STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213 A (Rev 6/03)

☒ **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED** ______ **Pages**

AGREEMENT NUMBER	AMENDMENT NUMBER
05MHF074	A11
REGISTRATION NUMBER	
4280100598468.	

1. This Agreement is entered into between the State Agency and Contractor named below:
   STATE AGENCY'S NAME
   Managed Risk Medical Insurance Board
   CONTRACTOR'S NAME
   County of San Mateo
2. The term of this Agreement is July 1, 2005 through December 31, 2013
3. The maximum amount of this Agreement after this amendment is: $3,775,692.69 ($199,985.86 added)
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:

This Agreement is amended for the following purposes:

A. Extend the end of the term to December 31, 2013.
B. Add $199,985.86 to the Agreement.
C. Replace Exhibit A and Exhibit B in their entirety
D. Specify the confidential rates of payment as provided in Attachment IV.

The effective date of this amendment is October 1, 2013.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR		**CALIFORNIA Department of General Services Use Only**
CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)* County of San Mateo		
BY *(Authorized Signature)* ✍	DATE SIGNED *(Do not type)*	
PRINTED NAME AND TITLE OF PERSON SIGNING Don Horsley, President, Board of Supervisors, San Mateo County		
ADDRESS 225 37th Avenue, San Mateo, CA 94403		
STATE OF CALIFORNIA		
AGENCY NAME Managed Risk Medical Insurance Board		
BY *(Authorized Signature)* ✍	DATE SIGNED *(Do not type)*	
PRINTED NAME AND TITLE OF PERSON SIGNING Tony Lee, Deputy Director of Administration		☒ Exempt per: Insurance Code sec. 12699.54
ADDRESS 1000 G Street, Suite 450, Sacramento, CA 95814		

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EXHIBIT A
SCOPE OF WORK

I. INTRODUCTION

A. Act and Regulation

This Agreement is in accord with and pursuant to Section 12699.50 et. seq., Part 6.4 of Division 2 of the California Insurance Code, which establishes the County Health Initiative Matching Fund, which shall hereinafter be called the County Children's Health Initiative Program (C-CHIP). The Agreement is also in accord and pursuant to Title XXI of the Social Security Act, Public Law 105-33, and its implementing federal regulations, which establishes the State Children's Health Insurance Program (S-CHIP), which provides authorization and federal funding for the Healthy Families Program (HFP), and Title 10, Chapter 5.8 of the California Code of Regulations which is adopted by the Managed Risk Medical Insurance Board to implement the HFP, and shall hereinafter be called the HFP Regulations. Terms and conditions used in the HFP Regulations shall have the same and identical meanings in this Agreement. The C-CHIP develops applications and program materials; receives, processes and screens applications; determines eligibility and conducts eligibility re-determinations; forwards applications; enrolls eligible applicants; and provides health, dental and vision health coverage to S-CHIP eligible subscribers. Senate Bill 36 (Simitian) (Chapter 416, statues 2011), expands potential coverage to uninsured children with income at or below 400 percent (400%) of the Federal Poverty Level (FPL) from the previous threshold of 300 percent (300%) of FPL. This Agreement is for the purpose of administering the C-CHIP and providing the eligible contractors access to federal funding through the County Health Initiative Matching Fund.

II. CONTRACT TERM

A. Term of Agreement

The term of this Agreement shall be from July 1, 2005, through December 31, 2013~~September 30, 2013~~. The State may exercise the option to negotiate an Agreement for subsequent one-year terms. Such extension shall be by an amendment to this Agreement. Reimbursement rates applicable to each subsequent one-year term shall be negotiated by the parties and included in the amendment. Renewal of the Agreement is contingent upon successful performance by the Contractor, as determined by the State at its sole discretion.

III. DELEGATION

A. Delegation, Delegates and Subcontractors

In Accordance with the Acts and Regulations cited in Exhibit A. Item I of this Agreement and with the federal Centers for Medicare and Medicaid Services' (CMS) approval of California's Title XXI State Plan Amendment the Agreement establish an intergovernmental transfer mechanism for the purpose of using

federal and local funding to support C-CHIP. In order to clarify the unique nature and structure of the mechanism and this agreement, the following items are set forth:

1. The State is contracting directly with a local county government and that entity shall be known as the Contractor within this Agreement.

2. The Contractor may delegate to or subcontract with other entities to provide contracted services or meet contract requirements. This may include delegating to or subcontracting with other branches of local county government. The Contractor is responsible to the State for the contracted activities and services provided by any and all delegates and subcontractors.

3. The Contractor shall subcontract with Department of Managed Health Care (DMHC) or Department of Insurance (DOI) licensed health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 for the provision of covered health, dental and specialized (vision) services and benefit that are required by the Agreement. The Contractor shall monitor and evaluate the performance of its subcontractors to assure the State that services are in compliance with the terms of the Agreement and all applicable statutes. These entities shall be known as the Contractor's plans.

4. The Contractor shall provide the State copies of all delegation and subcontract agreements entered into by the Contractor for the provision of services under this Agreement, upon request. The State reserves the right to verify and approve agreements' conformance with the terms of this Agreement.

5. For the purpose of providing county matching funds for the intergovernmental transfer, the Contractor is prohibited from receiving funds from the Contractor's plans and/or the plans' provider networks. Also, the Contractor is prohibited from receiving any State or local obligation reductions based on the intergovernmental transfers and related payments for C-CHIP.

IV. CONTRACTOR ADMINISTRATION RESPONSIBILITIES-ELIGIBILITY AND ENROLLMENT OPERATIONS:

The Contractor is responsible for all aspects of the day-to-day administration and operations for the C-CHIP. The Contractor may use designees/subcontractors to accomplish the administrative and operational tasks specified in the Agreement. These tasks include maintaining privacy and security of applicant information and subscriber information; initial receipt of applications; mailroom functions; application processing; income screening; eligibility determinations; enrollment; disenrollment; transmission of data to healthcare plans and the State; development and maintenance of data systems; maintaining toll-free telephone line; providing customer service; developing and

production of applications and project materials; carrying out project financial administration; conducting re-determinations; and conducting project's appeal process. The operational requirements are detailed in Exhibit A, Item IV of this Agreement.

A. Initial Application Processing

1. The Contractor shall establish and conduct all application processing, including mailroom functions; record tracking of all applications (e.g., initial application and re-determination form) and supporting documentation received/processed; screening of applications; and eligibility determinations of each application. The record tracking process shall have the ability to identify and track applications by at least the following elements: date received, date processed, applicants name and each person being applied for.

2. The Contractor shall establish and maintain processing procedures for premium payments that accompany any application or are received by the mailroom. The procedures shall include record tracking, banking deposit requirements, account posting requirements and financial reconciliation processes.

3. The Contractor shall establish and maintain procedures for evaluating and processing complete and incomplete applications

4. The Contractor shall screen each application to determine whether there are persons eligible for full scope no-cost Medi-Cal and/or the Healthy Families Program (HFP). If as a result of the screening, the family income for each child being applied for is determined to meet no-cost Medi-Cal or HFP requirements, the application and all supporting documentation shall be forwarded to the appropriate State program, if authorized by the applicant.

5. The Contractor shall establish and maintain procedures for tracking and forwarding no-cost Medi-Cal and or HFP eligible applications to the appropriate State program.

6. The Contractor shall also screen each application to determine whether any person being applied for is enrolled in no-cost Medi-Cal. If, as a result of the screening, it is determined that the person being applied for already has active health coverage through no-cost Medi-Cal, a full eligibility determination is not required and C-CHIP enrollment is not authorized. The Contractor shall establish and maintain procedures to notify applicants in writing of the finding of active health coverage through a State program.

B. Eligibility Determination

1. The Contractor shall review each application for the C-CHIP requirements as specified in Exhibit A, Item I of the Agreement, the Contractor's County eligibility standards and shall determine whether the persons for whom applications are being made are qualified to participate in C-CHIP. The C-CHIP eligibility period shall be twelve (12) consecutive months. This requirement does not apply to children who enrolled with an effective date on or after January 1, 2013, with family income above 300 percent (300%) of the FPL.

2. The Contractor shall establish and maintain procedures to notify applicants in writing of the eligibility determination results for each person being applied for and each application forwarded to no-cost Medi-Cal or the HFP within thirty (30) calendar days. The procedures shall include record tracking of all notifications and shall have the ability to track date notification sent, applicant's name and eligibility determination for persons being applied for.

