



REVISED

AGENCY ADMIN. & FINANCE
1000 San Leandro Boulevard, Suite 300
San Leandro, CA 94577
Tel: (510) 618-3452
Fax: (510) 351-1367

June 26, 2012

The Honorable Board of Supervisors
County Administration Building
1221 Oak Street
Oakland, CA 94612

Dear Board Members:

SUBJECT: Approval of the Standard Agreement with the Alameda Alliance for Health to serve as the Third Party Administrator (TPA) for HealthPAC

RECOMMENDATIONS:

1. Approve a Standard Agreement with the Alameda Alliance for Health (Principal: Ingrid Lamirault, Chief Executive Officer; Location: Alameda; Procurement #7763) in the amount of \$1,951,728 for the period beginning July 1, 2012 and ending June 30, 2013, to act as the Third Party Administrator (TPA) for HealthPAC;
2. Approve the attached budget adjustments

DISCUSSION/FINDINGS:

On November 2, 2010, the federal government approved California's five year, "Bridge to Reform" Section 1115 waiver proposal. Through the 1115 waiver, California will advance program changes that will help the state transition to the federal reforms that will take effect in January, 2014 related in particular to Medi-Cal expansion. It establishes the Low Income Health Program (LIHP) that enables California to draw down federal revenue for a portion of its current Section 17000 Medically Indigent population.

The Standard Terms and Conditions (STCs) mandate that the LIHP program must adhere to the Medi-Cal managed care criteria and standards for health plans as set forth in statutes, regulations and policies adopted by the Department of Health Care Services. Given these criteria, Health Care Services Agency contracted with the Alameda Alliance for Health (Alliance), Alameda County's Local Initiative Managed Care Health Plan, to act as the Third Party Administrator for HealthPAC starting on July 1, 2011, approved by your Board on June 28, 2011. The Alliance has an infrastructure in place to

meet the criteria mandated in the STCs. The Alliance will perform the following services for the County:

- Work with the County to develop HealthPAC program materials and print and deliver said materials to eligible participants
- Maintain a customer service call center to respond to inquiries from individuals
- Coordinate, authorize and manage all non-emergency medically related transportation services
- Participate in and comply with the HealthPAC Utilization Management and Quality Improvement Program and prepare reports
- Submit encounter data to the County in electronic format monthly
- Handle all grievances and appeals in accordance with the requirements established in the County's Grievance and Appeal process.
- Provide written reports as requested by the County but not limited to: grievances and appeals, utilization, inpatient and outpatient services, out of network encounters, quality improvement program
- Handle the credentialing and re-credentialing of all HealthPac providers

SELECTION CRITERIA:

The Alameda Alliance for Health is a public entity and is Alameda County's local initiative managed care plan that is licensed to operate a Health Care Services Plan under the Knox-Keen Health Care Service Plan Act of 1975. Alameda County has a long standing relationship with the Alliance and they are the only local plan that could provide the required administrative activities that the State and Federal governments require. The Alameda Alliance for Health is a nonprofit organization and is exempt from the requirements of the SLEB program.

FINANCING:

Funding for this contract is partially included in the FY12/13 budget. The attached financial recommendation in the amount of \$251,728 is additional Federal funding. Approval of the recommendations as stated in this Board letter will have no impact on County General Fund Revenue.

Sincerely,



Alex Briscoe, Director
Alameda County Health Care Services Agency

Cc: County Administrator
County Counsel
Auditor-Controller
CEO, Alameda Alliance for Health
HealthPAC Program Administrator

FINANCIAL RECOMMENDATION

AGENDA DATE: 7/10/2012

Subject of Board Letter:

Approve a contract with Alameda Alliance for Health

BY: 2013

FUND: 10000

The use of Designations, as follows:

NAME OF DESIGNATION	ORG	AMOUNT

The increase (decrease) in anticipated revenue, as follows:

Informational

ORG	ACCT	PROG	PROJ/GR	AMOUNT
350100	456120	00000		\$251,728
ORG TOTAL				\$251,728

Informational

ORG	ACCT	PROG	PROJ/GR	AMOUNT
ORG TOTAL				\$0

GRAND TOTAL ANTICIPATED REVENUE \$251,728

The increase (decrease) in appropriations, as follows:

Informational

ORG	ACCT	PROG	PROJ/GR	AMOUNT
350100	610000	00000		\$251,728
ORG TOTAL				\$251,728

Informational

ORG	ACCT	PROG	PROJ/GR	AMOUNT
ORG TOTAL				\$0

GRAND TOTAL APPROPRIATION \$251,728

QUESTIONNAIRE FOR DETERMINING THE WITHHOLDING STATUS

INSTRUCTIONS: This questionnaire is to be completed by the County department for services contracts and must be included as part of the contract package. Be sure to answer all of the questions in Sections I and II and to complete the certifications on page 2. Sections III and IV contain supplemental questions to be answered for contractors in certain service categories.

CONTRACTOR NAME: Alameda Alliance for Health DEPT #: _____

TITLE/SERVICE: HealthPAC TPA

DEPT. CONTACT: Rachel Metz PHONE: 510-618-1923

I. INFORMATION ABOUT THE CONTRACTOR **YES NO**

1. Is the contractor a corporation or partnership? (Y) ()

2. Does the contractor have the right per the contract to hire others to do the work agreed to in the contract? (Y) ()

3. If the answer to BOTH questions is YES, provide the employer ID number here:
20-3674364.

No other questions need to be answered. Withholding is not required.

4. If the answer to question 1 is NO and 2 is YES, provide the individual social security number here: _____

No other questions need to be answered. Withholding is not required.

5. If the answer to question 2 is NO, continue to Section II.

II. RELATIONSHIP OF THE PARTIES **YES NO**

1. Does the County have the right to control the way in which the work will be done, i.e., will the County be able to specify the sequence of steps or the processes to be followed if it chooses to do so? () ()

2. Is the contractor restricted from performing similar services for other businesses while he is working for the County? () ()

3. Will the contractor be working for more than 50% of the time for the County (50% = 20 hrs/wk; 80 hrs/mo)? () ()

4. Is the relationship between the County and the contractor intended to be ongoing? () ()

III. FOR CONSULTANTS, PROJECT MANAGERS, PROJECT COORDINATORS

- 1. Is the contractor being hired for a period of time rather than for a specific project? () ()
- 2. Will payment be based on a wage or salary (as opposed to a commission or lump sum)? () ()

IV. FOR PHYSICIANS, PSYCHIATRISTS, DENTISTS, PSYCHOLOGISTS

- 1. Will the agreement be with an individual who does not have an outside practice? () ()
- 2. Will the contractor work more than an average of ten hours per week? () ()


IF THE ANSWER TO 2 IS YES, ANSWER QUESTIONS 3.

- 3. Will the County provide more than 20% of the contractor's income? () ()
- 4. If the answer to either question 1.a, or if required, question 1.b is NO, the entire answer is NO.

A "yes" answer to any of the questions in Section II, or, if applicable, Sections III or IV constitutes justification for paying the contractor through the payroll system as an "employee for withholding purposes."

CERTIFICATIONS:

I hereby certify that the answers to the above questions accurately reflect the anticipated working relationship for this contract.



 Contractor Signature

 Agency/Department Head/Designee
 Signature

Ingrid Lamirault



 Alex Briscoe

6/12/12

 Date

6/12/12

 Date

**COUNTY OF ALAMEDA
STANDARD SERVICES AGREEMENT**

This Agreement, dated as of July 1, 2012, is by and between the County of Alameda, Health Care Services Agency, hereinafter referred to as the "County", and **Alameda Alliance for Health** hereinafter referred to as the "Contractor".

WITNESSETH

Whereas, County desires to obtain **Health Plan Third Party Administrative ("TPA Services")** for services which are more fully described in Exhibit A;

Whereas, Contractor is professionally qualified to provide such services and is willing to provide same to County; and

Now, therefore it is agreed that County does hereby retain Contractor to provide **TPA Services**, and Contractor accepts such engagement, on the General Terms and Conditions hereinafter specified in this Agreement, the Additional Provisions attached hereto, and the following described exhibits, all of which are incorporated into this Agreement by this reference:

- Exhibit A-1 Scope of Services
- Exhibit A-2 HealthPAC Plan
- Exhibit A-3 HealthPAC Plan Interpretation and Procedures
- Exhibit A-4 HealthPAC Participant Grievance Process
- Exhibit B Payment Terms
- Exhibit C Insurance Requirements
- Exhibit D Debarment and Suspension Certification
- Exhibit E Business Associate Agreement

The term of this Agreement shall be from July 1, 2012 through June 30, 2013.

The compensation payable to Contractor hereunder shall not exceed *one million, nine hundred and fifty-one thousand, seven hundred and twenty-eight (\$1,951,728)* for the term of this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

COUNTY OF ALAMEDA

ALAMEDA ALLIANCE FOR HEALTH

By: _____
Signature

By:  _____
Signature

Name: _____
(Printed)

Name: Ingrid Lamirault
(Printed)

Title: President of the Board of Supervisors

Title: Chief Executive Officer

Date: _____

Date: 6/12/12

Approved as to Form, DONNA ZIEGLER,
County Counsel for the County of Alameda:

By:  _____
Sen. Dep. County Counsel Ray Lara

By signing above, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement.

GENERAL TERMS AND CONDITIONS

1. **INDEPENDENT CONTRACTOR:** No relationship of employer and employee is created by this Agreement; it being understood and agreed that Contractor is an independent contractor. Contractor is not the agent or employee of the County in any capacity whatsoever, and County shall not be liable for any acts or omissions by Contractor nor for any obligations or liabilities incurred by Contractor.

Contractor shall have no claim under this Agreement or otherwise, for seniority, vacation time, vacation pay, sick leave, personal time off, overtime, health insurance medical care, hospital care, retirement benefits, social security, disability, Workers' Compensation, or unemployment insurance benefits, civil service protection, or employee benefits of any kind.

Contractor shall be solely liable for and obligated to pay directly all applicable payroll taxes (including federal and state income taxes) or contributions for unemployment insurance or old age pensions or annuities which are imposed by any governmental entity in connection with the labor used or which are measured by wages, salaries or other remuneration paid to its officers, agents or employees and agrees to indemnify and hold County harmless from any and all liability which County may incur because of Contractor's failure to pay such amounts.

In carrying out the work contemplated herein, Contractor shall comply with all applicable federal and state workers' compensation and liability laws and regulations with respect to the officers, agents and/or employees conducting and participating in the work; and agrees that such officers, agents, and/or employees will be considered as independent contractors and shall not be treated or considered in any way as officers, agents and/or employees of County.

Contractor does, by this Agreement, agree to perform his/her said work and functions at all times in strict accordance with currently approved methods and practices in his/her field and that the sole interest of County is to insure that said service shall be performed and rendered in a competent, efficient, timely and satisfactory manner and in accordance with the standards required by the County agency concerned.

Notwithstanding the foregoing, if the County determines that pursuant to state and federal law Contractor is an employee for purposes of income tax withholding, County may upon two week's notice to Contractor, withhold from payments to Contractor hereunder federal and state income taxes and pay said sums to the federal and state governments.

2. **INDEMNIFICATION:** See REPLACEMENT AND ADDITIONAL PROVISIONS.

3. **INSURANCE AND BOND:** Contractor shall at all times during the term of the Agreement with the County maintain in force those insurance policies and bonds as designated in the attached Exhibit C, and will comply with all those requirements as stated therein.

4. **PREVAILING WAGES:** Pursuant to Labor Code Sections 1770 et seq., Contractor shall pay to persons performing labor in and about Work provided for in Contract not less than the general prevailing rate of per diem wages for work of a similar character in the locality in which the Work is performed, and not less than the general prevailing rate of per diem wages for legal holiday and overtime work in said locality, which per diem wages shall not be less than the stipulated rates contained in a schedule thereof which has been ascertained and determined by the Director of the State Department of Industrial Relations to be the general prevailing rate of per diem wages for each craft or type of workman or mechanic needed to execute this contract.
5. **WORKERS' COMPENSATION:** Contractor shall provide Workers' Compensation insurance, as applicable, at Contractor's own cost and expense and further, neither the Contractor nor its carrier shall be entitled to recover from County any costs, settlements, or expenses of Workers' Compensation claims arising out of this Agreement.
6. **CONFORMITY WITH LAW AND SAFETY:**
 - a. In performing services under this Agreement, Contractor shall observe and comply with all applicable laws, ordinances, codes and regulations of governmental agencies, including federal, state, municipal, and local governing bodies, having jurisdiction over the scope of services, including all applicable provisions of the California Occupational Safety and Health Act. Contractor shall indemnify and hold County harmless from any and all liability, fines, penalties and consequences from any of Contractor's failures to comply with such laws, ordinances, codes and regulations.
 - b. **Accidents:** If a death, serious personal injury or substantial property damage occurs in connection with Contractor's performance of this Agreement, Contractor shall immediately notify the Alameda County Risk Manager's Office by telephone. Contractor shall promptly submit to County a written report, in such form as may be required by County of all accidents which occur in connection with this Agreement. This report must include the following information: (1) name and address of the injured or deceased person(s); (2) name and address of Contractor's sub-Contractor, if any; (3) name and address of Contractor's liability insurance carrier; and (4) a detailed description of the accident and whether any of County's equipment, tools, material, or staff were involved.
 - c. Contractor further agrees to take all reasonable steps to preserve all physical evidence and information which may be relevant to the circumstances surrounding a potential claim, while maintaining public safety, and to grant to the County the opportunity to review and inspect such evidence, including the scene of the accident.
7. **DEBARMENT AND SUSPENSION CERTIFICATION:** (Applicable to all agreements funded in part or whole with federal funds and contracts over \$25,000).

- a. By signing this agreement and Exhibit D, Debarment and Suspension Certification, Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations, including but not limited to 7 Code of Federal Regulations (CFR) 3016.35, 28 CFR 66.35, 29 CFR 97.35, 34 CFR 80.35, 45 CFR 92.35 and Executive Order 12549.
- b. By signing this agreement, Contractor certifies to the best of its knowledge and belief, that it and its principals:
 - (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;
 - (2) Shall not knowingly enter into any covered transaction with a person who is proposed for debarment under federal regulations, debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction.
8. PAYMENT: For services performed in accordance with this Agreement, payment shall be made to Contractor as provided in Exhibit B hereto.
9. TRAVEL EXPENSES: Contractor shall not be allowed or paid travel expenses unless set forth in this Agreement.
10. TAXES: Payment of all applicable federal, state, and local taxes shall be the sole responsibility of the Contractor.
11. OWNERSHIP OF DOCUMENTS: Contractor hereby assigns to the County and its assignees all copyright and other use rights in any and all proposals, plans, specification, designs, drawings, sketches, renderings, models, reports and related documents (including computerized or electronic copies) respecting in any way the subject matter of this Agreement, whether prepared by the County, the Contractor, the Contractor's sub-Contractors or third parties at the request of the Contractor (collectively, "Documents and Materials"). This explicitly includes the electronic copies of all above stated documentation.

