~~6.0~~5.0 REPORTING:

~~6.1~~5.1 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

~~7.0~~6.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.