3. The Contractor shall establish and maintain refund procedures for premium payments from applications determined to be ineligible.

4. The Contractor shall establish and maintain procedures for analyzing suspected cases of fraudulent eligibility/enrollment and have fraud prevention safeguards. The procedures shall include review, evaluation and documenting processes for suspected cases of fraud.

5. If a C-CHIP project reaches its enrollment capacity, the Contractor shall maintain a separate data set of names, addresses and telephone numbers of applicants. The Contractor shall maintain a waiting list.

C. Accuracy of Eligibility Determinations

The Contractor is responsible for correct and accurate eligibility determinations based on the complete application. The Contractor shall assure that the State shall be held harmless for any federal disallowance resulting from any Contractor errors in eligibility determinations. The State shall recoup any federal and State disallowances and adjustments from the Contractor including any State costs related to the disallowances.

D. Enrollment and Disenrollment

1. The Contractor shall establish and maintain procedures for enrollment of eligible subscribers and disenrollment of no longer eligible subscribers. The procedures shall be in accordance with the C-CHIP enacting statute, regulations and all other applicable statutes as specified in Exhibit A, Item I of this Agreement.

2. If a person has been determined eligible by the Contractor for the C-CHIP, the Contractor shall enroll the person in the applicant's choice of

participating health, dental and vision plans, if choice of plans is available. In the event that any of the selected plans are not available, the Contractor shall contact the applicant for an alternate choice, if choice of plans is available. The Contractor shall document all attempts to obtain the applicant's alternative choice.

3. The Contractor shall establish the effective date of coverage and shall notify the applicant in writing, and shall notify the participating plans, in accordance with Health Insurance Portability Accountability Act of 1996 (HIPAA) standards, of the languages spoken and written, the enrollment information, and the effective date of coverage for each person determined eligible on the application.

4. The Contractor shall establish and maintain a C-CHIP Welcome Packet which shall include all necessary program information for new subscribers. The Contractor shall send the Welcome Packet out prior to subscribers' effective dates of coverage by postal service in sufficient time to arrive prior to the effective date.

5. If a person has been determined ineligible for continued C-CHIP coverage by the Contractor, the Contractor shall disenroll the person from the plans in which the person is enrolled. The Contractor's reasons for disenrollment shall include the following:

   a. The subscriber is found to no longer be eligible, or fails to provide the necessary information, during the annual eligibility review period; or

   b. The subscriber attains an age that is no longer eligible for coverage; or

   c. The subscriber is determined not to be a citizen, non-citizen national, or a qualified alien eligible for coverage or fails to provide required documentation within established time period; or

   d. The applicant fails to pay the required family contribution within the established time period; or

   e. The applicant so requests in writing on behalf of the subscriber(s) for whom the applicant has applied; or

   f. The applicant has intentionally made false declarations in order to establish C-CHIP eligibility for any subscriber; or

   g. The subscriber has died; or

   h. Any other applicable C-CHIP disenrollment reason such as mid year re-evaluation.

6. Prior to an involuntary disenrollment of a subscriber, the Contractor shall provide written notification to the applicant at least thirty (30) days prior to the effective date of disenrollment. The notification shall include the reason for disenrollment, the effective date of the disenrollment, and an explanation of the appeal process including the need for the applicant to request continued coverage during appeal process.

7. The Contractor shall notify the applicant and the participating plans of the subscriber's disenrollment in accordance with the statutory requirements specified in Exhibit A, Item I of the Agreement. The Contractor shall notify the applicant in writing when the subscriber is disenrolled from the C-CHIP and such notice shall be sent by postal service within the required time period before the effective date of disenrollment. The notification shall include the reason for disenrollment, the effective date of the disenrollment, and an explanation of the appeal process including the need for the applicant to request continued coverage during appeal process.

8. The Contractor shall mail the applicant for any disenrolled subscribers a notice summarizing each subscriber's eligible months of creditable coverage while enrolled in C-CHIP and the notice shall be in accordance with the federal HIPAA requirements.

E. Change in C-CHIP Enrollment Status

1. The Contractor shall administer and record any changes in enrollment status during any C-CHIP eligibility period. This includes the addition of new subscribers who were not eligible when the applicant applied to C-CHIP, disenrollment of subscribers who are no longer eligible for the C-CHIP, changes in subscribers' plan selections and annual eligibility review evaluations.

2. The Contractor shall recalculate C-CHIP family contribution when adding or disenrolling a subscriber and shall bill the applicant to reflect the revised amounts due. The recalculated family contribution shall not affect the prepaid free month that the family had qualified for prior to the adding or disenrolling a subscriber. The Contractor's data systems shall maintain accessible C-CHIP records including all changes in enrollment of all applicants/subscribers with the date of the enrollment status changes.

F. Processing Correspondence From Applicants

1. Written correspondence and requests from the applicant, which are not determined to be appeals pursuant to the statutory requirements specified in Exhibit A, Section I of this Agreement, shall be defined as correspondence. The Contractor shall establish and maintain procedures

to receive, review, process and respond to all correspondence received from applicants.

2. The Contractor shall respond directly to the applicant in writing, in order to inform the applicant about the outcome of the Contractor's review or evaluation of the applicant's inquiry. The written responses shall be completed within thirty (30) calendar days.

G. C-CHIP Annual Eligibility Review (AER)

1. The Contractor shall annually reevaluate each C-CHIP subscriber for eligibility to determine whether the persons applied for continue to qualify for coverage, in accordance with the statutory requirements specified in Exhibit A, Section I of this Agreement.

2. The Contractor shall establish and maintain an annual eligibility review (AER) process. The process shall include an AER package that shall be produced in the same languages in which the Contractor's plans produce their HFP materials. The AER packet shall include all applicant, subscriber and household information known to the Contractor and shall be sent prior to each subscriber's anniversary date with C-CHIP. The Contractor shall have the ability to re-generate and resend the AER package, if requested by the applicant.

3. If the Contractor has not received a returned completed AER package within thirty (30) calendar days prior to anniversary date, the Contractor shall send out a reminder postcard that informs the applicant that failure to respond by the applicant's anniversary date will result in subscriber disenrollment and that indicates the disenrollment date.

4. The Contractor shall establish and maintain timelines and procedures for the AER process, including procedures for processing complete (or made complete) AER packages. The Contractor shall prioritize AER package processing based on applicants' anniversary dates and pending disenrollment dates in order to maintain C-CHIP eligibility.

5. The Contractor shall review each complete AER package for compliance with the C-CHIP statutory requirements specified in Exhibit A, Section I of this Agreement, the Contractor's County eligibility standards and shall determine if the persons for whom application is being made qualify for continued coverage through the C-CHIP. If subscribers determined ineligible qualify for no-cost Medi-Cal or HFP, their AER packages shall be forwarded to the appropriate State program.

6. The Contractor shall notify the applicant in writing of the results of the eligibility determination for each person whose eligibility is being re-determined at AER. The notice shall include, for each person eligible, the eligibility determination, the plans the listed subscribers are enrolled in,

the recalculated family contribution, and the twelve (12) month time period for the eligibility determination. For those subscribers determined ineligible, the notice shall include the eligibility determination, disenrollment date, and an explanation of the appeal process, including the option for the applicant to request continued coverage during appeal process.

7. The Contractor shall establish and maintain AER appeals procedures with established appeal time periods, including the applicant's ability to request continued coverage during the appeal process.

H. Accuracy of C-CHIP AER Eligibility Determinations

The Contractor is responsible for correct and accurate eligibility determinations based on the complete AER package. The Contractor shall assure that the State shall be held harmless for any federal disallowance resulting from any Contractor errors in eligibility determinations. The State shall recoup any federal and State disallowances and adjustments from the Contractor including any State costs related to the disallowances.

I. C-CHIP Appeals

1. The Contractor shall establish and maintain appeal procedures in accordance with the statutory requirements in Exhibit A, Section I of this Agreement. The appeals shall relate to C-CHIP eligibility. The Contractor shall inform applicants of their benefit related appeal rights to the appropriate licensing agency (Department of Managed Health Care or Department of Insurance). All inquiries not meeting the requirements of a formal appeal shall be responded to as a correspondence, as specified in Exhibit A, Item IV.F of this Agreement.

2. The Contractor shall provide notice of appeal rights in all appropriate appeals correspondence with applicants and shall assure compliance with all established timeframes, including the applicant's right to request continuing eligibility in the C-CHIP while the appeal determination is pending.