Contractor also hereby assigns to the County and its assignees all copyright and other use rights in any Documents and Materials including electronic copies stored in Contractor's Information System, respecting in any way the subject matter of this Agreement.

Contractor shall be permitted to retain copies, including reproducible copies and computerized copies, of said Documents and Materials. Contractor agrees to take such further steps as may be reasonably requested by County to implement the aforesaid assignment. If for any reason said assignment is not effective, Contractor hereby grants the County and any assignee of the County an express royalty – free license to retain and use said Documents and Materials. The County's rights under

this paragraph shall apply regardless of the degree of completion of the Documents and Materials and whether or not Contractor's services as set forth in Exhibit "A" of this Agreement have been fully performed or paid for.

In Contractor's contracts with other Contractors, Contractor shall expressly obligate its Sub-Contractors to grant the County the aforesaid assignment and license rights as to that Contractor's Documents and Materials. Contractor agrees to defend, indemnify and hold the County harmless from any damage caused by a failure of the Contractor to obtain such rights from its Contractors and/or Sub-Contractors.

Contractor shall pay all royalties and license fees which may be due for any patented or copyrighted materials, methods or systems selected by the Contractor and incorporated into the work as set forth in Exhibit "A", and shall defend, indemnify and hold the County harmless from any claims for infringement of patent or copyright arising out of such selection. The County's rights under this Paragraph 11 shall not extend to any computer software used to create such Documents and Materials.

12. ~~CONFLICT OF INTEREST; CONFIDENTIALITY: The Contractor covenants that it presently has no interest, and shall not have any interest, direct or indirect, which would conflict in any manner with the performance of services required under this Agreement. Without limitation, Contractor represents to and agrees with the County that Contractor has no present, and will have no future, conflict of interest between providing the County services hereunder and any other person or entity (including but not limited to any federal or state wildlife, environmental or regulatory agency) which has any interest adverse or potentially adverse to the County, as determined in the reasonable judgment of the Board of Supervisors of the County. See REPLACEMENT AND ADDITIONAL PROVISIONS~~

The Contractor agrees that any information, whether proprietary or not, made known to or discovered by it during the performance of or in connection with this Agreement for the County will be kept confidential and not be disclosed to any other person. The Contractor agrees to immediately notify the County by notices provided in accordance with Paragraph 13 of this Agreement, if it is requested to disclose any information made known to or discovered by it during the performance of or in connection with this Agreement. These conflict of interest and future service provisions and limitations shall remain fully effective five (5) years after termination of services to the County hereunder.

13. NOTICES: All notices, requests, demands, or other communications under this Agreement shall be in writing. Notices shall be given for all purposes as follows:

Personal delivery: When personally delivered to the recipient, notices are effective on delivery.

First Class Mail: When mailed first class to the last address of the recipient known to the party giving notice, notice is effective three (3) mail delivery days after deposit in a United States Postal Service office or mailbox. Certified Mail: When mailed certified

mail, return receipt requested, notice is effective on receipt, if delivery is confirmed by a return receipt.

Overnight Delivery: When delivered by overnight delivery (Federal Express/Airborne/United Parcel Service/DHL WorldWide Express) with charges prepaid or charged to the sender's account, notice is effective on delivery, if delivery is confirmed by the delivery service. Telex or facsimile transmission: When sent by telex or facsimile to the last telex or facsimile number of the recipient known to the party giving notice, notice is effective on receipt, provided that (a) a duplicate copy of the notice is promptly given by first-class or certified mail or by overnight delivery, or (b) the receiving party delivers a written confirmation of receipt. Any notice given by telex or facsimile shall be deemed received on the next business day if it is received after 5:00 p.m. (recipient's time) or on a non-business day.

Addresses for purpose of giving notice are as follows:

To County: COUNTY OF ALAMEDA
Health Care Services Agency
1000 San Leandro Blvd, Suite 300
San Leandro, CA 94577
Attn: Rachel Metz

To Contractor: Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502
Attn: Leila Saadat

Any correctly addressed notice that is refused, unclaimed, or undeliverable because of an act or omission of the party to be notified shall be deemed effective as of the first date that said notice was refused, unclaimed, or deemed undeliverable by the postal authorities, messenger, or overnight delivery service.

Any party may change its address or telex or facsimile number by giving the other party notice of the change in any manner permitted by this Agreement.

14. USE OF COUNTY PROPERTY: Contractor shall not use County property (including equipment, instruments and supplies) or personnel for any purpose other than in the performance of his/her obligations under this Agreement.
15. EQUAL EMPLOYMENT OPPORTUNITY PRACTICES PROVISIONS: Contractor assures that he/she/it will comply with Title VII of the Civil Rights Act of 1964 and that no person shall, on the grounds of race, creed, color, disability, sex, sexual orientation, national origin, age, religion, Vietnam era Veteran's status, political affiliation, or any other non-merit factor, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement.
 - a. Contractor shall, in all solicitations or advertisements for applicants for employment placed as a result of this Agreement, state that it is an "Equal Opportunity Employer" or that all qualified applicants will receive consideration

for employment without regard to their race, creed, color, disability, sex, sexual orientation, national origin, age, religion, Vietnam era Veteran's status, political affiliation, or any other non-merit factor.

- b. Contractor shall, if requested to so do by the County, certify that it has not, in the performance of this Agreement, discriminated against applicants or employees because of their race, creed, color, disability, sex, sexual orientation, national origin, age, religion, Vietnam era Veteran's status, political affiliation, or any other non-merit factor.
- c. If requested to do so by the County, Contractor shall provide the County with access to copies of all of its records pertaining or relating to its employment practices, except to the extent such records or portions of such records are confidential or privileged under state or federal law.
- d. Contractor shall recruit vigorously and encourage minority - and women-owned businesses to bid its subcontracts.
- e. Nothing contained in this Agreement shall be construed in any manner so as to require or permit any act, which is prohibited by law.
- f. See REPLACEMENT AND ADDITIONAL PROVISIONS

16. DRUG-FREE WORKPLACE: Contractor and Contractor's employees shall comply with the County's policy of maintaining a drug-free workplace. Neither Contractor nor Contractor's employees shall unlawfully manufacture, distribute, dispense, possess or use controlled substances, as defined in 21 U.S. Code § 812, including, but not limited to, marijuana, heroin, cocaine, and amphetamines, at any County facility or work site. If Contractor or any employee of Contractor is convicted or pleads nolo contendere to a criminal drug statute violation occurring at a County facility or work site, the Contractor within five days thereafter shall notify the head of the County department/agency for which the contract services are performed. Violation of this provision shall constitute a material breach of this Agreement

17. AUDITS; ACCESS TO RECORDS: The Contractor shall make available to the County, its authorized agents, officers, or employees, for examination any and all ledgers, books of accounts, invoices, vouchers, cancelled checks, and other records or documents evidencing or relating to the expenditures and disbursements charged to the County, and shall furnish to the County, its authorized agents, officers or employees such other evidence or information as the County may require with regard to any such expenditure or disbursement charged by the Contractor.

The Contractor shall maintain full and adequate records in accordance with County requirements to show the actual costs incurred by the Contractor in the performance of this Agreement. If such books and records are not kept and maintained by Contractor within the County of Alameda, California, Contractor shall, upon request of the County, make such books and records available to the County for inspection at a location

within County or Contractor shall pay to the County the reasonable, and necessary costs incurred by the County in inspecting Contractor's books and records, including, but not limited to, travel, lodging and subsistence costs. Contractor shall provide such assistance as may be reasonably required in the course of such inspection. The County further reserves the right to examine and reexamine said books, records and data during the five (5) year period following termination of this Agreement or completion of all work hereunder, as evidenced in writing by the County, and the Contractor shall in no event dispose of, destroy, alter, or mutilate said books, records, accounts, and data in any manner whatsoever for five (5) years after the County makes the final or last payment or within five (5) years after any pending issues between the County and Contractor with respect to this Agreement are closed, whichever is later.

18. DOCUMENTS AND MATERIALS: Contractor shall maintain and make available to County for its inspection and use during the term of this Agreement, all Documents and Materials, as defined in Paragraph 11 of this Agreement. Contractor's obligations under the preceding sentence shall continue for five (5) years following termination or expiration of this Agreement or the completion of all work hereunder (as evidenced in writing by County), and Contractor shall in no event dispose of, destroy, alter or mutilate said Documents and Materials, for five (5) years following the County's last payment to Contractor under this Agreement.

19. TIME OF ESSENCE: Time is of the essence in respect to all provisions of this Agreement that specify a time for performance; provided, however, that the foregoing shall not be construed to limit or deprive a party of the benefits of any grace or use period allowed in this Agreement.

20. TERMINATION: See REPLACEMENT AND ADDITIONAL PROVISIONS

21. SMALL LOCAL AND EMERGING BUSINESS PARTICIPATION:

SMALL, LOCAL AND EMERGING BUSINESS (SLEB) PARTICIPATION: Contractor has been approved by County to participate in contract without SLEB participation. As a result, there is no requirement to subcontract with another business in order to satisfy the County's Small and Emerging Locally owned Business provision.

However, if circumstances or the terms of the contract should change, Contractor may be required to immediately comply with the County's Small and Emerging Local Business provisions, including but not limited to:

- a. Contractor must be a certified small or emerging local business(es) or subcontract a minimum 20% with a certified small or emerging local business(es).
- b. SLEB subcontractor(s) is independently owned and operated (i.e., is not owned or operated in any way by Prime), nor do any employees of either entity work for the other.

- c. Small and/or Emerging Local Business participation and current SLEB certification status must be maintained for the term of the contract. Contractor shall ensure that their own certification status and/or that of participating subcontractors (as is applicable) are maintained in compliance with the SLEB Program.
- d. Contractor shall not substitute or add any small and/or emerging local business(s) listed in this agreement without prior written approval from the County. Said requests to substitute or add a small and/or emerging local business shall be submitted in writing to the County department contract representative identified under Item #13 above. Contractor will not be able to substitute the subcontractor without prior written approval from the Alameda County Auditor Controller Agency, Office of Contract Compliance (OCC).
- e. All SLEB participation, except for SLEB prime contractor, must be tracked and monitored utilizing the Elation compliance System.

County will be under no obligation to pay contractor for the percent committed to a SLEB (whether SLEB is a prime or subcontractor) if the work is not performed by the listed small and/or emerging local business.

For further information regarding the Small Local Emerging Business participation requirements and utilization of the Alameda County Contract Compliance System contact the County Auditor- Controller's Office of Contract Compliance (OCC) located at 1221 Oak St., Rm. 249, Oakland, CA 94612 at Tel: (510) 891-5500, Fax: (510) 272-6502 or via E-mail at ACSLEBcompliance@acgov.org.

- 22. FIRST SOURCE PROGRAM: For contracts over \$100,000, Contractor shall provide County ten (10) working days to refer to Contractor, potential candidates to be considered by Contractor to fill any new or vacant positions that are necessary to fulfill their contractual obligations to the County that Contractor has available during the contract term before advertising to the general public.
- 23. CHOICE OF LAW: This Agreement shall be governed by the laws of the State of California.
- 24. WAIVER: No waiver of a breach, failure of any condition, or any right or remedy contained in or granted by the provisions of this Agreement shall be effective unless it is in writing and signed by the party waiving the breach, failure, right or remedy. No waiver of any breach, failure, right or remedy shall be deemed a waiver of any other breach, failure, right or remedy, whether or not similar, nor shall any waiver constitute a continuing waiver unless the writing so specifies.
- 25. ENTIRE AGREEMENT: This Agreement, including all attachments, exhibits, and any other documents specifically incorporated into this Agreement, shall constitute the entire agreement between County and Contractor relating to the subject matter of this Agreement. As used herein, Agreement refers to and includes any documents

incorporated herein by reference and any exhibits or attachments. This Agreement supersedes and merges all previous understandings, and all other agreements, written or oral, between the parties and sets forth the entire understanding of the parties regarding the subject matter thereof. The Agreement may not be modified except by a written document signed by both parties.

26. HEADINGS herein are for convenience of reference only and shall in no way affect interpretation of the Agreement.
27. ADVERTISING OR PUBLICITY: Contractor shall not use the name of County, its officers, directors, employees or agents, in advertising or publicity releases or otherwise without securing the prior written consent of County in each instance.
28. MODIFICATION OF AGREEMENT: This Agreement may be supplemented, amended or modified only by the mutual agreement of the parties. No supplement, amendment or modification of this Agreement shall be binding unless it is in writing and signed by authorized representatives of both parties.
29. ASSURANCE OF PERFORMANCE: If at any time County believes Contractor may not be adequately performing its obligations under this Agreement or that Contractor may fail to complete the Services as required by this Agreement, County may request from Contractor prompt written assurances of performance and a written plan acceptable to County, to correct the observed deficiencies in Contractor's performance. Contractor shall provide such written assurances and written plan within ten (10) calendar days of its receipt of County's request and shall thereafter diligently commence and fully perform such written plan. Contractor acknowledges and agrees that any failure to provide such written assurances and written plan within the required time is a material breach under this Agreement.
30. SUBCONTRACTING/ASSIGNMENT: Contractor shall not subcontract, assign or delegate any portion of this Agreement or any duties or obligations hereunder without the County's prior written approval.
 - a. Neither party shall, on the basis of this Agreement, contract on behalf of or in the name of the other party. Any agreement that violates this Section shall confer no rights on any party and shall be null and void.
 - b. Contractor shall use the subcontractors identified in Exhibit A and shall not substitute subcontractors without County's prior written approval.
 - c. Contractor shall remain fully responsible for compliance by its subcontractors with all the terms of this Agreement, regardless of the terms of any agreement between Contractor and its subcontractors.
31. SURVIVAL: The obligations of this Agreement, which by their nature would continue beyond the termination on expiration of the Agreement, including without limitation, the obligations regarding Indemnification (Paragraph 2), Ownership of Documents

(Paragraph 11), and Conflict of Interest (Paragraph 12), shall survive termination or expiration.

32. SEVERABILITY: If a court of competent jurisdiction holds any provision of this Agreement to be illegal, unenforceable, or invalid in whole or in part for any reason, the validity and enforceability of the remaining provisions, or portions of them, will not be affected, unless an essential purpose of this Agreement would be defeated by the loss of the illegal, unenforceable, or invalid provision.
33. PATENT AND COPYRIGHT INDEMNITY: Contractor represents that it knows of no allegations, claims, or threatened claims that the materials, services, hardware or software ("Contractor Products") provided to County under this Agreement infringe any patent, copyright or other proprietary right. Contractor shall defend, indemnify and hold harmless County of, from and against all losses, claims, damages, liabilities, costs expenses and amounts (collectively, "Losses") arising out of or in connection with an assertion that any Contractor Products or the use thereof, infringe any patent, copyright or other proprietary right of any third party. County will: (1) notify Contractor promptly of such claim, suit or assertion; (2) permit Contractor to defend, compromise, or settle the claim; and, (3) provide, on a reasonable basis, information to enable Contractor to do so. Contractor shall not agree without County's prior written consent, to any settlement, which would require County to pay money or perform some affirmative act in order to continue using the Contractor Products.
- a. If Contractor is obligated to defend County pursuant to this Section 33 and fails to do so after reasonable notice from County, County may defend itself and/or settle such proceeding, and Contractor shall pay to County any and all losses, damages and expenses (including attorney's fees and costs) incurred in relationship with County's defense and/or settlement of such proceeding.
 - b. In the case of any such claim of infringement, Contractor shall either, at its option, (1) procure for County the right to continue using the Contractor Products; or (2) replace or modify the Contractor Products so that that they become non-infringing, but equivalent in functionality and performance.
 - c. Notwithstanding this Section 33, County retains the right and ability to defend itself, at its own expense, against any claims that Contractor Products infringe any patent, copyright, or other intellectual property right.
34. OTHER AGENCIES: Other tax supported agencies within the State of California who have not contracted for their own requirements may desire to participate in this contract. The Contractor is requested to service these agencies and will be given the opportunity to accept or reject the additional requirements. If the Contractor elects to supply other agencies, orders will be placed directly by the agency and payments made directly by the agency.
35. EXTENSION: This agreement may be extended for two additional one year terms by mutual agreement of the County and the Contractor.

36. SIGNATORY: By signing this agreement, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement.

[END OF GENERAL TERMS AND CONDITIONS]

REPLACEMENT AND ADDITIONAL PROVISIONS

1. *Section 2: The first paragraph is deleted and replaced with the following two paragraphs:*

Except as otherwise provided in Division 3.6 (commencing with Section 810) of Title 1 of the California Government Code, relating to claims and actions against public entities and public employees, each party shall defend, indemnify and hold the other party, its directors, employees, and representatives free and harmless against any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to reasonable attorneys' fees and court costs), which may result or arise out of any business dispute with a HealthPAC Participant, any breach of contract, or any defamation, fraud, malpractice, negligence, or intentional misconduct caused or alleged to have been caused by the indemnifying part or its agents, employees, or representatives in the performance or omission of any act or responsibility assumed by the indemnifying party under this Agreement.

Nothing in this section shall be construed to require either party to hold the other party harmless for that other party's own acts or omissions or those of its agents, employees, representatives or contractors, although a finding of liability may be based on the doctrines of equitable indemnity, comparative negligence, contribution or other common law basis for liability.

2. *Section 2 the following is added as the last paragraph:*

Contractor is a public agency and a PERS employer. In no event shall County be responsible for any enrollment or contributions of Contractor's employees, agents, or subcontractors, Contractor shall indemnify defend, and hold harmless County for the payment of any employee and/or employer contributions on behalf of its employees, agents, or subcontractors, as well as for the payment of any penalties and interest on such contributions, including those that are currently or will be enrolled in PERS.

3. *Section 15 (f) is deleted and replaced with the following:*

f. The Contractor shall include the provisions set forth in paragraphs A through E (above) in all contracts/subcontracts that Contractor enters into to fulfill its obligations under this Contract.

4. *The first paragraph in Section 12 is deleted and replaced with the following:*

Contractor is the health authority for the County of Alameda, and a public agency. Both parties will abide by applicable conflict of interest rules and regulations in dealings related to this Contract.

5. *Section 20 is deleted and replaced with the following:*

TERMINATION: The County has and reserves the right to suspend, terminate or abandon the execution of any work by the Contractor without cause at any time upon 60 days written notice to Contractor. However, if County must stop or reduce the HealthPAC program or terminate this contract due to any decrease in funding, Contractor shall use best efforts to immediately reduce costs and wind down service during the 60 day notice period, as directed by County. In the event that the County should abandon, terminate or suspend the Contractor's work, the Contractor shall be entitled to payment for services provided hereunder prior to the effective date of said suspension, termination or abandonment. Said payment shall be computed in accordance with Exhibit B hereto, provided that the maximum amount payable to Contractor for its services shall not exceed \$1,951,728 payment for services provided hereunder prior to the effective date of said suspension, termination or abandonment.

6. *The following is added as an Additional Term:*

HealthPAC BENEFIT PLAN INFORMATION. County will deliver to Contractor detailed information for the Health Program of Alameda County (HealthPAC) on the scope of benefits and eligibility ("HealthPAC Plan Information"). County will provide updated information to Contractor if the HealthPAC Plan Information is changed or amended. The HealthPAC Plan Information will contain information needed to accomplish the customer services tasks. County shall use best efforts to provide HealthPAC Plan Information changes to Contractor within thirty (30) days of the date such changes shall become effective (the "Change Date"), except that changes to HealthPAC Plan Information that are to be effective on July 1st of any given year may be provided to Contractor at least ninety (90) days prior to July 1st in order to be processed. County understands that a failure to provide HealthPAC Plan Information changes within the time frames may result in delay in processing the changes.

County Counsel Signature: 

EXHIBIT A -1**SCOPE OF SERVICES**

Contractor shall administer and act as a TPA for the Health Program of Alameda County ("HealthPAC"). Contractor shall follow the HealthPAC Plan and the HealthPAC Plan Interpretation and Procedures (collectively HealthPAC Plan Information) in providing its Services. The term "HealthPAC Plan," shall mean the most current HealthPAC Plan adopted by the Board of Supervisors, which defines the scope of available healthcare services, eligibility criteria and eligibility determination process as may be amended from time to time. The current HealthPAC Plan is attached hereto as Exhibit A-2 and the HealthPAC Plan Interpretation and Procedures is attached as Exhibit A-3. As TPA the services that will be provided by Contractor are customer service, non-emergency transportation, provider relations, quality management, appeals and grievances, and other services as set forth below ("Services").

1. Program Materials.

a. **Creation and Distribution.** Contractor shall work with County to develop HealthPAC program materials. Once the created materials have been approved by County, Contractor will print, and deliver program materials to participants. This shall include:

- i. Eligible Participant Identification Card (in English language only)
 - ID cards for the HealthPAC program shall contain the HealthPAC name and mark, unless an alternative format is specifically agreed to in writing by County
- ii. Eligible Participant Handbook (in English, Spanish, and Chinese)
 - The Eligible Participant Handbook shall provide information about covered benefits, participating providers, cost-sharing requirements, grievance and appeals procedures, and more.

b. **Services.** Contractor shall oversee the printing, translating, warehousing, mailing, and distribution of program materials, including but not limited to those listed above. Contractor shall pay for printing, mailing and distributing materials and invoice County for reimbursement. County will notify Contractor of other program materials that are to be printed, warehoused and distributed.

c. **Changes.** If substantive changes occur with respect to eligibility, fees, benefits, or program procedures, Contractor will notify Eligible Participants through an Eligible Participant Letter, an insert to the Eligible Participant Handbook, or through a revised Eligible Participant Handbook. If there is a dispute as to if a change is sufficiently substantive to rise to the creation of a revised handbook or insert, Contractor shall abide by County's determination.

2. Eligible Participants

a. **Eligible Participant List.** County will provide Contractor with the names of the individuals entitled to services under the HealthPAC ("Eligible Participants" or "Participants"). The County shall provide to Contractor a data file of Eligible Participants (the "Eligible Participants List") prior to the program start date, and then on a quarterly basis going forward as well as a daily change file. The data will be supplied in the 834 Benefit Enrollment and Maintenance transaction set format (i.e., ASC X12N 834 004010X095A1) via the County's eligibility vendor. Contractor shall maintain a system compatible with this data format, including upgrades.

- b. **Provision of Materials to Eligible Participants** Contractor shall provide the Eligible Participant identification card, Eligible Participant Handbook, and Participant welcome letter to Eligible Participants within seven (7) days of receiving an eligibility file from the County.
- c. **Renewals:** Contractor shall send Participants renewal letters sixty days prior to the Participant's expiration from HealthPAC.
- d. **Notification of Potential Fraud:** Contractor shall notify the County within thirty (30) days of discovery of any potential fraudulent use of the Eligible Participant ID Card or identification number that it identifies.
- e. **Eligibility file.** Contract will provide eligibility file as requested by the County. The eligibility file will be sent daily to Ramsell, the Pharmacy Benefit Administrator, HealthPAC Medical Homes, and Behavioral Health Care Services.

3. Medical Home Assignment

Contractor shall assign a Medical Home to those Eligible Participants who do not have a Medical Home identified in the eligibility file sent by the County and who subsequently do not select a Medical Home. Contractor shall use a process for assigning Medical Homes that has been presented to and approved by County.

4. Customer Service

- a. **Customer Services Center- Individuals** Contractor shall maintain a customer service call center (Customer Service Center) to respond to inquiries from individuals. Contractor shall be prepared to respond to inquiries including the following:
 - i. Confirmation of eligibility in the HealthPAC program.
 - ii. Confirmation of Medical Home assignment.
 - iii. Assistance with complaints.
 - iv. Coordination of medically related transportation (as set forth below).
 - v. Information about the HealthPAC Provider Network including language capacity of each provider.
- b. **Customer Services Center- Providers** Contractor's Customer Services Center shall also be prepared to respond to inquiries from individuals or organizations which provide health care services or equipment and, unless otherwise noted, has a contract with HealthPAC to provide such services or equipment to Eligible Participants ("Providers"), including the following:
 - i. Facilitation of non-emergency medical transportation on behalf of an Eligible Participant
 - ii. Assistance with complaints and resolving Grievances and Appeals.
- c. **Toll Free Number.** Contractor shall make available a toll-free number for the Customer Service Center.
- d. **Minimum Customer Services.** The Customer Service Center shall be open during usual business hours and provide customer telephone services, in accordance with standard business practices. Contractor will comply with the following in providing such services:
 - I. Call center will operate during normal business hours, which includes Monday through Friday, 8:00 AM to 5:00 PM.
 - II. Contractor shall answer eighty-five percent (85%) of all incoming customer calls within thirty (30) seconds of call being connected to Contractor.

- III. The abandonment rate will not exceed five percent (5%) of all calls being connected to Contractor. An abandon happens when the customer hangs up before being connected to an agent. The abandonment rate is the number of Abandons divided by the number of inbound and outbound calls.
- IV. Contractor's call center staff itself, or through contracted services, will provide service to non-English speaking and hearing impaired Eligible Participants.

e. **Knowledge.** Contractor Customer Service Center staff shall be trained and able to provide and respond to inquiries and questions on the following:

- I. The benefit plan, covered services, network providers, co-payments, and Eligible Participant rights.
- II. Contractor's call center staff will provide Customer Service to support HealthPAC Quality Improvement Plan.
- III. Respond to requests for new Medical Home assignments.
- IV. Answer billing questions arising from out-of-network services.
- V. Request for medically related transportation consistent with the transportation protocols approved by County.

5. Transportation

a. **Requests for Medical Transportation.** Contractor shall receive, process, bill and perform all other administrative services for the transportation covered by HealthPAC for non-emergency medically related transportation ("Medical Transportation Services").

b. **Authorization Review.** Contractor shall receive and review all requests for Medical Transportation Services. Contractor shall review and assess if the request qualifies for coverage, as determined by the most recent HealthPAC Plan Information provided to Contractor. Contractor agrees that in performance of authorization requests, Contractor shall comply with the authorization policies and procedures and guidelines used and approved by the County. Contractor shall make authorization decisions based on relevant documentation received.

c. **Timeframes.** Contractor shall review and make authorization decision on all requests for Medical Transportation Services within forty-eight (48) hours of receipt of information reasonably necessary to make a decision. If Contractor does not have all information reasonably necessary to make a decision, Contractor shall promptly, and not more than forty-eight (48) hours after receiving the request, notify the provider or other individual or entity from whom the information must be obtained that the authorization request has been pended until the specified information is provided or until the Contractor denies the request for failure to provide the information within the time period specified in the notice. If the provider or other individual or entity fails to timely provide the necessary information, or to timely request an extension of time to provide the information, Contractor shall deny the authorization. In no event shall any authorization request be pended for more than 20 days due to failure to provide required information.

d. **Coordination of Transportation.** Once Contractor has verified eligibility, Contractor shall make all arrangements for the Medical Transportation Services, including notifications to the

organization that will be providing the transportation, the individual being transported and, if the request came from a Provider, to the Provider. Contractor shall also follow all procedure and process for Medical Transportation Services as set forth in HealthPAC plan documents or instructions from the County.

e. **Invoice Processing.** The Contractor shall pay the organization providing the transportation directly and invoice County for reimbursement. County shall reimburse Contractor for actual costs of transportation on all approved invoices.

6. Discharge Planning. Contractor shall work with hospitals for all HealthPAC patients and coordinate their discharge Planning. Contractor will work directly with the patient, the patient's medical home, and the hospital to ensure that the patient has needed Durable Medical Equipment, access to medications and a follow-up visit at their medical home.

7. Data Management

a. **Encounter Data Reporting.** Contractor shall submit encounter data to the County in electronic form, as requested by County. Contractor shall supply encounter data at least monthly, by the tenth (10th) of the month following the third month of claim processing. Contractor will employ appropriate data security procedures to ensure secure, rapid recovery and transmittal of all encounter data.

b. **Encounter Data Transmittal.** Contractor is the source of encounter data for transportation, medical services provided as a result of the grievance and appeal process, and claims paid for out-of-network emergency services and inpatient services. All other encounter data in the comprehensive report described above shall be obtained from County.

8. Utilization and Medical Management

a. **Utilization Management and Quality Improvement Program.** Contractor shall cooperate with, participate in, and comply with the HealthPAC Utilization Management and Quality Improvement Program, including any revisions and updates that may occur upon review.

b. **Utilization Management and Quality Improvement Reports.** Contractor shall prepare and submit standard written Eligible Participant, medical services utilization, and disease prevalence and management reports as required by County. Contractor shall use data obtained from providing services under this Agreement and data provided by or through County. Contractor shall review utilization trends to identify repeated hospital admissions, avoidable emergency room visits, specialty care and other opportunities for improved quality and cost efficiency. Reports shall be produced for County and Participating Providers including responsibility for developing reports for program meetings. Monthly quality improvement reports will be provided (see attached list of reports).