3. The Contractor shall maintain all business records of written and oral contacts with applicants, enrollees, subscribers, and their representatives in a manner that will enable such records to be introduced as evidence, pursuant to Evidence Code Section 1271. The Contractor shall have the ability to respond directly to an applicant's authorized representative or other third party for whom the applicant has a signed authorization on file with the Contractor.

4. The Contractor shall receive, review, make appeal determination and respond, in writing, to all C-CHIP requests for continued enrollment and appeals within thirty (30) calendar days. The Contractor shall evaluate

and determine whether the subscriber is entitled to receive continued enrollment in the C-CHIP and shall respond in writing with its determination. The Contractor shall also respond, in writing, to the applicant with its appeal determination for all appeals submitted.

5. The Contractor shall establish and maintain procedures for paying medical expenses incurred by applicant due to the Contractor inaccurate determination that delayed or prevented health coverage that was subsequently determined through the appeal process.

6. The Contractor shall establish and maintain a C-CHIP appeals tracking system which has the ability to identify, list, track and report all C-CHIP appeals and requests for continued enrollment, including the date on which appeal and request was received; whether or not each subscriber was granted continued enrollment; the beginning and end date of continued enrollment; the date Contractor made a determination; the findings and determination; and the date written notification was sent to the applicant.

J. Transmission of C-CHIP Enrollment Data

1. The Contractor shall assure the State that it shall transmit enrollment, subscriber data updates, reinstatement and disenrollment information to each participating plan using Electronic Data Interchange (EDI). All EDI transmissions to participating plans shall be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any applicable regulations.

2. The Contractor shall establish and maintain a secured EDI transmission process to provide participating plan with enrollment data. The process must use industry standard password protection and encryption procedures to maintain C-CHIP security and integrity of the data.

3. The Contractor shall transmit enrollment and financial data to the State in accordance with Exhibit B of this Agreement.

4. The Contractor acknowledges that all Contractors and its designees/subcontractors must be HIPAA compliant and agrees to conduct all operations, and requires all designees and subcontractors, in compliance with HIPAA.

5. The Contractor shall provide EDI instructions and data mapping formats to participating plans upon request. The Contractor shall provide additional technical assistance, by telephone, by email, or in person at the Contractor's site, to plans new to EDI data transmission as plans establish electronic capabilities.

K. C-CHIP Applications and Program Materials

1. The Contractor shall establish and maintain the C-CHIP application and necessary program materials in order to administer the project, in accordance with the statutory requirements specified in Exhibit A, Item I of this Agreement.

2. The Contractor shall translate the application and necessary program materials into the same languages in which the Contractor's plans produce their HFP materials. To assure translation accuracy, the Contractor shall retain certified translation service to conduct initial English to non-English translation.

3. The Contractor shall establish and maintain an adequate inventory of the C-CHIP applications and necessary program materials in the appropriate languages to serve the eligible population in the Contractor's county. The Contractor shall have the ability to replenish its inventory of the C-CHIP applications and necessary program materials, whenever the supply is depleted.

4. The Contractor shall assure that all written materials are understandable by low reading level applicants and subscribers, no higher than a sixth grade reading level.

L. C-CHIP Telephone and Customer Service

1. The Contractor shall establish and maintain a toll-free telephone number for C-CHIP applicants and subscribers; the toll-free line shall be available during normal business hours, Monday-Friday 8:00 am to 5:00 pm.

2. The Contractor shall have sufficient number of trained bilingual staff to provide customer service to the eligible population in the Contractor's county. The Contractor shall also have the capability to provide telephone services via a translation service in any other languages and TDD service for the hearing impaired.

3. The Contractor's toll-free line shall be staffed with personnel trained to:

   a. Answer application status questions regarding C-CHIP;

   b. Answer eligibility questions regarding C-CHIP;

   c. Assist applicants in completing the C-CHIP application;

   d. Refer callers to Enrollment Entities to assist with the completion of the application, if so requested;

e. Refer callers to the appropriate County Welfare Department (CWD) for Medi-Cal coverage and the HFP toll-free telephone line for HFP coverage.

f. Answer C-CHIP Annual Eligibility Review questions and status questions;

g. Answer C-CHIP appeal questions and follow-ups;

h. Answer C-CHIP billing questions; and

i. Answer other C-CHIP related questions

M. C-CHIP System Requirements

1. The Contractor shall establish and maintain data systems that support fully integrated C-CHIP eligibility, enrollment and financial/accounting systems. The systems shall have the ability to track all applications received, application eligibility determinations, and shall include an inventory control process for tracking disposition and aging of all applications received. The systems shall also maintain an eligibility determination record for each application for the initial determination and each subsequent determination for additional eligibility periods. The record shall include the exact calculations used to determine C-CHIP eligibility as a permanent record for auditing purposes.

2. The Contractor's systems shall maintain a family contribution program income accounting subsystem with documented internal controls to track all family contribution activity for each applicant and for each eligible and enrolled subscriber for C-CHIP. The system shall have the ability to track initial and ongoing payments by payment type and source, such as check, cash, credit card, and any other payment source. The Contractor's system shall maintain the family contribution historical payment activity for auditing purposes.

3. The Contractor shall establish and maintain a refund system for the C-CHIP, with documented internal controls that shall ensure timely, complete and accurate processing and payment of both automated and manual refunds of family contributions. The Contractor shall ensure that a family contribution payment is verified for validity of funds prior to issuing any refund.

4. The Contractor shall have sufficient dedicated systems, operations and maintenance staff whose sole purpose shall be to assure that the Contractor's system is fully functional and complies with all the administrative requirements within this Agreement.

N. C-CHIP Family Contributions

1. The Contractor shall collect C-CHIP family contributions as specified in the statutory requirements in Exhibit A, Section I of this Agreement, the Contractor's County requirements and as approved by CMS in the 7th California State Plan Amendment, Title XXI.

2. The Contractor shall calculate the amount of C-CHIP family contribution, including any rate changes, balances due, and payments made, and shall notify applicants of their required family contributions.

3. The Contractor shall refund, by check to the applicants, family contributions from applications determined to be ineligible for C-CHIP within six (6) weeks. Net adjustments to family contributions that result in overpayment shall be refunded to the applicant, except when the applicant requests a credit to his or her account.

4. The Contractor shall establish and maintain an American Indian/Alaskan Native family contribution exemption in accordance with the statutory and regulatory requirement specified in Exhibit A, Section I of this Agreement.

V. CONTRACTOR RESPONSIBILITIES-HEALTH CARE COVERED SERVICES AND BENEFITS

The Contractor is responsible for all aspects of the administration and provision of covered health care services including health, dental and vision benefits as specified in the HFP regulations. The Contractor shall purchase the covered health care services required in Exhibit A, Section V through subcontracted Department of Managed Health Care (DMHC) or Department of Insurance (DOI) licensed health care service plans. These tasks include maintaining privacy and security of applicant information and subscriber information; enrollment of eligible subscribers; disenrollment of ineligible subscribers; receipt of enrollment data from Contractor's administrator; transmission of enrollment data to healthcare providers; assigning primary care providers when applicable; providing plan ID cards, plan provider directories and plan evidence of coverage booklets; administering plan grievance procedures; administering cultural and linguistic services; administering California Children's Services (CCS) and Serious Emotional Disturbance (SED) benefits; administering subscriber co-payments; administering clinical quality measures and management practices; development and maintenance of plan data systems; maintaining plan toll-free telephone line; and providing plan customer service. The operational requirements are detailed in this Section V of Exhibit A, of this Agreement.

A. Health Care Service Plan

This Agreement is entered into by the Contractor and the State for the purpose of purchasing and providing health coverage for subscribers determined to be eligible for C-CHIP. The Contractor shall purchase covered health care services from DMHC licensed health care service plans which includes a County Organized Health System. The method of delivery of the insured health benefits

shall be a health maintenance organization and/or a preferred provider organization. The Contractor, through its subcontracted plan, agrees to utilize the health maintenance organization and/or the preferred provider organization which includes a County Organized Health System.

B. Dental Care Service Plan

This Agreement is entered into by the Contractor and the State for the purpose of purchasing and providing dental coverage for subscribers determined to be eligible for C-CHIP. The Contractor shall purchase health covered services from DMHC or DOI licensed health care service plans. The method of delivery of the insured dental benefits shall be a dental maintenance organization and/or a preferred provider organization. The Contractor, through its subcontracted plan, agrees to utilize the dental maintenance organization and/or the preferred provider organization.