9. Complaints: Grievances and Appeals

a. **State Requirements.** Contractor shall handle all complaints in accordance with requirements for CALIFORNIA BRIDGE TO REFORM WAIVER HEARINGS AND APPEALS PROCESS FOR LOW INCOME HEALTH PROGRAMS (LIHP Process). Any requirements that are updated by the State for LIHP Process shall be incorporated by Contractor in its process. Contractor shall abide by any other State requirement applicable to the services provided. If the LIHP Process is revised by the State, or a separate process is created, Contractor shall create procedures in compliance with the revised rules or guidelines and present them to County.

b. **HealthPAC Participant Grievance Process.** Attached as Exhibit A-4 hereto (and Appendix G in the HealthPAC Plan) is the approved HealthPAC Participant Grievance and Appeals Process which has. Contractor shall follow the process in the handling of all complaints, grievances and appeals, as it may be amended by the State, or as it may be amended or updated by County from time to time.

c. **Grievance Log.** Contractor shall maintain a grievance log and make it available upon request to the County. The grievance log will include the following information:

- Date and time the grievance was filed.
- Name of the member filing the grievance.
- Name of the HealthPAC provider or staff receiving the grievance.
- Description of the grievance or problem.
- Description of the action taken by the Contractor or provider to investigate and resolve the grievance.
- The proposed resolution by the Contractor or provider.
- The name of the HealthPAC provider or staff person responsible for resolving the grievance.
- The date of notification of the participant of the proposed resolution.

10. Reports

a. **County Reports.** Contractor shall prepare and provide written reports in a format as directed by County on information including demographic, encounter, quality and cost data the County requests. Contractor shall also prepare and provide in written reports any information that is required to perform mandated disclosure, planning, reporting, administrative, supervisory, and other functions required by the California Department of Health Care Services and under applicable State and Federal laws and regulations.

b. **Requested Reports:** Contractor shall prepare and provide reports as directed by County including, but not limited to the following:

i. Grievances and Appeals. Contractor will report quarterly information about the receipt and processing of grievances and appeals, including but not limited to:

1. The number of grievances received;
2. The number of grievances resolved beyond forty-five (45) days;
3. The number of appeals received;
4. The number of appeals upheld;
5. The number of appeals overturned; and
6. The number of appeals resolved beyond forty-five (45) days.

ii. Utilization. Contractor shall prepare and submit a written report on utilization rates and provide other ad hoc reports as requested or required by County to conduct access, quality, and cost analysis.

iii. Inpatient and Outpatient Services. Contractor will prepare and submit a written report with quarterly information about the use of services under HealthPAC, including utilization of inpatient and other hospital-based care, primary care, and specialty care.

vi. Out of Network Encounters. Contractor will prepare and submit a written report quarterly on all encounters by Eligible Participants that occurred outside of the network of approved and contracted Providers under HealthPAC.

v. *Quality Improvement Program*. Contractor will prepare and submit written reports to support the HealthPAC Quality Improvement Program in a format and containing information as directed by County.

c. **State Requirements**. Contractor shall prepare and provide, in the required format and timeframes, all reports in accord with state of California requirements that apply to HealthPAC.

d. **Additional Information**. Contractor may need program and participant data to complete required and requested reports. County shall provide any information that is reasonably necessary to complete reports, or refer Contractor to where the information can be obtained. If there is any information that cannot be obtained by Contractor, the report shall be prepared with the information available and a notation of the information that is not included.

11. Quality Improvement Program

Contractor will perform the following quality measurement oversight, monitoring and evaluation functions for HealthPAC and prepare and submit written reports as requested:

1. Have a representative attend all meetings and participate in the Clinical Integration Workgroup (CIWG);
2. Collect information and perform necessary tasks to credential participating providers, as required by the state or requested by County;
 - a. Contractor shall provide HCSA with the most up to date information on the credentialing of physicians and non-physicians. Contractor will notify County within 15 calendar days when a provider has been terminated from either Medicare or Medicaid/Medi-Cal or placed on the Suspended and Ineligible Provider List. County will conduct an annual audit to confirm that all physicians and non-physicians are credentialed.
3. Prepare and provide written quarterly reports on HEDIS-like measures to County ;
4. Prepare and provide written reports on utilization trends to County on a quarterly basis and as otherwise requested by County; and
5. Prepare and provide written reports on the number of grievances and appeals received, upheld and overturned to County on a quarterly basis and as otherwise requested by County.

12. Compliance with Confidentiality Requirements

Contractor shall perform all services, including reports, working with electronic eligibility tapes and responding to requests for information in full compliance with all state and federal confidentiality laws, including but not limited to HIPAA and the California Confidentiality of Medical Information Act. Contractor shall also comply with all guidelines and requirements for confidentiality from County.

HealthPAC CIWG Measures June 2012

ENROLLMENT

1. The number of clients enrolled at a medical home by month
2. Renewal by medical home [in development]

MEDICAL HOME/OUTPATIENT UTILIZATION

1. # of unduplicated clients served: Total and by medical home
2. The percentage of patients assigned to the medical home with no outpatient visits of any kind (specialty or primary care) during the prior 12 months, provided as a total, and by medical home. Continuous enrollment for 120 days, with the last assigned medical home is applied.

INPATIENT ADMISSION AND READMISSIONS (within 30 DAYS)

1. The number of admissions/1000 members to ACMC Highland Hospital and John George
2. Percent readmissions (any diagnosis) within 30 days to ACMC Highland Hospital and John George
3. The percentage of patients with an inpatient stay who received an outpatient visit (a medical visit if it was a Highland admit and a specialty mental health visit if it was a John George admit) within 30 days.

EMERGENCY ROOM VISITS

1. The number of out-of-network ER visits/1000 members
2. The number of emergency room visits/ 1000 members for Highland
3. The number of emergency room visits/1000 members for John George
4. The number of clients who have 3 or more ER visits in the quarter

SPECIALTY CARE

1. Number of people with specialty mental health visit with no primary care visit in the prior 12 months. (In development)
2. Number of people with specialty care visits (non-mental health) with no primary care visit in the prior 12 months. (In development)

ACCESS

1. Time between enrollment and first visit.
2. Number of people enrolled that have not yet had a primary care visit by medical home during timeframe beginning in July 2011-present.

3. Time between referral to specialty behavioral health and first visit (pt seen). [THIS WILL BE REPORTED BY BHCS NOT ALLIANCE]

AVOIDABLE ER USAGE

1. The number of avoidable ER visits/1000 members, including diagnosis report.
 - Avoidable visits are defined by a core set of ICD-9 diagnosis codes established by a current Medi-Cal Managed Care Quality Improvement Collaborative. Avoidable visits reflect the number of ER visits that could have been more appropriately managed by and/or referred to a PCP in an office or clinic setting.

Data Conditions

1. HCSA will send data on the 20th of each month. It will be two months back, so February 2012 data will be sent April 20th. If for some reason all of the data hasn't come in, the data will not be sent.
2. All measures will include: breakdown of total patients by medical home, program (MCE, HCCI, County), race, ethnicity, language, and gender, with a patient-level data list by medical home that includes zip code for follow-up.
3. Inpatient Admissions/Readmissions, ER Visits, Specialty Care will also include breakdowns by discharge diagnosis (top 10), plus up to 5 diagnoses per encounter for patient-level data.



HealthPAC

Health Program of Alameda County


Alameda County Health Care Services Agency
POLICY AND PROCEDURE

Policy Name	Enrollment and Eligibility
Department Owner	HealthPAC Administrator
Lines of Business	LIHP – MCE / HCCI
Effective Date	7/1/12

HealthPAC Plan:

Eligibility, Applications, Enrollment, and Services

Signature



Alex Briscoe

Date: 6/5/12

Director, Alameda County Health Care Services Agency

TABLE OF CONTENTS
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN

A. Policy Statement and Program Objectives1

B. Program Management.....2

C. Scope of Services2

D. Eligibility.....2

E. Application.....3

F. Enrollment4

G. Financial Liability.....6

H. Audit Protocol7

I. Quality Measurement and Improvement.....7

APPENDICES

APPENDIX A: HealthPAC Division of Financial Responsibility

APPENDIX B: Federal Poverty Level Schedule

APPENDIX C: Guidelines for Determining Family Size

APPENDIX D: Using Federal Tax Forms to Document Income

APPENDIX E: HealthPAC Verification Documents

APPENDIX F: Exceptions to Five Year Bar for Legal Residency

APPENDIX G: HealthPAC Appeal and Grievance Procedures

APPENDIX H: HealthPAC Statement of Income and Residency

APPENDIX I: HealthPAC Liability Schedule

APPENDIX J: HealthPAC Quality Measurement and Improvement Plan

APPENDIX K: HealthPAC Name Change Form

APPENDIX L: HealthPAC Event Change Form

**ALAMEDA COUNTY
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN**

A. POLICY STATEMENT AND PROGRAM OBJECTIVES:

As mandated per Section 17000 of the Welfare and Institutions Code, it is the policy of the County of Alameda to provide comprehensive health care services through a contracted network of health care providers to its medically indigent population. This program is referred to as the Health Program of Alameda County (HealthPAC). Health care services are provided through the HealthPAC Provider Network, which includes the Alameda County Medical Center (ACMC), Alameda County Behavioral Health Care Services community-based organizations.

The Program objectives are to (1) optimize patient health and well-being by focusing on prevention and proactive health management, (2) control health care costs through a variety of means including reductions in the inappropriate utilization of crisis and emergency services, (3) provide an equitable and uniform method of payment for health services, (4) provide consistency in application of eligibility standards, (5) develop a standardized and coordinated demographic and service database and (6) more fully empower patients to take a more active role in their own care.

HealthPAC includes three populations of individuals that must also meet county residency requirements:

1) HealthPAC Medi-Cal Coverage Expansion (MCE)

Individuals meeting the criteria of the Medi-Cal Coverage Expansion (MCE) population, which are individuals between the ages of 19 and 64 who have family incomes at or below 133 percent of the Federal Poverty Level (FPL), are not eligible for Medicaid or CHIP, are not pregnant, and who are a United States citizen or have been a legal permanent resident for at least five years; and

2) HealthPAC Health Care Coverage Initiative (HCCI)

Individuals who meet the criteria of the Health Care Coverage Initiative (HCCI) population, which are individuals between the ages of 19 and 64 who have family incomes above 133% FPL through 200% of the FPL, are not eligible for Medicaid or CHIP, are not pregnant, and are a United States citizen or have been a legal permanent resident for at least five years; and

3) HealthPAC County

Individuals enrolled in HealthPAC who are not eligible for MCE or HCCI and are between 0 and 200% of the FPL.

HealthPAC MCE is for individuals who will be eligible for Medi-Cal in January 2014 and HealthPAC HCCI is for individuals who will be eligible for the Health Exchange in January 2014 (see eligibility section below). HealthPAC MCE has the added benefit of covering out-of-network emergency and post-stabilization services. The scope of services for HealthPAC HCCI and HealthPAC County is the same.

B. PROGRAM MANAGEMENT:

The HealthPAC Plan, under the direction of the Board of Supervisors, is administered by the Alameda County Health Care Services Agency (HCSA). The Alameda Alliance for Health (the Alliance) serves as the Third Party Administrator (TPA) for the program. Through a contract with HCSA, the Alliance is responsible for:

- Printing and distributing educational materials to new participants at enrollment.
- Providing customer service.
- Coordinating non-emergency transportation.
- Processing appeals and grievances.
- Sending renewal letters.
- Providing eligibility tapes
- Developing monitoring and performance reports

C. SCOPE OF SERVICES

The HealthPAC services are the Medi-Cal Scope of Services as defined in Section 14132 of the Welfare and Institutions Code with the following exceptions to be consistent with the Low Income Health Program developed under the California Bridge to Reform 1115 Demonstration Medicaid Waiver (November 2010):

- The “optional” benefits that are offered under Medi-Cal to individuals under 21, are only offered to individuals under 19 in HealthPAC,
- Podiatry is an added benefit
- Hospice and home health care are not covered
- In general, services are only covered if they are provided through the network; HealthPAC MCE participants are eligible for out-of-network emergency and post-stabilization services¹.

See Appendix A, the HealthPAC Division of Financial Responsibility (DOFR) for more information. HealthPAC is always the payor of last resort. HealthPAC uses the ACMC formulary.

D. ELIGIBILITY:

1. TO BE ELIGIBLE FOR HealthPAC COVERAGE INDIVIDUALS MUST:

- a. Be a current County of Alameda resident, with proof of residency.
 - i. persons with a valid Visa are not eligible, **and**
- b. Have a gross monthly household income level at or below 200% of the Federal Poverty Level (FPL) (refer to Appendix, B, Federal Poverty Level Schedule, Appendix C, Guidelines for Determining Family Unit Size, and Appendix D, Using Federal Income Tax Forms for Documenting Income), **and**
- c. Not be enrolled in or eligible for full-scope Medi-Cal
- d. Enrollment is voluntary.

¹ In accordance with California Bridge to Reform Section 1115 Demonstration Waiver Standard Terms and Conditions.

e. Enrollment discrimination is prohibited.

2. TO BE ELIGIBLE FOR HealthPAC MCE (0-133% FPL) and HealthPAC HCCI (above 133 to 200% FPL) INDIVIDUALS MUST:

a. Be a current County of Alameda resident, with proof of residency.

b. i. persons with a valid Visa are not eligible, **and**

c. Have a gross monthly household income level at or below 200% of the Federal Poverty Level (FPL) (refer to Appendix, B, Federal Poverty Level Schedule, Appendix C, Guidelines for Determining Family Unit Size, and Appendix D, Using Federal Income Tax Forms for Documenting Income), **and**

d. Be age 19 through 64, **and**

e. Not be eligible for any Medi-Cal Programs or the Access for Infants and Mothers Program, Children's Health Insurance Program **and**

f. Have documentary evidence of United States citizenship (or Legal Residency for five years) and identity (refer to Appendix E HealthPAC Verification Documents and Appendix F Exceptions to Five Year Bar for Legal Residency).

E. APPLICATION:

1. SCREENING FOR THE HealthPAC APPLICATION:

The HealthPAC Provider Network should determine HealthPAC eligibility for the entire family unit using One-e-App, the web-based health enrollment system.