C. Specialized Health Care Service Plan

This Agreement is entered into by the Contractor and the State for the purpose of purchasing and providing vision coverage for subscribers determined to be eligible for C-CHIP. The Contractor shall purchase health covered services from DMHC or DOI licensed health care service plans. The method of delivery of the insured vision benefits shall be a specialized health care service plan. The Contractor, through its subcontracted plan, agrees to utilize the specialized health care service plan.

D. Geographic Areas Covered

1. The Contractor's plans' participation in the Program is limited to enrollment of Program subscribers who reside in the Contractor's plans' C-CHIP licensed service area accepted by the State. The geographic area is San Mateo County, California.

2. The Contractor shall ensure that the Contractor's plans C-CHIP geographic coverage shall be the same geographic coverage provided for the HFP.

E. Changing Health Care Providers

1. The Contractor shall ensure that the Contractor's plans have an adequate network of providers to provide services to C-CHIP subscribers and shall establish a mechanism to ensure adequate access to the providers. These providers (institutional and professional) are listed in the Contractor's plans' Provider Directories. The Contractor agrees to provide copies of the Provider Directories to the State upon request.

2. Health, dental and specialized (vision) care providers shall be deemed added to or deleted from the Contractor's plans Provider Directories as

contracts between the Contractor's plans and health, dental and specialized (vision) care providers begin or end.

3. The Contractor agrees to maintain the availability of those providers listed at any time during the benefit year in the Contractor's plans' Provider Directories until the end of the benefit year, if elimination of the provider would impact twenty-five (25) or more subscribers enrolled with the Contractor's plans through C-CHIP. For the purpose of this section, the term "provider" may refer to a solo practitioner, a provider group or a clinic.

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

F. Eligibility

All subscribers who are determined C-CHIP eligible and not placed on the waiting list by the Contractor in accordance with the C-CHIP statute and all other applicable statutes and regulations are eligible to enroll in a health, dental and specialized (vision) plan. The Contractor certifies that its enrollment process will not be prejudicial to the participating health, dental and specialized (vision) plans.

G. Conditions of Enrollment

The Contractor shall ensure that the Contractor's health, dental and specialized (vision) plans shall enroll all C-CHIP eligible subscribers on the effective date of coverage specified by the Contractor.

H. Disenrollment

1. The Contractor shall ensure that the Contractor's health, dental and specialized (vision) plans shall disenroll subscribers when notified to do so by the Contractor on the date specified by the Contractor.

2. In no event shall any individual subscriber be entitled to the payment of any benefits with respect to health, dental and specialized (vision) care services rendered, supplies or drugs received or expense incurred following termination of coverage consistent with state and federal law. For the purposes of this Agreement, a charge shall be considered incurred on the date the service or supply giving rise to the charge is rendered or received.

I. Commencement of Coverage

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

J. Identification Cards, Provider Directory, and Evidence of Coverage

1. The Contractor shall ensure that the Contractor's health, dental and specialized (vision) plans, no later than the effective date of coverage, issue to applicants on behalf of subscribers an Identification Card, Provider Directory, and Evidence of Coverage booklet setting forth a statement of the services, benefits, and grievance procedure to which the subscriber is entitled. The Contractor agrees that the materials sent to applicants on behalf of subscribers shall also include information to subscribers regarding how to access services. The information shall be in addition to the description provided in the Evidence of Coverage booklet. Examples of acceptable forms of information include, but are not limited to: a brochure on How to Access Services, inclusion in a cover letter of the specific pages in the Evidence of Coverage booklets relating to accessing services, or a magnet listing the telephone numbers to call to schedule an appointment with providers.

2. The Contractor through its subcontracted plans shall ensure that fifteen (15) calendar days prior to the start of a new benefit year each applicant on behalf of the subscribers enrolled in the Contractor's plan shall be issued an updated Evidence of Coverage booklet setting forth a statement of the services and benefits to which the subscriber is entitled in the next benefit year.

3. The Contractor shall ensure that the Contractor's plans' Provider Directories are updated and distributed by the Contractor's plans to applicants on behalf of subscribers whenever there is a material change in the Contractor's plans' provider networks.

4. The Contractor's plans' Provider Directories shall indicate the language capabilities of the providers.

5. The Contractor shall provide copies of the Contractor's plans' Evidence of Coverage booklets and Provider Directories to any person requesting such materials, by telephone or in writing, within ten (10) calendar days of the request.

6. The Contractor shall send the State, upon request; copies of the Contractor's plans updated Evidence of Coverage Booklets and updated Provider Directories.

7. Written informational material provided to subscribers shall be no higher than a sixth grade reading level and that is approved by the State, to the extent that compliance with this provision does not conflict with regulatory agency directives or other legal requirements.

K. Primary Care Provider Assignment **(HMOs and DMOs only)**

1. The Contractor, through its subcontracted plans, agrees to ensure that all subscribers shall be enrolled with a primary care physician within thirty (30) days of the effective date of coverage in the plan. The Contractor shall provide the Contractor's health and dental plans with the name of each subscriber's chosen primary care provider, if the name of the primary care provider is listed on the C-CHIP application. If the Contractor assigns a primary care provider to a subscriber, the Contractor shall use a fair and equitable method of assignment from the Contractor's plans' provider networks and shall promptly notify subscribers of the selection and of the opportunity to change the assigned primary care providers. The method of assignment shall take into account the geographic accessibility and language capabilities of providers. The Contractor shall ensure that the Contractor's plans notify the primary care providers promptly that they have been chosen by the subscriber or assigned by the Contractor.
2. Whenever the Contractor's plans assign a subscriber to a group or clinic, the Contractor shall ensure that the Contractor's plans notify the subscriber of his or her right to select a new primary care provider immediately or at any future time, including such time as the selected primary care provider is no longer affiliated with the clinic. The Contractor shall ensure that the Contractor's plans notify the subscriber of his or her rights immediately after the assignment to the clinic has been made.

L. Right to Services

Possession of the Contractor's Plan Identification Cards confers no right to services or other benefits of the C-CHIP. To be entitled to services or benefits, the holder of the card must, in fact, be a subscriber enrolled in the C-CHIP. Therefore, any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement, including the law specified in Exhibit A, Item I, is personally responsible for the cost of all health care services.

M. Enrollment Data

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

1. The Contractor shall ensure that the Contractor's plans transmit subscriber enrollment and disenrollment information, subscriber data updates, as well as transfer and reinstatement information, to the Contractor's health, dental and specialized (vision) plans using Electronic Data Interchange (EDI). The Contractor shall ensure that the Contractor's plans accept the information via EDI. The Contractor shall receive the transmitted information, data and file sent through the EDI in a

manner and format that comply with HIPAA standards for electronic transactions and code sets.

2. The Contractor shall ensure that the Contractor's plans accept written confirmation of enrollments from the Contractor, in the event that system errors cause enrollment transactions to be delayed. The Contractor agrees that the written confirmations are valid and acceptable alternative notifications to the Contractor's plans until the failed or delayed enrollment transaction can be generated and sent to the Contractor's plans.

3. The Contractor shall ensure that the Contractor's plans provide EDI instructions and data mapping formats to the Contractor's plans upon request. The Contractor shall provide additional technical assistance to Contractor's plans in order to establish electronic capability.

N. Traditional and Safety Net Providers

The Contractor shall ensure that the Contractor's plans establish, with traditional and safety net providers as described in Article 4 of the HFP regulations, network membership and payment policies which are no less favorable than its policies with other providers.

O. Public Awareness

1. The Contractor shall ensure that all public awareness efforts by the Contractor's plans have been approved by the Contractor before being released in public and must be in compliance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments and applicable regulations.

2. The Contractor shall ensure that the Contractor's plans do not directly, indirectly, or through its agents, conducting in person, door to door, mail or telephone solicitation of applicants for enrollment and that the Contractor's plans are prohibited from these activities

3. The Contractor shall ensure that the Contractor's plans' marketing shall be in compliance with all applicable statutes and regulations as specified in Exhibit A, Item I of this Agreement.

P. Telephone Customer Service for Plan Subscribers

The Contractor shall ensure that the Contractor's plans provide a toll free telephone number for applicant and subscriber plan inquiries. This telephone service shall be available on regular business days from the hours of 8:30 a.m. to 5:00 p.m. Pacific Standard Time. The Contractor's plans shall provide staff bilingual in English and Spanish during all hours of telephone service. The

Contractor's plans shall have the capability to provide telephone services via an interpretive service for all limited English proficient (LEP) persons.

Q. Grievance Procedures

1. Department of Managed Health Care Licensees:

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

b. The Contractor shall ensure that the Contractor's plans report to the Contractor and the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the C-CHIP. Benefit grievances include, but are not limited to, complaints about waiting time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the C-CHIP.

2. Department of Insurance Licensees:

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

b. The Contractor shall ensure that the Contractor's plan report to the Contractor and the State by February 1 of each year, in a format determined by the State, the number and types of benefit grievances filed by subscribers and by applicants on behalf of subscribers in the previous calendar year in the Program. Benefit grievances include, but are not limited to, complaints about waiting

time for appointments, timely assignment to a provider, issues related to cultural or linguistic sensitivity, difficulty with accessing specialists and the administration and delivery of health care benefits in the C-CHIP.

R. Cultural and Linguistic Services

1. Linguistic Services

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

b. The Contractor shall ensure that the Contractor's plans provide twenty-four (24) hour access to interpreter services for all (LEP) subscribers seeking health services within the Contractor's plans provider networks. The Contractor's plans shall use face-to-face interpreter services, if feasible. If face-to-face interpreter services are not feasible, the Contractor's plans may use telephone language lines for interpreter services. The Contractor shall ensure that the Contractor's plans develop and implement policies and procedures for ensuring access to interpreter services for all LEP subscribers, including, but not limited to, assessing the cultural and linguistic needs of its subscribers, training of staff on the policies and procedures, and monitoring its language assistance program. The Contractor shall ensure that the Contractor's plans' procedures include ensuring compliance of any subcontracted providers with these requirements.

c. The Contractor shall ensure that when the need for an interpreter has been identified by the provider or requested by a subscriber, the Contractor's plans' provide a competent interpreter for scheduled appointments. The Contractor shall ensure that the Contractor's plans avoid unreasonable delays in the delivery of health care services to persons of limited English proficiency. The Contractor shall ensure that the Contractor's plans instruct the providers within the plan's provider networks to record the language needs of subscribers in the medical record.

d. The Contractor shall ensure that the Contractor's plans and their providers do not require or encourage subscribers to utilize family members or friends as interpreters. After being informed of his or her right to use free interpreter services provided by the

Contractor's plan, a subscriber may use an alternative interpreter of his or her choice at his or her cost. The Contractor shall ensure that the Contractor's plans encourage the use of qualified interpreters. Minors shall not be used as interpreters except in the most extraordinary circumstances, such as medical emergencies. The Contractor shall ensure that the Contractor's plans document the request or refusal of language or interpreter services in the medical records of providers in the Contractor's plans provider networks.

e. The Contractor shall ensure that the Contractor's plan inform subscribers of the availability of linguistic services. Information provided to subscribers regarding interpreter services shall include but not be limited to: the availability of interpreter services to subscribers at no charge; the right not to use family members or friends as interpreters; the right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers; the right to receive subscriber materials; and the right to file a complaint or grievance if linguistic needs are not met.

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

g. The Contractor shall ensure that the Contractor's plans identify and report the on-site linguistic capability of providers and provider office staff through the plans provider directories.

2. Translation of Written Materials

a. The Contractor shall ensure that the Contractor's plans translate written informing materials for subscribers including, but not limited to, the Evidence of Coverage booklet; form letters; notice of action letters; consent forms; letters containing important information regarding participation in the health plan; notices pertaining to the reduction, denial, modification, or termination of services; notices of the right to appeal such actions or that require a response from subscribers; notices advising LEP subscribers of the availability of free language assistance services; other outreach materials; and medical care reminders. Written

informing materials for subscribers shall be provided a no higher than a sixth grade reading level, to the extent that compliance with this requirement does not conflict with regulatory agency directives or other legal requirements. Translation of these materials shall be in the same languages in which the Contractor's plans produce their HFP materials. The Contractor shall ensure that the Contractor's plans that have members who are unable to read the written materials that have been translated into non-English languages have an alternate form of access to the contents of the written materials.

b. The Contractor shall ensure that the Contractor's plans validate the quality of the translated material. The Contractor shall ensure that the Contractor's plans use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The Contractor shall ensure that the Contractor's plans include in the translation process the use of qualified translators for translating and editing, proofreading and professional review.

c. Upon request, the Contractor shall ensure that the Contractor 's plans submit to the Contractor and State one copy of all materials routinely provided to new subscribers pursuant to this Agreement for each language in which the materials are translated.

3. <u>Operationalizing Cultural and Linguistic Competency</u>

a. The Contractor shall ensure that the Contractor's plans develop internal systems that meet the cultural and linguistic needs of its C-CHIP subscribers, in the same manner as for the HFP subscribers. The Contractor shall ensure that the Contractor's plans provide initial and continuing training on cultural competency to staff and providers. Ongoing evaluation and feedback on cultural competency training shall include, but not be limited to, feedback from subscriber surveys, staff, providers, and encounter/claims data.

b. The Contractor shall ensure that the Contractor's plans report to the Contractor and the State upon request, the linguistically and culturally appropriate services provided and proposed to be provided to meet the needs of limited-English proficient C-CHIP applicants and subscribers. This report shall address types of services including, but not limited to, linguistically and culturally appropriate providers and clinics available, interpreters, marketing materials, information packets, translated written materials, referrals to culturally and linguistically appropriate community services and programs, and training and education activities for providers. The Contractor shall ensure that the Contractor's plans

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

S. Covered and Excluded Benefits

1. Except as required by any provision of applicable law, only those benefits described in Article 3, Sections 2699.6700 through 2699.6707, of the HFP regulations shall be covered benefits under the terms of this Agreement. Except as required by any provision of applicable law, those benefits excluded in Article 3 of the Program regulations shall not be covered benefits. The Contractor shall ensure that the Contractor's plans shall set out the plan of coverage in an Evidence of Coverage booklet.

2. The parties understand that terms of coverage under this Agreement are set forth in the Contractor's plans' Evidence of Coverage booklets. In the case of conflicts, terms of coverage set forth in the Evidence of Coverage booklets shall be binding notwithstanding any provisions in this Agreement which are less favorable to the subscriber.

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

T. California Children's Services (CCS)

1. The Contractor shall ensure that the Contractor's plans identify subscribers with a suspected CCS condition and shall refer them to the local CCS Program for a full determination of residential, medical and financial eligibility. Once CCS eligibility is determined as defined in Title 22, CCR, Section 41518, medically necessary services to treat a C-CHIP subscriber for a CCS eligible condition shall be provided by the local CCS Program. The Contractor shall ensure that the Contractor's plans provide all medically necessary services including the treatment of CCS conditions when the C-CHIP subscriber does not meet the CCS eligibility requirements to the extent that they are covered services under the HFP. The Contractor shall ensure that the Contractor's plans provide the applicant on behalf of the subscriber referred to CCS with a CCS one page (double sided) informational flyer. The State agrees to provide the Contractor and the Contractor's plans with camera-ready copies of the California Children's Services informational flyer.

2. The Contractor shall ensure that the Contractor's plans implement written policies and procedures for identifying and referring subscribers with suspected CCS eligible conditions to the local CCS Program. The policies and procedures shall include, but not be limited to:

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

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

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

   d. Procedures that provide for continuity of care between the Contractor's plans providers and CCS providers.

3. The Contractor shall ensure that the Contractor's plans annually report to the State and Contractor the number of C-CHIP subscribers who were referred to the local CCS program. The first report is due thirty (30) calendar days following the end of the first year of C-CHIP implementation. The format for the report shall be format used for the HFP.

4. Until eligibility for the CCS Program is established, the Contractor shall ensure that the Contractor's plans continue to be responsible for arranging for the delivery of all covered medically necessary health care and case management services for a subscriber referred to CCS. Services which are provided by a CCS paneled provider or approved facility on the date of referral, or afterwards, and which are authorized by the CCS program for a CCS eligible child, shall be paid through the CCS Program at the CCS reimbursement rate retroactively to the provider of services.

5. Once eligibility for the CCS Program is established for a subscriber:

   a. The Contractor shall ensure that the Contractor's plans continue to provide covered primary care and all other medically necessary covered services other than those provided through the CCS Program for the CCS eligible condition and shall ensure the coordination of services between its primary care providers, the CCS specialty providers and the local CCS Program.