- a. All reasonable efforts should be made to initiate HealthPAC applications prior to the clinical appointment in order to ensure HealthPAC coverage.
 - i. Eligibility for unscheduled services, i.e., Emergency Room/Urgent Care should be determined at time of service unless previously enrolled.
 - ii. No application assistor or fellow employee of an assistor is to process, complete or access a HealthPAC application in One-e-App for that assistor or their immediate family.
 - iii. Assistors are not to get involved in the normal handling of any applications of self, relatives, friends, fellow employees, or acquaintances.
- b. In some cases, HealthPAC applications will be started at a specialty mental health services site. The initial screening will be conducted by the provider and data will be transferred to One-e-App.
- c. During the application process, the applicant will be asked to choose a medical home. If an applicant does not choose a medical home, the applicant will be contacted by the Alameda Alliance for Health. If the applicant still does not choose a medical home, they will be assigned a medical home based on factors that may include geographic

proximity, demographic and language factor. It is the responsibility of the medical home clinic to ensure clients have access to care. If the clinic is at capacity and cannot see any new patients, the clinic must immediately report to their closed status HealthPAC Customer Service. Participants can choose to change their medical home through a clinic location or by calling HealthPAC customer service.

- d. As part of the application process the application assistor will inform applicants of their right to file an internal grievance or appeal.
- e. One-e-App assigns the applicant to the correct program based on income and ability to meet DRA requirements.
- f. Applications are audited and approved or denied by County staff. If an application is missing verification documentation, it may be returned to the application assistor. The application assistor has 45 calendar days to complete and return the application to the auditor. If the application is not completed, it will be denied and a notification letter will be sent to the applicant stating the specific denial reason.

2. **APPEAL PROCESS FOR DENIED APPLICATIONS**

- a. Applicants may appeal the decision of denial in **HealthPAC** by contacting HealthPAC Customer Service within 60 days of the notice of action (i.e. denial of HealthPAC enrollment). HealthPAC Customer Service will acknowledge the receipt of the appeal in writing. Written notice of the resolution of the appeal will be provided within forty-five (45) calendar days of receipt of the appeal (see Appendix G: HealthPAC Appeal and Grievance Process).

F. ENROLLMENT:

1. **ENROLLMENT PERIOD**

Enrollment period for HealthPAC will be for a one-year period.

The enrollment period starts on the first day of the month in which the application was started.

2. **DOCUMENTATION REQUIREMENTS:**

- a. Enrollment in **HealthPAC** requires documentation to prove identity, income, and Alameda County residency (see Appendix E, HealthPAC Verification Documents, Appendix F, Exceptions to Five Year Bar for Legal Residency, and Appendix H, HealthPAC Statement of Income and Residency).
- b. Enrollment in HealthPAC MCE and HealthPAC HCCI requires documentation to prove identity, income, Alameda County residency, age, and United States citizenship (or

Legal Residency for five years) (see Appendix E, HealthPAC Verification Documents, Appendix F, Exceptions to the Five Year Bar for Legal Residency, and Appendix H, HealthPAC Statement of Income and Residency).

3. **RETROACTIVE ENROLLMENT:**

- a. There is no retroactive eligibility for **HealthPAC**.

4. **SERVING PARTICIPANTS**

- a. HealthPAC eligibility determined **for any participant** by any provider within the HealthPAC **outpatient** provider network shall be honored by all providers within the HealthPAC **outpatient** provider network for the duration of the eligibility determination period providing there has been no change of circumstance impacting eligibility.
- b. All new HealthPAC participants will receive an identification card indicating membership and a designated medical home chosen by the participant. Primary care services will be provided by the medical home provider. Specialty, emergency room, and inpatient services will be provided through the Alameda County Medical Center at the Highland Campus.
- c. A medical home provides:
 - i. Enrollment (renewal) assistance in HealthPAC
 - ii. A primary health care contact who facilitates the participant's access to preventive, primary, specialty, behavioral health, or chronic illness treatment, as appropriate.
 - iii. An intake assessment of each new participant's general health status.
 - iv. Referrals to qualified professionals, community resources, or other agencies as needed.
 - v. Care coordination for the beneficiary across the service delivery system, as agreed to between the medical home and the County. This may include facilitating communication among participant's health care providers, including appropriate outreach to mental health providers.
 - vi. Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the County.
 - vii. Use of clinical guidelines and other evidence-based medicine when applicable for treatment of the participant's health care issues and timing of clinical preventive services.
 - viii. Focus on continuous improvement in quality of care.
 - ix. Timely access to qualified health care interpretation as needed and as appropriate for participants with limited English proficiency, as determined by applicable federal guidelines.
 - x. Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

- d. Primary Care and related pharmacy, radiology and laboratory is provided by the patient's medical home. All specialty, inpatient, and emergency services (and related pharmacy, radiology, and laboratory) are provided by the Alameda County Medical Center, Highland hospital. Specialty behavioral health services are provided through Alameda County Behavioral Health Care Services (BHCS) or a contractor of BHCS. Once a patient is stabilized (either by County specialty mental health or ACMC), and sent back to primary care, the care and related pharmacy is the responsibility of the medical home. If Highland hospital does not provide a covered specialty or inpatient service, ACMC will contract out to another provider. MCE participants are covered for emergency and post-stabilization services at Highland Hospital as well as designated acute care hospitals within all 50 states, the District of Columbia and the U.S. territories².
- e. Enrollees have a choice of medical home, Primary Care Physician, and health care provider.

5. **DISENROLLMENT:**

- a. A person may be disenrolled from **HealthPAC** for the following reasons:
 - i. He/she no longer meets the Federal Poverty Level requirement (disenrolled back to date of circumstance change),
 - ii. He/she no longer meets the Alameda County residency requirement (disenrolled back to date of circumstance change) ,
 - iii. He/she provided false information at the time of enrollment (disenrolled back to first day of enrollment period),
 - iv. He/she is deceased.
 - v. He/she did not comply with other payor application process. Specifically, for those individuals who were determined preliminarily eligible in One-e-App for Medi-Cal or Healthy Families but did not complete the application process, withdrew from the application process, or **were** denied due to failure to comply with the application process (disenrolled back to first day of enrollment period),
 - vi. He/she is incarcerated (disenrolled back to day of incarceration),
 - vii. He/she is institutionalized in IMD (disenrolled back to day institutionalized),
 - viii. He/she requests disenrollment (disenrolled back to the requested date),
 - ix. He/she turns 65 (disenrolled as of 65th birthday).
- b. Disenrollment discrimination is prohibited.

G. **FINANCIAL LIABILITY:**

- 1. HealthPAC eligible participants may be responsible for a co-payment (refer to Appendix I, HealthPAC Liability Schedule).
 - a. No enrollment fees or premiums are allowed.

² In accordance with the Low Income Health Programs: Out-of-Network Emergency Services Provider Bulletin (February 08, 2012). http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20252.asp

- b. The total cost for a family in a year can NOT exceed 5 percent of the family's income.
2. HealthPAC eligible persons who have a referral from the Public Health Department that requires a mandated Public Health Service shall have their HealthPAC co-payment waived. This includes assessment, evaluation, and treatment for: outpatient Tuberculosis (TB), sexually transmitted diseases (STDs), immunizations, vaccine preventable diseases, enteric infections and other acute communicable disease related medical services for cases and suspected cases and contacts.

H. AUDIT PROTOCOL:

HealthPAC audits will be conducted remotely via the ACHCSA centralized database (One-e-App). Audits will be comprehensive and will include, but not be limited to the following:

1. Review of verifications of U.S. Citizenship/Naturalization or Legal Permanent Residency status.
2. Review of verifications of Identifications.
3. Review of verifications of income.
4. Review of current Full Scope Medi-Cal coverage or non-compliance with Medi-Cal enrollment.
5. Review of appropriate "opt-outs" or suspension of preliminary Medi-Cal determination.
6. Review of consent signatures and dates.

I. QUALITY MEASUREMENT AND IMPROVEMENT:

Health Care Services Agency will objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to participants of HealthPAC (see Appendix J, HealthPAC Quality Measurement and Improvement Plan).



HealthPAC
Health Program of Alameda County

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

HealthPAC PLAN:

Eligibility, Applications, Enrollment, and Services Interpretations and Procedures

Effective: July 1, 2012

TABLE OF CONTENTS
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN

A. Policy Statement and Program Objectives 1

B. Program Management 2

C. Scope of Services 2

D. Eligibility 3

E. Application 4

F. Enrollment 5

G. Financial Liability 9

H. Audit Protocol 9

I. Quality Measurement and Improvement 10

APPENDICES

APPENDIX A: HealthPAC Division of Financial Responsibility

APPENDIX B: Federal Poverty Level Schedule

APPENDIX C: Guidelines for Determining Family Size

APPENDIX D: Using Federal Tax Forms to Document Income

APPENDIX E: HealthPAC Verification Documents

APPENDIX F: Exceptions to Five Year Bar for Legal Residency

APPENDIX G: HealthPAC Appeal and Grievance Procedures

APPENDIX H: HealthPAC Statement of Income and Residency

APPENDIX I: HealthPAC Liability Schedule

APPENDIX J: HealthPAC Quality Measurement and Improvement Plan

APPENDIX K: HealthPAC Name Change Form

APPENDIX L: HealthPAC Event Change Form

**ALAMEDA COUNTY
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN**

A. POLICY STATEMENT AND PROGRAM OBJECTIVES:

As mandated per Section 17000 of the Welfare and Institutions Code, it is the policy of the County of Alameda to provide comprehensive health care services through a contracted network of health care providers to its medically indigent population. This program is referred to as the Health Program of Alameda County (HealthPAC). Health care services are provided through the HealthPAC Provider Network, which includes the Alameda County Medical Center (ACMC), Alameda County Behavioral Health Care Services, and community-based organizations.

The Program objectives are to (1) optimize patient health and well-being by focusing on prevention and proactive health management, (2) control health care costs through a variety of means including reductions in the inappropriate utilization of crisis and emergency services, (3) provide an equitable and uniform method of payment for health services, (4) provide consistency in application of eligibility standards, (5) develop a standardized and coordinated demographic and service database and (6) more fully empower patients to take a more active role in their own care.

HealthPAC includes three populations of individuals that must also meet county residency requirements:

1) HealthPAC Medi-Cal Coverage Expansion (MCE)

Individuals meeting the criteria of the the Medi-Cal Coverage Expansion (MCE) population, which are individuals between the ages of 19 and 64 who have family incomes at or below 133 percent of the Federal Poverty Level (FPL), are not eligible for Medicaid or CHIP, are not pregnant, and who are a United States citizen or have been a legal permanent resident for at least five years; and

2) HealthPAC Health Care Coverage Initiative (HCCI)

Individuals who meet the criteria of the Health Care Coverage Initiative (HCCI) population, which are individuals between the ages of 19 and 64 who have family incomes above 133% FPL through 200% of the FPL, are not eligible for Medicaid or CHIP, are not pregnant, and are a United States citizen or have been a legal permanent resident for at least five years; and

3) HealthPAC County

Individuals enrolled in HealthPAC who are not eligible for MCE or HCCI and are between 0 and 200% of the FPL.

HealthPAC MCE is for individuals who will be eligible for Medi-Cal in January 2014 and HealthPAC HCCI is for individuals who will be eligible for the Health Exchange in January 2014 (see eligibility section below). HealthPAC MCE has the added benefit of covering out-of-network emergency and post-stabilization services. The scope of services for HealthPAC HCCI and HealthPAC County is the same.

B. PROGRAM MANAGEMENT:

The HealthPAC Plan, under the direction of the Board of Supervisors, is administered by the Alameda County Health Care Services Agency (HCSA). The Alameda Alliance for Health (the Alliance) serves as the Third Party Administrator (TPA) for the program. Through a contract with HCSA, the Alliance is responsible for:

- Printing and distributing educational materials to new participants at enrollment.
- Providing customer service.
- Coordinating non-emergency transportation.
- Processing appeals and grievances.
- Sending renewal letters.
- Providing eligibility tapes.
- Developing monitoring and performance reports

C. SCOPE OF SERVICES

The **HealthPAC** services are the Medi-Cal Scope of Services as defined in Section 14132 of the Welfare and Institutions Code with the following exceptions to be consistent with the Low Income Health Program developed under the California Bridge to Reform 1115 Demonstration Medicaid Waiver (November 2010):

- The “optional” benefits that are offered under Medi-Cal to individuals under 21, are only offered to individuals under 19 in HealthPAC,
- Podiatry is an added benefit
- Hospice and home health care are not covered
- In general, services are only covered if they are provided through the network; HealthPAC MCE participants are eligible for out-of-network emergency and post-stabilization services¹.

See Appendix A, the HealthPAC Division of Financial Responsibility (DOFR) for more information. HealthPAC is always the payor of last resort. HealthPAC uses the ACMC formulary.

Interpretations:

- *If the Alameda County resident with private insurance whose income is below the 200% FPL has a service denied, or not fully covered, then the patient is HealthPAC eligible for only the denied service or amount not covered by insurance. The patient’s liability is based on the HealthPAC liability schedule (refer to Appendix I, HealthPAC Liability Schedule).*
- *Patients that are enrolled in or preliminarily eligible for Emergency or Pregnancy-related Medi-Cal are not eligible for those covered services under HealthPAC.*
- *An Alameda County resident with an unmet Medi-Cal share of cost whose income is below the 200% FPL is eligible for HealthPAC County. The patient’s liability is based on the HealthPAC liability schedule, not the Medi-Cal share of cost.*
- *If an Alameda County resident with private insurance has an income below the 200% FPL and has a deductible, the patient is HealthPAC eligible until the deductible is met. The Patient’s liability is based on the HealthPAC liability schedule.*

¹ In accordance with California Bridge to Reform Section 1115 Demonstration Waiver Standard Terms and Conditions.

NOTE: HealthPAC applicants can be enrolled in HealthPAC County to allow for coverage of services under special circumstances such as:

- *Healthy Families application is pending and child is in need of urgent care services*
- *Medi-Cal disability- related application is pending and applicant is in need of services*

D. ELIGIBILITY:

1. TO BE ELIGIBLE FOR HEALTHPAC COVERAGE INDIVIDUALS MUST:

- a. Be a current County of Alameda resident, with proof of residency.
 - i. persons with a valid Visa are not eligible, **and**
- b. Have a gross monthly household income level at or below 200% of the Federal Poverty Level (FPL) (refer to Appendix, B, Federal Poverty Level Schedule, Appendix C, Guidelines for Determining Family Unit Size, and Appendix D, Using Federal Income Tax Forms for Documenting Income), **and**

Interpretations:

- *For an Alameda County resident whose income is below the 200% FPL with no monthly income- living off savings account- consider interest and dividend income only in determining monthly income.*
- *In calculating rental property it is: total rental income minus total mortgage payment minus actual documented expenses, e.g., insurance, utilities, maintenance, etc.*
- *If a patient is receiving free board in lieu of rental payment, e.g., he/she manages an apartment unit, then the income for free board would not be considered in calculating income.*
- *Student loans, grants and scholarships are not counted as income.*
- *Care expenses are not deducted from income. This includes but is not limited to alimony, child/elderly support.*
- *When social security benefits are used to establish income, the gross monthly income is the social security income before the Medicare premium is deducted.*
- *For those persons who present a U.S. Individual Income Tax Return, IRS Form 1040 as proof of income Gross Income should be determined by using the sum of the positive numbers in lines 7 through 21 in Form 1040 (see Appendix D for more detail). The sum should be divided by 12 to determine gross monthly income.*

- A. Not be enrolled in or eligible for full-scope Medi-Cal
- B. Enrollment is voluntary.
- C. Enrollment Discrimination is prohibited.