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

c. For the purposes of Item V.T.5.b, above, initial referral means referral by a Contractor's plans network physician, or by any other entity permissible under CCS regulations.

U. <u>Mental Health: Family Members</u>

The Contractor agrees to involve appropriate family members in the mental health and/or substance abuse services provided to a subscriber who has experienced family dysfunction and/or trauma to the extent it is required as a course of treatment for the health and recovery of the child.

V. <u>Mental Health: Services for Subscriber Children</u>

The Contractor shall ensure that the Contractor's health plans provide covered benefits that include mental health services in accordance with Section 1372.74 of the California Health and Safety Code, which include the provision of mental health services for children with Serious Emotional Disturbances (SED) or with a serious mental disorder.

W. <u>Other Public Linkages</u>

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

X. <u>Pre-existing Condition Coverage Exclusion Prohibition</u>

No pre-existing condition exclusion period or post-enrollment waiting period shall apply to subscribers.

Y. <u>Exercise of Cost Control</u>

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

Z. Co-Payments

1. The Contractor shall ensure that the Contractor's plans impose co-payments for subscribers as described in Article 3 of the HFP regulations. The Contractor agrees that co-payment maximums as described in Article 3 of the HFP regulations shall be applied for each benefit year and shall be renewed on July 1 of each year. The Contractor shall ensure that the Contractor's plans' Evidence of Coverage or Certificate of Insurance document describe the process to be used by applicants on behalf of subscribers to document that the annual two hundred and fifty dollar ($250) out-of-pocket family maximum has been reached.

2. The Contractor shall ensure that the Contractor's plans' shall work with its provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which co-payments are required. When feasible, the Contractor shall ensure that the Contractor's plans instruct its provider network to offer extended payment plans whenever a family's co-payments exceed twenty-five dollars ($25) in one month.

3. The Contractor shall ensure that the Contractor's plans report the number of subscribers who meet the co-payment maximum in the previous benefit year by October 1 of each year. The format for the report shall be the same format as used in the HFP.

4. The Contractor shall ensure that the Contractor's plans implement an administrative process that waives all co-payments for American Indian and Alaska Native subscribers in the Program.

AA. Coordination of Benefits

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

BB. Acts of Third Parties

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

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

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

CC. Workers' Compensation Insurance

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

DD. Use of Subcontractors

The Contractor may, in its discretion, use the services of subcontractors to recover on the liens provided for under Items IV.J and IV.K of this Exhibit. The subcontractor's compensation may be paid out of any lien recoveries obtained. The State understands and agrees that lien recoveries are chargeable with a prorata contribution toward the injured person's attorney fees under the Common Fund Doctrine. The Contractor may compromise liens as may be reasonable and appropriately consistent with normal business practices.

EE. Health Insurance Portability and Accountability Act of 1996 Conformity

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

FF. Interpretation of Coverage

The Contractor shall ensure that the Contractor's plans' Evidence of Coverage booklet provides clear and complete notice of terms of coverage to C-CHIP subscribers. In the event of ambiguity regarding terms of coverage, the Contractor shall ensure that the Contractor's plans interpret those terms in the interest of the subscriber. In the event of ambiguity regarding an exclusion from coverage, the Contractor shall ensure that the Contractor's plans interpret the language of the exclusion in the interest of the subscriber. Nothing in this provision shall supersede the common law rules for interpretation of insurance contracts.

GG. Measuring Consumer Satisfaction

To the extent that the Contractor and the Contractor's plans elect to conduct consumer satisfaction surveys, the results of the surveys shall be made available to the State for informational purposes.

HH. Standards Designed to Improve the Quality of Care

1. The Contractor assures the State that the Contractor's plans providers shall use, and the Contractor's plans shall monitor, the most recent recommendations of the American Academy of Pediatrics (AAP) with regard to Recommendations For Preventative Pediatric Health Care and the most recent version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

2. The Contractor shall ensure that the Contractor's plans notify the applicants associated with all subscriber children enrolled in Contractor's plans through the C-CHIP, on an annual basis, of the recommended schedule of preventive care visits.

II. Quality Management Processes

1. The Contractor represents that the Contractor's plans shall maintain a system of accountability for quality improvement activities, including participation of the governing body of the Contractor's plans' organization, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the Contractor's plans' process of Quality Improvement development and performance. Evidence of such activities shall be provided to the State upon request.

2. The Contractor represents that the Contractor's plans' Quality Management processes have been reviewed and found to be satisfactory by one of the following review organizations: The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National

Committee for Quality Assurance (NCQA), or the California Department of Managed Health Care.

EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS
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EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

I. PAYMENT PROVISIONS

A. General

The Contractor agrees to arrange for the provision of medical benefits and case management services for eligible and enrolled child and infant subscribers as described in Exhibit A.

B. Fees Provided to Contractor

1. As specified in Items I.C and I.D of this Exhibit, the State shall provide Title XXI federal reimbursement to the Contractor based on a flat fee per month for each child subscriber starting in the month of the child's first birthday and ending in the month of the child's eighteenth birthday. This fee is for health, dental and vision benefit expenses. This fee is set forth in Attachment I, Confidential Attachment, Rates of Payment.

2. As specified in Items I.C and I.D of this Exhibit, the State shall provide Title XXI federal reimbursement to the Contractor based on a flat fee per month for each infant subscriber. This monthly fee shall be paid during the first month of enrollment through twelfth months of the infant's life, but shall not exceed twelve payments. This fee is for health, dental and vision benefit expenses. This fee is set forth in Attachment I., Confidential Attachment, Rates of Payment.

3. In cases of subscriber eligibility and enrollment appeals which result in liability of health care costs by the Contractor, the Contractor shall require its contracted plans to arrange for payment to the provider who rendered services. The State shall provide Title XXI federal reimbursement to the Contractor the actual costs of services received. However, the Contractor shall reimburse and claim for such services at any discounted rate that the Contractor's plan may have in place with the provider participating in the C-CHIP and that is accepted by the provider as payment in full.

4. Administrative Costs

a. As specified in Items I.C and I.D of this Exhibit, the State shall provide Title XXI federal reimbursement to the Contractor based on total administrative costs for the month.

b. For the purposes of this Agreement, Administrative Costs are those related to administering the program which include costs related to eligibility determinations and C-CHIP enrollment services, outreach and state support costs. Administrative costs shall not include those costs of providing or directly administering medical services which are already included in the benefit rates set forth in the Confidential Attachment, Rates of Payment.

c. Contractor Administrative Costs must be in accordance with 45 CFR, Part 74, Section 74.27, "Allowable Costs" and the provisions of OMB Circular A-87. In accordance with federal law, Title XXI, Sec. 2105 (a), the State is limiting payments of administrative costs to ten percent (10%) of the combined administrative costs and benefit costs reduced by monthly contributions (or net benefits). Benefit costs are defined as a combination of Items I.B.1 through I.B.3.

d. The State shall receive compensation for State administrative services, based on the non federal share of total State personnel and overhead costs. The State administrative costs shall be equally shared by all contractors currently participating in C-CHIP. The Contractor shall be billed its monthly pro-rata share of total State administrative costs. The Contractor shall pay the applicable non federal share to the CHIM fund. These funds shall be retained for the draw of Title XXI reimbursement and made available to the State for services provided under the Agreement.

e. The Contractor shall receive federal Title XXI reimbursement for actual, justifiable, allowable Administrative Costs of no more than ten percent (10%) of net benefit costs.

5. Retroactive Payments for Subscriber Services

a. As allowed by the State Plan Amendment for C-CHIP, the State agrees to pay retroactively from January 1, 2003 (SPA

filing date) through June 30, 2005, allowable benefit costs for subscribers with effective dates of coverage for the period of retroactivity. The State shall provide Title XXI federal reimbursement to the Contractor based on actual, allowable benefit costs for the county's existing Healthy Kids program enrollment of federally eligible children for the periods of retroactivity. The State reimbursement shall be calculated based on a predetermined flat fee per month for each child and infant subscriber enrolled for each period of retroactivity. This fee is for health, dental and vision benefit expenses for the retroactive claiming periods. These fees and the periods of retroactivity are set forth in Attachment I, Confidential Attachment, Rates of Payment.

b. When the Centers for Medicare and Medicaid Services (CMS) approves State Plan Amendment 19 (SPA 19) for C-CHIP regarding changes enacted in Senate Bill 36 (Chapter 416, statutes 2011), then the State agrees to pay retroactively from January 1, 2012, through the end of the federal fiscal quarter following the date of approval of SPA 19 allowable benefit costs for subscribers with effective dates of coverage for the period of retroactivity who are above three hundred percent (300%) up to four hundred percent (400%) of FPL. The State shall provide Title XXI federal reimbursement to the Contractor based on actual, allowable benefit costs for the county's existing Healthy Kids program enrollment of federally eligible children for the periods of retroactivity. The State reimbursement shall be calculated based on a predetermined flat fee per month for each child and infant subscriber enrolled for each period of retroactivity. This fee is for health, dental and vision benefit expenses for the retroactive claiming periods. These fees and the periods of retroactivity are set forth in Attachment I, Confidential Attachment, Rates of Payment.

Notwithstanding this section I.B.5(b):

1) The State will not provide Title XXI Federal reimbursement to the Contractor for any such children for services received on or after January 1, 2013.

2) The State will not provide Title XXI Federal reimbursement to the Contractor for any such children

enrolled with an effective date on or after January 1, 2013.

6. Offset of Subscriber Contributions

a. As specified in Exhibit A, Item IV.N, the Contractor shall collect a subscriber contribution flat fee per month for each subscriber enrolled.

b. The Contractor shall report to the State the monthly subscriber contributions collected in the Monthly Financial Report as specified in Item I.D of this Exhibit.

c. The State shall reduce the amount of benefit fees paid to the contractor for expenditures described in Item I.D of this Exhibit by the amount of subscriber contributions collected on a monthly basis. Reduction of subscriber contributions shall be based on the actual amount of subscriber contributions collected for the billed month.

C. Payment Schedule

1. The State agrees to draw Title XXI federal fund reimbursement for payments incurred in Items I.B.1 through 4 and the retroactive benefit costs as described in Items I.B.5.b of this Exhibit at the federal matching fund rate of sixty-five percent (65%) for children above two hundred fifty percent (250%) up to three hundred percent (300%) of FPL; and at the federal matching fund rate of fifty percent (50%) for children above three hundred percent (300%) up to four hundred percent (400%) of FPL.

2. The State agrees to draw Title XXI federal fund reimbursement for payments incurred in Items I.B.1 through 4 of this Exhibit and return the Contractor's share, minus State administrative costs as set forth in Item I.B.4.d of this Exhibit, monthly in arrears. Payment is contingent on the State approval of the monthly Financial and Enrollment Reports described in Item I D of this Exhibit and the submission of .electronically transferred county funds for the Title XXI reimbursement. The State shall pay the Contractor the Title XXI fund reimbursement within 30 days of the receipt of corresponding County contribution.

3. The State agrees to draw Title XXI federal fund reimbursement for the retroactive benefit costs as described in Items I.B.5.b of this Exhibit on a one time basis upon submission of an approved

Retroactive Benefit Report and the submission of electronically transferred county funds for the Title XXI reimbursement. Payment shall be made within 30 days of the receipt of County contribution.

D. Financial and Enrollment Reports

1. Monthly Financial Reports

a. The Contractor shall also submit to the State a monthly financial report for children above two hundred fifty percent (250%) up to three hundred percent (300%) of FPL for each month within the federal fiscal quarter by the fifteenth (15th) day after the end of the federal fiscal quarter with supporting documentation and a certificate attesting the validity of costs and services provided in an electronic and paper format specified by the State.

b. Except as provided in section I.B.5.b, ~~B~~beginning with the end of the federal fiscal quarter following the date SPA 19 is approved, the Contractor shall also submit to the State a monthly financial report for children above three hundred percent (300%) up to four hundred percent (400%) of FPL for each month within the federal fiscal quarter by the fifteenth (15th) day after the end of the federal fiscal quarter with supporting documentation and a certificate attesting the validity of costs and services provided in an electronic and paper format specified by the State.

c. The monthly financial reports shall justify and request payment for services provided to program subscribers pursuant to Section I, Items B.1, 2, 3, 4 and 6 of this Exhibit.

d. The monthly financial reports shall indicate the total county contribution to be transferred by the Contractor to the Children's Health Initiative Matching (CHIM) fund. The report shall indicate how much of the amount being transferred is (i) for children above two hundred fifty percent (250%) to three hundred percent (300%) of FPL, and (ii) for children above three hundred percent (300%) up to four hundred percent (400%) of FPL. The county reimbursement amount on the monthly financial reports will also include the applicable State administrative costs, as determined in Section I, Item B.4.d of this Exhibit, for State administration services provided under this Agreement. Because the

period of availability of federal funds is limited to two (2) years, the Contractor shall submit the monthly financial reports no later than ninety (90) days prior to the end of the time limit contained in 45 C.F.R. 95.7 to ensure availability of the federal funds for reimbursement.

e. The monthly financial reports shall provide adequate documentation for State approval of Title XXI reimbursement for allowable county administrative costs, which will not be in excess of the established ten percent (10%) of net benefits costs for contractor administrative costs.

2. Monthly Enrollment Report

a. The Contractor shall submit to the State monthly enrollment reports along with the monthly financial report described in Exhibit B, Section I, Item D.1, by the fifteenth (15th) day after the end of the federal fiscal quarter in a standardized electronic and paper format specified by the State. The monthly enrollment reports shall be submitted with the corresponding HIPAA compliant enrollment files as specified in Exhibit A, Section IV, Item J.3. The State shall use the monthly enrollment reports to verify the Contractor's calculations of the applicable monthly Title XXI contribution to be transferred to the CHIM fund. Because the period of availability of federal funds is limited to two (2) years, the Contractor shall submit the monthly enrollment reports no later than ninety (90) days prior to the end of the time limit contained in 45 C.F.R. 95.7 to ensure availability of the federal funds for reimbursement.

b. Beginning with the end of the federal fiscal quarter following approval of SPA 19, the Contractor shall submit to the State two separate monthly enrollment reports. Each enrollment report will be in accordance with the requirements set forth in Section I, Item D.2.a. One enrollment report shall be submitted for children between above two hundred fifty percent (250%) up to three hundred percent (300%) of FPL, and the other shall be submitted for children above three hundred percent (300%) up to four hundred percent (400%) of FPL.

3. Retroactive Benefits Payment Report

No later than sixty (60) calendar days after submission of the first set of monthly financial reports, the Contractor shall submit to the State a retroactive benefits payment report covering the periods set forth in Section I, Item B.5 of this Exhibit, along with the supporting enrollment reports in a standardized electronic and paper format specified by the State. The supporting enrollment reports shall be submitted with the corresponding HIPAA compliant enrollment files as specified in Exhibit A, Section IV, Item J.3. The State shall use the enrollment reports to verify eligibility for retroactive payments, as well as the Contractor's calculations of the applicable Title XXI contribution to be transferred to the CHIM fund. The Contractor retroactive benefits payment report submissions shall be in accordance with submission requirements specified in Exhibit B, Section I, Item D.2.

4. Quarterly Budget Report

a. The Contractor shall submit to the State a quarterly budget report sixty (60) days prior to the start of each federal quarter in a standardized electronic and paper format specified by the State. The quarterly budget report shall include monthly estimates of enrollment and corresponding expenditures in a two-year State fiscal period. A State fiscal period is defined as the twelve-month period beginning July 1 through June 30. This report is a federal requirement, therefore, the State's ability to pay the Contractor is contingent on the timely submission of the quarterly budget report.

b. Upon approval of SPA 19, the Contractor shall make changes to the Quarterly Budget Report if requested by the State.

5. Quarterly Statistical Enrollment Report

a. The Contractor shall submit to the State a quarterly statistical enrollment report by the tenth (10th) day after the end of the quarter in an electronic and paper format as specified by the State. The quarterly statistical enrollment report shall include actual enrollment for each federal quarter, including statistics on new enrollment, disenrollment and ever-enrolled subscribers. This report is a federal requirement; therefore, the State's ability to pay the

Contractor is contingent on the timely submission of the quarterly statistical enrollment report.

b. Upon approval of SPA 19, the Contractor shall make changes to the Quarterly Statistical Enrollment Report if requested by the State.

6. Any financial, enrollment, retroactive payment, budget or statistical enrollment report received not completed in accordance with Section I, Items D.1 through 5 of this Exhibit shall be considered unacceptable and returned to the Contractor unprocessed with an explanation of any problems with the financial report. The Contractor may resubmit an acceptable report. The State reserves the right to make minor corrections to the report and process the reports for payment or reporting with the corrections.