2. **TO BE ELIGIBLE FOR HEALTHPAC MCE (0-133% FPL) and HEALTHPAC HCCI (above 133 to 200% FPL) INDIVIDUALS MUST:**

- a. Be a current County of Alameda resident, with proof of residency.
 - i. persons with a valid Visa are not eligible, **and**
- b. Have a gross monthly household income level at or below the 200% Federal Poverty Level (FPL) (refer to Appendix B, Federal Poverty Level Schedule, Appendix C, Guidelines for Determining Family Unit Size, and Appendix D, Using Federal Income Tax Forms for Documenting Income), **and**
- c. Be age 19 through 64, **and**
- d. Not be eligible for any Medi-Cal Programs, or the Access for Infants and Mothers Program, Children's Health Insurance Program, **and**
- e. Have documentary evidence of United States citizenship (or Legal Residency for five years) and identity (refer to Appendix E HealthPAC Verification Documents and Appendix F Exceptions to Five Year Bar for Legal Residency).

E. APPLICATION:

1. **SCREENING FOR THE HEALTHPAC APPLICATION:**

The HealthPAC Provider Network should determine HealthPAC eligibility for the entire family unit using One-e-App, the web-based health enrollment system.

Interpretation: Applicants may apply for and be enrolled in HealthPAC (i.e., issued a HealthPAC card) without seeking services. Since the applicant includes full household information as a part of the One-e-App process, these other household members are considered for and if eligible, may be enrolled in HealthPAC.

- a. All reasonable efforts should be made to initiate HealthPAC applications prior to the clinical appointment in order to ensure HealthPAC coverage.
 - i. Eligibility for **unscheduled** services, i.e., ER/UC should be determined at time of service unless previously enrolled.
 - ii. No application assistor or fellow employee of an assistor is to process, complete or access a HealthPAC application in One-e-App for that assistor or their immediate family.

Interpretation: If you are at a CBO these applications should be referred to and completed by a Health Insurance Technician at the HCSA offices at 1000 San Leandro, Suite 300, San Leandro, CA 94577. At the ACMC, the Supervisor may complete the application, refer the application to another assistor, or refer to HCSA as the Supervisor deems appropriate.

- iii. Assistors are not to get involved in the normal handling of any applications of self, relatives, friends, fellow employees, or acquaintances.

Interpretation: Any such application should be referred to a Supervisor. If an assistor erroneously begins an application in One-e-App involving a relative, friend, fellow employee, or acquaintance, the assistor shall immediately notify his/her Supervisor. The Supervisor will decide if the application needs to be transferred to another assistor or to the HCSA offices for completion.

- b. In some cases, HealthPAC applications will be started at a specialty behavioral health services site. The initial screening will be conducted by the provider and data will be transferred to One-e-App.
- c. During the application process, the applicant will be asked to choose a medical home. If an applicant does not choose a medical home, the applicant will be contacted by the Alameda Alliance for Health. If the applicant still does not choose a medical home, they will be assigned a medical home based on factors that may include geographic proximity, demographic and language factor. It is the responsibility of the medical home clinic to ensure clients have access to care. If the clinic is at capacity and cannot see any new patients, the clinic must immediately report their closed status to HealthPAC Customer Service. Participants can choose to change their medical home through a clinic location or by calling HealthPAC customer service.
- d. As part of the application process the application assistor will inform applicants of their right to file an internal grievance or appeal.
- e. One-e-App assigns the applicant to the correct program based on income and ability to meet DRA requirements.
- f. Applications are audited and approved or denied by County staff. If an application is missing verification documentation, it may be returned to the application assistor. The application assistor has 45 calendar days to complete and return the application to the auditor. If the application is not completed, it will be denied and a notification letter will be sent to the applicant stating the specific denial reason.

2. APPEAL PROCESS FOR DENIED APPLICATIONS

- a. Applicants may appeal the decision of denial in **HealthPAC** by contacting HealthPAC Customer Service within 60 days of the notice of action (i.e. denial of HealthPAC enrollment). HealthPAC Customer Service will acknowledge the receipt of the appeal in writing. Written notice of the resolution of the appeal will be provided within forty-five (45) calendar days of receipt of the appeal (see Appendix G: HealthPAC Appeal and Grievance Process).

F. ENROLLMENT:

1. ENROLLMENT PERIOD

Enrollment period for HealthPAC will be for a one-year period.

The enrollment period starts on the first day of the month in which the application was started.

Interpretation:

- *HealthPAC enrollment is for one year. For example, if a person is enrolled on 10/15/11 then enrollment starts on 10/1/11 and is good through 9/30/12.*
- *After a year, there will be a redetermination. Applicants must bring in new income documentation and verify residency. If this is not done the enrollment period will end and the person will be disenrolled from the program.*
- *Renewals can be done up to 60 days prior to the renewal month. If the enrollment date starts on 10/1/11; renewals can begin as early as 8/1/12.*
- *HealthPAC enrollment must be honored regardless of the enrollment entity, i.e a provider must honor the enrollment even if a different agency completed the application. If the provider does not have the capacity to take on new patients, the provider must report themselves as "closed" via the HealthPAC customer service line.*
- *The Alameda Alliance for Health will provide HealthPAC eligibility tapes to providers with valid enrollment periods.*

2. DOCUMENTATION REQUIREMENTS:

- a. Enrollment in **HealthPAC** requires documentation to prove identity, income, and Alameda County residency (see Appendix E, HealthPAC Verification Documents, Appendix F, Exceptions to Five Year Bar for Legal Residency, and Appendix H, HealthPAC Statement of Income and Residency).

Interpretation:

- *All reasonable efforts will be made to obtain required documentation. When documentary evidence is required but is unavailable and all other verification attempts that have been attempted are unsuccessful, then a sworn affidavit (HealthPAC Statement of Income and Residency) signed under penalty of perjury by the applicant is acceptable.*
- *Self-declaration for income is allowable after all other attempts at obtaining documentation have been made if the participant is:*
 - *Homeless²,*

² HealthPAC defines a homeless person based on the Stewart B. McKinney Act, 42 U.S.C. § 11301, et seq. (1994). A person is considered homeless who "lacks a fixed, regular, and adequate night-time residence; and... has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations... (B) An institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." The term "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of Congress or a state law." 42 U.S.C. § 11302(c)

- Receiving General Assistance,
 - Not a documented citizen.
 - Homeless applicants are required to provide proof of identification. If the homeless applicant is unable to provide written verification of their identity, the HealthPAC Statement of Income and Residency may also be used as verification of their identity.
 - General Assistance and CalWORKS recipients should provide a Notice of Action letter for proof of income. In lieu of a Notice of Action letter, all providers can verify the amount of the GA or CalWORKS grant through a screen print from the CalWIN system. Applicants that have income in addition to CalWORKS should provide supporting documentation of this income.
 - Applicants with an alias or name change (that aren't reflected on ID documents) should complete a HealthPAC Name Change Form (see Appendix K, HealthPAC Name Change Form),
 - Applicants with name and gender changes should complete a HealthPAC Event Change Form (see Appendix L, HealthPAC Event Change Form).
- b. Enrollment in **HealthPAC MCE and HealthPAC HCCI** requires documentation to prove identity, income, Alameda County residency, age, and United States citizenship (or Legal Residency for five years) (see Appendix E, HealthPAC Verification Documents, Appendix F, Exceptions to the Five Year Bar for Legal Residency, and Appendix H, HealthPAC Statement of Income and Residency).

Interpretation:

All reasonable efforts will be made to obtain required documentation for HealthPAC MCE and HCCI. When documentary evidence is required but is unavailable and all other verification attempts that have been attempted are unsuccessful, then a sworn affidavit signed under penalty of perjury by the applicant is acceptable to prove income and Alameda County residency, but not identity or citizenship.

3. RETROACTIVE ENROLLMENT:

- a. There is **no** retroactive eligibility for **HealthPAC**.

4. SERVING PARTICIPANTS

- a. HealthPAC eligibility determined **for any participant** by **any** provider within the HealthPAC **outpatient** provider network shall be honored by all providers within the HealthPAC **outpatient** provider network for the duration of the eligibility determination period providing there has been no change of circumstance impacting eligibility.
- b. All new HealthPAC participants will receive an identification card indicating membership and a designated medical home chosen by the participant. Primary care services will be provided by the medical home provider. Specialty, emergency room, and inpatient services will be provided through the Alameda County Medical Center at the Highland Campus.
- c. A medical home provides:

- i. Enrollment (renewal) assistance in HealthPAC
 - ii. A primary health care contact who facilitates the participant's access to preventive, primary, specialty, behavioral health, or chronic illness treatment, as appropriate.
 - iii. An intake assessment of each new participant's general health status.
 - iv. Referrals to qualified professionals, community resources, or other agencies as needed.
 - v. Care coordination for the beneficiary across the service delivery system, as agreed to between the medical home and the County. This may include facilitating communication among participant's health care providers, including appropriate outreach to mental health providers.
 - vi. Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the County.
 - vii. Use of clinical guidelines and other evidence-based medicine when applicable for treatment of the participant's health care issues and timing of clinical preventive services.
 - viii. Focus on continuous improvement in quality of care.
 - ix. Timely access to qualified health care interpretation as needed and as appropriate for participants with limited English proficiency, as determined by applicable federal guidelines.
 - x. Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.
- d. Primary Care and related pharmacy, radiology and laboratory is provided by the patient's medical home. All specialty, inpatient, and emergency services (and related pharmacy, radiology, and laboratory) are provided by the Alameda County Medical Center, Highland hospital. Specialty behavioral health services are provided through Alameda County Behavioral Health Care Services (BHCS) or a contractor of BHCS. Once a patient is stabilized (either by County specialty mental health or APMC), and sent back to primary care, the care and related pharmacy is the responsibility of the medical home. If Highland hospital does not provide a covered specialty or inpatient service, APMC will contract out to another provider. MCE participants are covered for emergency and post-stabilization services at Highland Hospital as well as designated acute care hospitals within all 50 states, the District of Columbia and the U.S. territories³
- e. Enrollees have a choice of medical home, Primary Care Physician, and health care provider.

³ In accordance with the Low Income Health Programs: Out-of-Network Emergency Services Provider Bulletin (February 08, 2012). http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20252.asp

5. DISENROLLMENT:

- a. A person may be disenrolled from **HealthPAC** for the following reasons:
- i. He/she no longer meets the Federal Poverty Level requirement (disenrolled back to date of circumstance change),
 - ii. He/she no longer meets the Alameda County residency requirement (disenrolled back to date of circumstance change),
 - iii. He/she provided false information at the time of enrollment (disenrolled back to the first day of the enrollment period),
 - iv. He/she is deceased.
 - v. He/she did not comply with other payor application process. Specifically, for those individuals who were determined preliminarily eligible in One-e-App for Medi-Cal or Healthy Families but did not complete the application process, withdrew from the application process, or were denied due to failure to comply with the application process (disenrolled back to the first day of the enrollment period).

- *Medi-Cal/Healthy Families Denial Codes/Description for Non-Compliance.*

For example:

<i>Code 098</i>	<i>Loss of Contact</i>
<i>Code 139</i>	<i>Failure to provide essential information</i>
<i>Code 240</i>	<i>Loss of Contact – whereabouts unknown</i>
<i>Code A</i>	<i>Client deceased</i>
<i>Code B</i>	<i>Application withdrawn</i>
<i>Code C</i>	<i>Applicant moved Out-of-State</i>
<i>Code D</i>	<i>Loss of contact/unable to locate applicant</i>
<i>Code E</i>	<i>Failure to cooperate</i>
<i>Code N</i>	<i>Receiving Medicaid in another state</i>
<i>Code 03</i>	<i>Discontinuance at recipient request</i>
<i>Code 04</i>	<i>Failure to cooperate</i>
<i>Code 60</i>	<i>Refused to provide CA7 or Medi-Cal status report</i>
<i>Code 61</i>	<i>Refused to provide essential information</i>
<i>Code 64</i>	<i>Failed to complete Medi-Cal midyear status</i>
<i>Code 65</i>	<i>Failed to complete Medi-Cal annual RV</i>
<i>Code 97</i>	<i>Discontinued at recipient request</i>

- vi. He/she is incarcerated (disenrolled back to first day of enrollment period)
- vii. He/she is institutionalized in IMD (disenrolled back to day institutionalized),
- viii. He/she requests disenrollment (disenrolled back to the requested date).

Interpretation: In order to complete disenrollment, notification of disenrolled individuals should be sent from the clinics or APMC to the One-e-App help desk.

- ix. He/she turns 65 (disenrolled as of 65th birthday).

- b. Disenrollment discrimination is prohibited.

G. FINANCIAL LIABILITY:

1. HealthPAC eligible participants may be responsible for a co-payment (refer to Appendix I, HealthPAC Liability Schedule).
 - a. No enrollment fees or premiums are allowed.
 - b. The total cost for a family in a year can NOT exceed 5 percent of the family's income.
2. HealthPAC eligible persons who have a referral from the Public Health Department that requires a mandated Public Health Service shall have their HealthPAC co-payment waived. This includes assessment, evaluation, and treatment for: outpatient Tuberculosis (TB), sexually transmitted diseases (STDs), immunizations, vaccine preventable diseases, enteric infections and other acute communicable disease related medical services for cases and suspected cases and contacts.

H. AUDIT PROTOCOL:

HealthPAC audits will be conducted remotely via the ACHCSA centralized database (One-e-App). Audits will be comprehensive and will include, but not be limited to the following:

1. Review of verifications of U.S. Citizenship/Naturalization or Legal Permanent Residency status.
2. Review of verifications of Identifications.
3. Review of verifications of income.
4. Review of current Full Scope Medi-Cal coverage or non-compliance with Medi-Cal enrollment.
5. Review of appropriate "opt-outs" or suspension of preliminary Medi-Cal determination.
6. Review of consent signatures and dates.

I. QUALITY MEASUREMENT AND IMPROVEMENT:

Health Care Services Agency will objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to participants of HealthPAC (see Appendix J, HealthPAC Quality Measurement and Improvement Plan).