7. Any financial, enrollment, and retroactive benefit payment report submitted as described under Section 1, Items D.1 through 3 of this Exhibit after review and approval by the State shall be considered valid and acceptable for processing of payment for benefit and administrative services provided to program subscribers.

8. The State will notify the Contractor when it has approved the monthly financial report and monthly enrollment report or the retroactive benefits payment report and request submission of the applicable county contribution to be submitted by the Contractor electronically to the State Treasurer's Office. Upon receipt of the county contribution, the State will process the payment of the Title XXI federal reimbursement in accordance with State and federal payment procedures.

II. FISCAL CONTROL PROVISIONS

A. Cost Controls Provided by Contractor

The Contractor shall ensure that the Contractor's plans provide routine monitoring of the cost, quantity, and quality of benefits provided by participating providers to subscribers, for the purpose of determining whether the level, type, and cost of such benefits are appropriate to the health care needs of the subscribers. The system of monitoring utilization shall include reporting to its providers of the findings of the Contractor's plans' monitoring activity.

B. Payment Limitation

Only eligible subscribers whom the Contractor has enrolled in the program are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the eligible subscriber is enrolled.

C. Availability of Federal Funds

1. It is mutually understood between the parties that this Agreement may have been written for the mutual benefit of both parties, based on then-existing regulations and federal executive agencies' interpretation and application of relevant regulations and statutes but before ascertaining the availability of Congressional appropriation of funds, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

2. This Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purposes of this program for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions made applicable at any time by:

   a. enactments of Congress

   b. regulations promulgated or amended by federal executive agencies, or

   c. the interpretation or application by federal executive agencies of relevant regulations and statutes that may affect the provisions, terms or funding of this Agreement in any manner.

3. The parties mutually agree that, if Congress does not appropriate sufficient funds for the Program or, as described in Items Exhibit B, II.C.2.a, b and c, restrictions, limitations or conditions affect the provisions, terms or funding of this Agreement, this Agreement shall be amended to reflect any reduction in funds and any restrictions, limitations or conditions that affect the Agreement's provisions, terms or funding.

4. The State has the option to invalidate this Agreement under the 30-day termination clause in Exhibit D, Item I.B, or to amend the Agreement to reflect any reduction in funds.

D. Prior to Fiscal Year/Crossing Fiscal Years

It is mutually agreed between the parties that this Agreement may have been signed and executed prior to the start of the 2013-20142012-2013 State fiscal year before ascertaining the availability of federal funds allocated through the State budget for the 2013-20142012-2013 State fiscal year. This Agreement has also been written with a term that crosses State fiscal years, and therefore before ascertaining the availability of legislative appropriation of federal funds for the 2012-2013 and 2013-2014 State fiscal years. This Agreement is valid and enforceable only if sufficient federal funds are made available through the 2012-2013 and 2013-2014 State budgets for the purposes of this program. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted in statute by the State Legislature which may affect the provision, term or funding of this Agreement in any manner. It is mutually agreed that if the State Legislature does not appropriate sufficient funds for this program, the Agreement shall be amended to reflect any reduction in funds.

E. CHIM Fund Encumbrance

There is no specific maximum amount assigned to this Agreement. Rather, the Contractor is paid through a general encumbrance from the CHIM Fund apportioned to the Contractor on an as needed basis. Payments under this Agreement are limited to the provisions of Items I.A. and I.B of this Exhibit.

F. Fiscal Solvency

1. The Contractor warrants that the Contractor's plans licensed by the Department of Managed Health Care shall at all times maintain the reserves required under the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated there under by the Department of Managed Health Care, including the Tangible Net Equity regulations.

   Evidence of above solvency shall be made available to the State upon request.

2. The Contractor warrants that the Contractor's health insurers, licensed by the Department of Insurance, shall at all times comply with all solvency requirements of its licensing statute and regulations and shall at all time maintain one of the following:

   a. A rating of A+ under Best insurance rating, or

   b. A surplus capable of paying one month of Contractor's paid claims. The amount of one month of the Contractor's paid claims shall be established by averaging claims paid in each of the previous twelve (12) months.

   Evidence of above solvency shall be made available to the State upon request.

G. Federally Funded Programs (Medicare & Medicaid)

The Contractor shall ensure that the Contractor's plans or insurers who participate in the federal Medicaid or Medicare programs remain in good standing with the State Department of Health Services (DHCS) for services provided to Medicaid (Medi-Cal) subscribers, with the federal Centers for Medicare and Medicaid Services for services provided to Medi-Cal or Medicare subscribers, and with the Office of the Inspector General of the Department of Health and Human Services. On request, the Contractor agrees to ensure that the Contractor's plans provide the State immediately with copies of all correspondence received by the plan(s) or insurer(s) from the DHCS~~Department of Health Services~~, the Centers for Medicare and Medicaid Services, and the Office of the Inspector General of the Department of Health and Human Services which pertains to the plans or Insurers standing with the respective departments. In addition, the Contractor shall immediately notify the State of any investigations in which there are allegations related to fraud, including but not limited to: 1) the receipt of an administrative subpoena from any state or federal agency, unless the plan or insurer is advised that it is not the target or subject of the investigation; 2) the receipt of a grand jury subpoena from any state or federal court, unless the plan or insurer is advised that it is not the target or subject of the investigation; 3) the execution of a search and seizure warrant at any of the selected plan's or insurer's offices or locations related to such investigations; and 4) the filing of any charges against the selected plan or insurer in any state or federal court related to such investigations. The Contractor shall ensure that the Contractor's plans immediately notify the State if the plan or insurer receives a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the

DHCS~~State Department of Health Services~~, the Centers for Medicare and Medicaid Services, or the Office of the Inspector General of the Department of Health and Human Services.

H. Licensure

The Contractor warrants the State that the Contractor's health plan or insurer has a license to provide services under this Agreement from its regulatory agency, the Department of Managed Health Care or the Department of Insurance.

I. Licensing Sanction Notifications

1. The Contractor warrants that the Contractor's plans shall remain in good standing with the Department of Managed Health Care. On request, the Contractor agrees to ensure that the Contractor's plans provide the State with copies of all correspondence from the Department of Managed Health Care that pertains to the plan standing with its regulatory entity. The Contractor shall immediately notify the State if the Contractor's plans receive a letter of pending sanction or formal corrective action (such as corrective action addressing audit findings or systemic problems) from the Department of Managed Health Care.

2. The Contractor warrants that the Contractor's health insurers shall remain in good standing with the Department of Insurance. The Contractor agrees to ensure that the Contractor's insurers provide the State with copies of all correspondence from the Department of Insurance that pertains to the insurer standing with their regulatory entity. The Contractor shall ensure that the Contractor's insurers immediately notify the State if the insurer receives a letter of pending significant sanction or corrective action from the Department of Insurance.

J. Responsibility for Audit, Investigation and Evaluation Findings

The Contractor shall hold the State harmless for any federal disallowances and adjustments resulting from the Contractor's performance under this Agreement. The State shall recoup any federal and state disallowances and adjustments from the Contractor including any State costs related to the disallowances.

ATTACHMENT I
CONFIDENTIAL RATES OF PAYMENT

This attachment is confidential, and is not open until, at the earliest October 1, 2017~~2016~~. See Exhibit D, Item II.N of this Agreement for the standards governing confidentiality.

HEALTHY FAMILIES PROGRAM RATES

County of San Mateo Composite Rates for Health, Dental & Vision		Region 3
Current Year Rate:	**Infant Rate**	**Child Rate**
2013/14 (10/1/13-12/31/13) ~~2012/13 (10/1/12-9/30/13)~~	180.89	101.00 ~~78.54~~
Prior Years Rates for Retroactive Claims		
	Infant Rate	**Child Rate**
2012/13 (10/1/12-9/30/13)	180.89	78.54
2011/12 (10/1/11-9/30/12)	180.89	78.54
2010/11 (10/1/10-9/30/11)	167.11	73.00
2010/11 (7/1/10 -9/30/10	167.11	73.00
2009/10 (11/1/09-6/30/10)	167.11	73.00
2009/10 (7/1/09-10/31/09	172.17	74.93
2008/09 (2/1/09-6/30/09)	157.43	71.92
2007/08	165.63	75.67
2006/07	165.63	75.64
2005/06	165.35	75.39
2004/05	212.11	92.00
2003/04	212.11	92.00
2002/03	226.87	96.90
San Mateo rates for 1-18 years were adjusted to deduct costs for State Supported Services		