HealthPAC

Health Program of Alameda County

Appendix A

Division of Financial Responsibility – DOFR
Effective July 1, 2012

Key:
 CBO= Community Based Organization
 ACMC= Alameda County Medical Center
 PCP= Primary Care Provider
 County= HCSA and/or one of its departments
 "x"= indicates this group is financially responsible for the provision of the designated service
 NA= Not Applicable

NOTE: All out-of-network emergency services apply only to the Medi-Cal Expansion (MCE) population

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
ABORTION / PREGNANCY SERVICES / FAMILY PLANNING	NA	NA		N	N	Limited to Family PACT (California Family Planning, Access, Care, and Treatment).
ACUPUNCTURE	x			N	N	Limited to age < 19
ALLERGY IMMUNOTHERAPY		x		Y	N	
ALLERGY TESTING, TREATMENT AND SERUM		x		Y	N	
AMBULANCE - EMERGENCY <ul style="list-style-type: none"> • In Area • Out of Area 			x NA	N	N	
Ambulance- Inter-hospital, non-emergency, specific to out-of-network inpatient admissions (Medi-Cal Expansion only)		x		Y	Y	Authorization done by Alliance
ANESTHESIOLOGY (related to surgery)		x		N	N	
AUDIOLOGY SERVICES (including Hearing Aids, repairs, maintenance, and surgically implanted)		x		Y	N	Limited to age < 19
BLOOD/BLOOD PRODUCTS <ul style="list-style-type: none"> • Blood Bank • Autologous/Homologous • Storage and Collection of Blood 		x x x		Y	N	
CARDIAC REHABILITATION -When associated with Inpatient, <ul style="list-style-type: none"> • Technical Component • Professional Component 		x x		Y	N	

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
CARDIAC REHABILITATION – If in MD office or referred by MD office, except when associated with IP stay <ul style="list-style-type: none"> • Technical Component • Professional Component 		x x		Y	N	
CCS				N/A	N/A	Carve out to CCS
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE	x		x	N	Y	Limited to authorized services for individuals with co-occurring mental health conditions. BHCS needs to authorize that client meets specialty mental health eligibility criteria.
CHEMOTHERAPY <ul style="list-style-type: none"> • Drugs, including Epogen, Neupogen and adjunctive therapies • Facility Component • Professional Component 		x x x		N	N	
CHIROPRACTIC	x			N	N	Limited to age < 19
COSMETIC SURGERY (Medically Necessary) <ul style="list-style-type: none"> • Facility Component • Professional Component 		x x		Y	N	
CRITICAL CARE VISITS <ul style="list-style-type: none"> • Facility • Professional 		x x		N/A	N/A	
DENTAL SERVICES – EMERGENCY ADULT <ul style="list-style-type: none"> • Facility Component • Professional Component 	x x	x x		N	N	Age (Adult) ≥ 19. Same definition as Medi-Cal.
DENTAL SERVICES CHILD <19 <ul style="list-style-type: none"> • Facility Component • Professional Component 	x x	x x		N	N	Age Limit < 19
DIAGNOSTIC TESTING IN OFFICE (EKG, X-RAY)	x			N	N	
DIAGNOSTIC TESTING (Including but not limited to sleep studies, CT Scans, PET Scans, MRIs, hearing tests, diagnostic colonoscopies, EEG etc.) <ul style="list-style-type: none"> • Facility Component • Professional Component 		x x		Y	N	When associated with IP stay, Ambulatory or OP Surgery and ER; includes outside facility during an IP stay.
DURABLE MEDICAL EQUIPMENT <ul style="list-style-type: none"> • Outpatient • Surgically Implanted 		x x		Y	Y	<ul style="list-style-type: none"> • Authorized by ACMC, PCP clinic provides MD contact, documentation of medical necessity • Process does not require

						that member register or visit ACMC site
EMERGENCY ADMISSIONS – Highland Hospital <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		N	N	ACMC

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
EMERGENCY ADMISSIONS pre-stabilization– Out-of-Area (Medi-Cal expansion only) <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		N	N	Within all 50 states, the District of Columbia and the U.S. territories. Notification must be done w/in 24 hours.
EMERGENCY ADMISSIONS post stabilization – Out-of-Area (Medi-Cal expansion only) <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		Y	Y	Within all 50 states, the District of Columbia and the U.S. territories. Notification must be done w/in 24 hours.
EMERGENCY ROOM VISITS – Highland Hospital <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		N	N	ACMC
EMERGENCY ROOM VISITS – pre-stabilization– Out-of- Area (Medi-Cal expansion only) <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		N	N	Within all 50 states, the District of Columbia and the U.S. territories. Must notify within 24 hours.
EMERGENCY ROOM VISITS – post-stabilization– Out-of- Area (Medi-Cal expansion only) <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		Y	Y	Within all 50 states, the District of Columbia and the U.S. territories. Must notify within 24 hours.
EXTENDED CARE/SKILLED NURSING FACILITY <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		Y	Y	ACMC authorization
HEMODIALYSIS <ul style="list-style-type: none"> • Facility Component • Dialysis Drugs • Professional Component 		X X X		Y	N	
HOSPITAL BASED PHYSICIANS – pre-stabilization-OUT OF AREA – (Medi-Cal Expansion only) –Emergency Admit <ul style="list-style-type: none"> • Professional Component • Emergency Room Staff MD (99281-99299 only) 		X X		N	N	Inpatient and ER Admissions. Within all 50 states, the District of Columbia and the U.S. territories. Must notify within 24 hours.
HOSPITAL BASED PHYSICIANS – post-stabilization OUT OF AREA – (Medi-Cal Expansion only) –Emergency Admit <ul style="list-style-type: none"> • Professional Component Emergency Room Staff MD (99281-99299 only)		X X		N	Y	Inpatient and ER Admissions. Within all 50 states, the District of Columbia and the U.S. territories. Must notify within 24 hours.
IMMUNIZATIONS – Standard Adult and Pediatric— NOT TRAVEL related and NOT work related.	X			N	N	
INCONTINENCE CREAMS / WASHES	X	X		Y	N	Limited to Age < 19
INJECTIBLES		X		Y	N	

LABORATORY SERVICES • Office • Reference lab (per defined CPT code)	X	X x		N Y	Y	Authorization for reference lab done by ACMC
HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
LITHOTRIPSY • Facility Component • Professional Component		x x		Y	N	
MEDICAL SUPPLIES	x	x		Y	N	
BEHAVIORAL HEALTH – John George/Inpatient and ER • Facility Component • Professional Component		x x			Y	No authorization required for ER. Services covered under separate contract b/w BHCS and ACMC.
BEHAVIORAL HEALTH-ER/ Inpatient-Out of Area (Medi-Cal expansion only) • Facility Component • Professional Component			x x	N	Y	Auth completed by BHCS. For psychiatric emergency and forensic.
BEHAVIORAL HEALTH – Outpatient • Facility Component • Professional Component	X x		X x	N	Y	Auth Completed by BHCS (for specialty behavioral health only)
OFFICE VISITS- Primary Care	X			N	N	
Out of Network Discharge Planning			X			Through Alameda Alliance TPA
PATHOLOGY- When associated with IP, Ambulatory Surgery or Emergency Room • Professional Component • Technical Component		x x		N	N	Except PAP smears
PATHOLOGY – In MD office or when referred by MD office, except when associated with, IP stay, OP/Ambulatory Surgery or ER, as noted above) • Technical Component • Professional Component		x x		N	N	
PHARMACY SERVICES	x	x		N/A	N	HealthPAC has an approved formulary available at http://www.acgov.org/health/indigent/pac-prov.htm . Clinics are responsible for filling prescriptions for patients assigned to medical home after being released from an inpatient stay. Hospitals generally provide a 3 day fill.
Pharmacy Services for LIHP clients with HIV			x			HealthPAC MCE and HealthPAC HCCI clients who have HIV/AIDS are covered by the HealthPAC HIV formulary.
PODIATRY	x	x		Y	N	Referral required for hospital based service only.
PROSTHETIC/ORTHOTIC DEVICES • Outpatient • Surgically Implanted		x x		Y	N	

PSYCHOLOGY SERVICES	X	X	X		Y (for County provided services)	Medi-Cal exclusion allows services at FQHC. County provides services for SMI population.
HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
RADIATION THERAPY		X		Y	N	
Specialty Care Office Procedures		X		Y	N	
Specialty Care Office Visits		X		Y	N	
Specialty Procedures <ul style="list-style-type: none"> • Diagnostic • Therapeutic 		X X		Y	N	
SURGERY - Inpatient <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		Y	N	
SURGERY – Outpatient <ul style="list-style-type: none"> • Facility Component • Professional Component 		X X		Y	N	
THERAPY: Physical <ul style="list-style-type: none"> • Inpatient • Outpatient/Office 		X X		Y	N	
<ul style="list-style-type: none"> • TRANSPLANTS Facility Component • Organ Procurement • Covered Immunosuppressive • Professional Component 	NA	NA		N/A	N	Not a covered benefit
TRANSPORTATION, NON EMERGENCY MEDICAL			X		Y	Authorization done by Alliance.

Health – PAC NON-COVERED SERVICES	
	COMMENTS
<p style="text-align: center;">NON-COVERED SERVICES</p> <ul style="list-style-type: none"> ● Acupuncture Age ≥ 19 ● Adult Day Health Care ● Alopecia treatment ● Artificial Insemination, Infertility Services and Conception by artificial means ● Audiology Age ≥ 19 ● Bariatric Surgery ● Biofeedback ● Chemical dependency services (without co-occurring mental health condition) ● Dental (only emergency dental covered for Age ≥ 19) ● Chiropractic Age ≥ 19 ● Custodial Care ● Cosmetic Services - to change the way you look, not medically necessary ● Exercise and hygiene equipment ● Home health ● Hospice Care ● Incontinence Supplies Age ≥ 19 ● Infertility Testing and Treatment... Refer to Family PACT ● Inpatient Convenience items ● Maternity - deliveries ● Organ Transplants ● Private Rooms ● Reversal of Sterilization ● Services provided as a requirement of employment, licensing or court order ● Speech and hearing exams ● Travel & lodging expenses ● Therapy- occupational, respiratory and speech. Speech is covered for under 19. ● Vision care - for Adults ≥ 19 services only include procedures for evaluation of visual system. Does NOT include eyeglasses or other eye appliances. ● Services provided outside of the US 	<p>NON-COVERED MEDICAL SERVICES</p>

APPENDIX B: HEALTH PROGRAM OF ALAMEDA COUNTY LIABILITY SCHEDULE

**ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
ALAMEDA COUNTY MEDICAL CENTER / COMMUNITY BASED ORGANIZATION
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) LIABILITY SCHEDULE
EFFECTIVE, April 1, 2012**

The total cost for a family in a year can NOT exceed 5 percent of the family's income.

% OF POVERTY LEVEL	HealthPAC CO-PAYMENT					***MAXIMUM GROSS MONTHLY INCOME PER FAMILY SIZE***										FOR EACH ADD'L MEMBER ADD:
	Emergency Co-Pay	Inpatient Co-Pay	Outpatient Co-Pay	Pharmacy Co Pay ¹	Special Procedure ² Co-Pay	1	2	3	4	5	6	7	8	9	10	
0-133%	0	0	0	0	0	1238	1677	2116	2555	2994	3433	3871	4310	4749	5188	439
133.01 - 150%	0	75	0	3	75	1396	1891	2386	2881	3376	3871	4366	4861	5356	5851	495
150.01 - 200%	0	125	0	3	125	1862	2522	3182	3842	4502	5162	5822	6482	7142	7802	660
Over 200%	PATIENTS WHOSE GROSS MONTHLY INCOME IS OVER 200% OF THE FEDERAL POVERTY INCOME GUIDELINES SHALL BE CONSIDERED PRIVATE PAY.															

¹ Pharmacy charge \$3 per prescription drug with \$36 per visit maximum.

² Examples of special procedures include:

- bronchoscopy
- cat scans
- cholecystectomy
- EKG
- EMG (electromyography)
- endoscopy
- holter monitor
- hysteroscopy
- implantation of pumps
- pacemakers
- stimulators or other devices
- IV infusion/chemotherapy (co-pay to cover duration of treatment plan)
- laparoscopy
- MRI (Magnetic Resonance Imaging)
- myelography
- nuclear med
- thoracscopy
- venous/arterial catheter placement

APPENDIX C: GUIDELINES FOR DETERMINING FAMILY SIZE

FAMILY UNIT:

A family unit is comprised of:

- 1) any child under age 21 living at home or away at a school and claim as tax dependent
- 2) a single adult with or without birth or adoptive children,
- 3) a married couple with or without birth, adoptive, or step children, or
- 4) an unmarried couple with common birth children.

Note: If there is more than one family unit living in the household—parents of adults, grandparents, uncles/aunts/cousins, etc.--each family would be *considered a separate Family Unit.*)

FAMILY INCOME:

Family income includes income from all family members including public funds, i.e., SSI, Cal-Works, etc.

- **Student loans, grants and scholarships are exempt from income.**
- **Care expenses are not deducted from gross income. This includes, but is not limited to alimony, child support, or elderly support.**

Table 1 provides scenarios for determining family unit and family income in order to help determine HealthPAC eligibility.

IN DETERMINING HealthPAC ELIGIBILITY, ELIGIBILITY OF ANY MEMBER IN THE FAMILY INTO OTHER HEALTH COVERAGE PROGRAMS, I.E., MEDI-CAL, HEALTHY FAMILIES, ETC. NEEDS TO BE PURSUED PRIOR TO ENROLLMENT INTO THE HealthPAC PROGRAM.

Table 1

SCENARIO	FAMILY UNIT	INCOME CONSIDERED (Refer to HealthPAC Liability Schedule to determine HealthPAC eligibility)
1. <i>Single working male/female</i>	<i>One</i>	<i>Total gross income</i>
2. <i>Married working couple w/no children</i>	<i>Two</i>	<i>Total gross income</i>
3. <i>Married working couple with four children under age 21 living in household.</i>	<i>Six</i>	<i>Total gross income</i>
4. <i>Married couple whose elderly parents live with them but parents have no income</i>	<i>Two separate family units</i> <ul style="list-style-type: none"> • <i>Married couple = 2</i> • <i>Elderly parents = 2</i> 	<ul style="list-style-type: none"> • <i>Married couple's gross income.</i> • <i>Elderly parents, aid in kind from adult children</i>
	<i>Two (foster parents)</i>	<i>Income of foster parents only. (Foster care allocation is not considered when determining gross monthly income.)</i>
5. <i>Grandparents taking care of grandchildren who are on CalWorks.</i>	<i>Two (grandparents)</i>	<i>Income of grandparents only. (CalWorks income for grandchildren is not considered when determining gross monthly income)</i>
6. <i>Married couple, husband receives SSI; wife needs health care and only income is husband's SSI.</i>	<i>Two</i>	<i>Husband's income from SSI.</i>
7. <i>Unmarried couple with no children.</i> <ul style="list-style-type: none"> • <i>Male is working, female is not working and has no health coverage.</i> • <i>Female presents for health care</i> 	<i>One</i> <ul style="list-style-type: none"> • <i>Male=1</i> • <i>Female=1</i> 	<i>Complete HealthPAC Statement of Income and Residency</i>
8. <i>Unmarried couple with two (2) common children and two (2) children from other marriages/relationships.</i> <ul style="list-style-type: none"> • <i>Male works, female does not work, no health coverage.</i> • <i>Male or female or common child presents for health care</i> 	<i>Six</i>	<i>Income from male</i>

Using Federal Income Tax Forms to Document Income for the HealthPAC Program

Using federal income tax forms documents the income only for those family members in the household whose income is reported on that form. Other family members whose incomes are counted and not listed (e.g., spouses filing separately, children who receive child support, Social Security, etc.) must provide separate proof of income.

Using the federal income tax form for the year prior to the previous year will only be accepted until the April 15th tax filing deadline. For example, if a family applied in February 2009, the 2007 federal tax forms could have been used to verify the family's income. After April 15th of each year, applicants can only use their federal tax forms for the previous year. If applicants submit federal tax forms from a period other than the previous year, the tax forms will be considered too old and will not be accepted as proof of income. Applicants will be required to submit their previous year's federal tax forms or some other form of documentation to prove their income. Instructions for using specific federal tax forms are listed below.

Form 1040 U.S. Individual Income Tax Form

Add together all of the positive amounts listed in the "Income Section" (Lines 7 through 21). If applicants have reported losses (negative amounts) on any of the lines of this section, these amounts are counted as zero (see example #1 below – line 12 should be counted as zero.)

So in the example below, the total income should be $45211 + 23 + 0 = 45,234$.

Remember: DO NOT subtract any losses from the positive gross income amount. This amount may be different. DO NOT use the amount on Line 22.

Income	7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	45211
	8a	Taxable interest. Attach Schedule B if required	8a	23
Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.	b	Tax-exempt interest. Do not include on line 8a	8b	
	9a	Ordinary dividends. Attach Schedule B if required	9a	
	b	Qualified dividends (see page 21)	9b	
	10	Taxable refunds, credits, or offsets of state and local income taxes (see page 22)	10	
	11	Alimony received	11	
	12	Business income or (loss). Attach Schedule C or C-EZ	12	-32311
	13	Capital gain or (loss). Attach Schedule D if required. If not required, check here	13	
	14	Other gains or (losses). Attach Form 4797	14	
If you did not get a W-2, see page 21.	15a	IRA distributions	15a	
	b	Taxable amount (see page 23)	15b	
Enclose, but do not attach, any payment. Also, please use Form 1040-V.	16a	Pensions and annuities	16a	
	b	Taxable amount (see page 24)	16b	
	17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	
	18	Farm income or (loss). Attach Schedule F	18	
	19	Unemployment compensation	19	
	20a	Social security benefits	20a	
	b	Taxable amount (see page 26)	20b	
	21	Other income. List type and amount (see page 28)	21	
	22	Add the amounts in the far right column for lines 7 through 21. This is your total income	22	12320

Form 1040A U.S. Individual Income Tax Form

Add together all the positive amounts listed in the "Income Section" (Lines 7 through 14b). This may be different than the amount listed on line 15.

So in the example below, the total income should be $45211 + 23 + 1900 = 47,134$

Income Attach Form(s) W-2 here. Also attach Form(s) 1099-R if tax was withheld. If you did not get a W-2, see page 23. Enclose, but do not attach, any payment.	7	Wages, salaries, tips, etc. Attach Form(s) W-2.	7	45211
	8a	Taxable interest. Attach Schedule 1 if required.	8a	23
	8b	Tax-exempt interest. Do not include on line 8a.	8b	
	9a	Ordinary dividends. Attach Schedule 1 if required.	9a	
	9b	Qualified dividends (see page 24).	9b	
	10	Capital gain distributions (see page 24).	10	
	11a	IRA distributions. 11a 2300	11b	Taxable amount (see page 24). 11b 1900
	12a	Pensions and annuities. 12a	12b	Taxable amount (see page 25). 12b
	13	Unemployment compensation and Alaska Permanent Fund dividends.	13	
	14a	Social security benefits. 14a	14b	Taxable amount (see page 27). 14b
	15	Add lines 7 through 14b (far right column). This is your total income.	15	47,134

Form 1040EZ U.S. Individual Income Tax Form

Use Line 4 (Lines 1 through 3) as gross income.

So in the example below, the total income should be $45,234$

Income Attach Form(s) W-2 here. Enclose, but do not attach, any payment.	1	Wages, salaries, and tips. This should be shown in box 1 of your Form(s) W-2. Attach your Form(s) W-2.	1	45211
	2	Taxable interest. If the total is over \$1,500, you cannot use Form 1040EZ.	2	23
	3	Unemployment compensation and Alaska Permanent Fund dividends (see page 11).	3	
	4	Add lines 1, 2, and 3. This is your adjusted gross income.	4	45234

**APPENDIX E: HEALTHPAC VERIFICATION DOCUMENTS (July 2012)
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY**

ACCEPTABLE CITIZENSHIP (for MCE and HCCI only) AND IDENTITY DOCUMENTS <ul style="list-style-type: none"> • U.S. Passport issued without limitation (expired ones are acceptable) • Certificate of U.S. Naturalization (N-350 or N-570) • Certificate of U.S. Citizenship (N-560 or N-561) 			
CITIZENSHIP or LEGAL PERMANENT RESIDENCY for Five years¹ <i>(for HealthPAC MCE and HCCI only)</i> <i>(Column 1)</i>	IDENTIFICATION <i>(Column 2)</i>	ALAMEDA COUNTY RESIDENCY <i>(Column 3)</i>	INCOME <i>(Column 4)</i>
❖ <i>If you do not have one of the documents above, provide one citizenship document from this column AND one identity document from the next column.</i>	❖ IDENTIFICATION THAT HAS A PICTURE IS REQUIRED FOR ENROLLMENT INTO HEALTHPAC MCE AND HCCI PRIMARY ACCEPTABLE DOCUMENTATION (WITH PHOTO ID):	❖ RECENT VERIFICATION AS AN ALAMEDA COUNTY RESIDENT	❖ MOST RECENT, FROM LESS THAN 45 DAYS AGO, PREFERRABLY ONE MONTH WORTH
1. U.S. Birth Certificate ²	1. A recent and valid California or out-of-state motor vehicle Driver's License	1. Current utility bill in applicant's/family name	1. Paycheck stubs (gross earnings including tips, commission, meal-in/dine-in. In certain circumstances HealthPAC may request additional pay stubs).
2. Certification of Report of Birth (DS-1350)	2. Identification card issued by the Department of Motor Vehicles	2. A current and valid California motor vehicle registration in applicant's/family's name	2. Social Security, RSDI, SSI/SSP, or VA: award letters, checks, or bank statement showing direct deposit
3. State Department of Certification of Birth (FS-545 or DS-1350)	3. Voter's Registration Card from other country which has picture, name and birth date	3. A recent Alameda County rent or mortgage receipt	3. Statement from providers of other income (contributions, gifts, loans, refunds, child support, etc.)
4. U.S. Citizen Identification Card (I-197 or I-179)	4. Check cashing card with photo	4. Evidence that applicant is receiving General Assistance in Alameda County	4. State Disability: check stubs or award letter
5. American Indian Card (I-872)	5. School Identification card with a photo	5. Paycheck stub w/home address	5. Self-employment information: Last year's 1040 tax return (add positive amounts in Lines 7 through 21. Negative amounts are counted as zero).
6. Northern Mariana Card (I-873)	6. A U.S. Passport <i>(issued with limitation)</i>	Other written documentation: <i>(Includes but not limited to the following)</i>	6. State Unemployment: check stubs or award letter
7. Final adoption decree showing a U.S. place of birth	7. Work badge, building pass	6. Voter Registration Card (Current)	7. Worker's Compensation: check stubs
8. Proof of employment by the U.S. civil service before June 1, 1976	8. Consulate identification <i>(Maricula Consular)</i>	7. Bank account statement w/home address	8. Retirement/pension benefits: check stubs or award letter
9. U.S. military service record that shows a U.S. place of birth	9. Tribal Enrollment Card w/photo	8. School Registration printout	9. Income tax documentation from prior calendar year (1040 only). If submitting a hand written tax return, must also provide the signature page.
10. U.S. hospital record established at the time of the person's birth	10. Border Crossing Card w/photo	9. Sworn statement from relative/friend with whom they are living, along with a utility bill in their name	10. Other Income – Interest from Savings account, annuity, etc: bank statement (For persons with no income other than from savings accounts, annuities, etc., complete a HealthPAC Statement of Income and Residency form)
11. Federal or State census record that shows the applicant's age and U.S. citizenship or place of birth*	11. Work Permit w/photo	10. CalWIN printout showing Alameda County residency	11. Personal checks count as cash income. Have applicant also complete the HealthPAC Statement of Income and Residency form
12. Seneca Indian tribal census record*	12. U.S. Military I.D. card or draft record	11. Student loan/grant award letter or loan grant papers with home address	Other written documentation: 12. CalWIN printout for GA and CalWORKS recipients only 13. Letter from Employer 14. Aid In-Kind
13. Bureau of Indian Affairs tribal census record of the Navajo Indians*	13. Federal, state, or local government I.D. card with same identifying information as a driver's license	<i>If a P.O. Box is used for mailing address, must provide verification of Residential address</i>	<i>HealthPAC Statement of Income and Residency form only for declaring no income, cash income, or other unverifiable income.</i>
14. U.S. State Vital Statistics birth registration notification*	14. U.S. Military dependent identification card	<i>HealthPAC Statement of Income and Residency form only when no other verification exists</i>	
15. An amended U.S. public birth record (amended more than 5 years after the person's birth)*	15. Certificate of Degree of Indian Blood or other U.S. American Indian/Alaska Native Tribal	ALAMEDA COUNTY RESIDENCY AND INCOME	
16. Statement of signed by doctor or midwife present at the time of birth*	16. U.S. Coast Guard Merchant Mariner Card	1. Award letter, check, or bank statement with home address showing amount of Social Security, RSDI, SSI/SSP or VA payment	2. GA printout showing amount currently received and home address
17. Admission papers from a nursing or skilled care facility, or other institution that shows a U.S. place of birth	<i>For alias* or name changes, complete a HealthPAC Name Change and/or Event form</i>	3. State Unemployment check stubs with home address or award letter	
18. I-551 Card (Lawful Permanent Resident/Resident Alien Card) with date indicating 5 years of residency (Current).	SECONDARY ACCEPTABLE DOCUMENTATION (for HealthPAC County only): <i>(Secondary documentation is required if ID does not have a photo)</i>	4. State Disability check stubs or award letter with home address	
19. Certified copy of an Entry of Birth-I-551 Card (Lawful Permanent Resident/Resident Alien Card) with date indicating 5 years of residency.	1. Birth Certificate	5. Worker's Compensation check stubs with home address	
	2. Church membership or baptism/confirmation record	6. Retirement/pension benefits check stubs or award letter with home address	
	3. Tribal Enrollment Card without photo	7. Income tax documentation from prior calendar year (1040 only) with current home address	
	<i>In rare cases, the HealthPAC Statement of Income and Residency form</i>	8. Notice of Action with home address	

¹ In order to be eligible for MCE or HCCI a person must have documentary evidence of United States citizenship (or Legal Residency for five years, also see Appendix E Exceptions to Five Year Bar for Legal Residency).

² Birth Certificates can be obtained either through a State Department or through www.VitalCheck.com, a service that provides assistance to electronic orders for vital records for all 50 States. If the applicant has a Social Security Number and/or was born in California you may be able to collect information that will allow ACHCSA make an acceptable Birth Record Match with State/federal records.

INSTRUCTIONS FOR NEEDED DOCUMENTATION

Enrollment in HealthPAC MCE & HCCI requires documentation to prove:

1. Citizenship or 5-years Legal Residency
2. Identity
3. Alameda County residency
4. Income

- The easiest way for U.S citizens or nationals to provide both proof of citizenship and identity is with one of the documents in the top row “Acceptable Citizen and Identity Documents.”
- If the applicant does not have one of those documents they need one citizenship document from the first column and one identity document from the identification column (Column 2).
- If the person has been born in California you can submit the person’s current name (first, middle and last) and name at birth (first, middle and last) date of birth, gender, birth county and mother’s maiden name to One-e-App to get a birth record match. A successful match can be used as proof of citizenship.
- Whenever possible, collect the person’s full name (both current and at birth), Social Security Number, place of birth, date of birth, and mother’s maiden name and ACHCS may be able to make a successful match to confirm citizenship.
- You should complete a DHCS 0005 form via One-e-App or on paper when citizenship can be verified.
- Applicants also need to prove Alameda County residency and income. They can do this with one Alameda County Residency document from the third column and one income document from the fourth column, or one document from the Alameda County Residency and Income section.
- The HealthPAC Statement of Income and Residency can be used to establish residency and income if all attempts have been made to get other documentation.
- *In rare cases, the HealthPAC Statement of Income and Residency can also be used to establish identity.*

Enrollment in HealthPAC County requires documentation to prove:

1. Identity
2. Alameda County residency
3. Income

- HealthPAC County Applicants do NOT need to prove Citizenship.
- Applicants DO need to provide one identity document from the second column and either one Alameda County Residency document from the third column and one income document from the fourth column, or one document from the Alameda County Residency and Income section.
- The HealthPAC Statement of Income and Residency can be used to establish residency and income if all attempts have been made to get other documentation.
- In rare cases, the HealthPAC Statement of Income and Residency can also be used to establish identity for **HealthPAC County Only**.

Appendix F:
Exemptions to Five Year Bar for Legal Residency for HealthPAC MCE and HCCI

Enrollment in HealthPAC MCE and HCCI requires legal residency for five years; however the **following qualified aliens are exempt** from the five-year bar to eligibility:

- Refugees;
- Asylees;
- Cuban and Haitian Entrants;
- Victims of a severe form of trafficking;
- Aliens whose deportation is being withheld;
- Qualified aliens who also are (1) an honorably discharged veteran, (2) on active duty in the U.S. military or (3) the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. military;
- Aliens admitted to the country as an Amerasian immigrant;
- Legal permanent residents who first entered the country under another exempt category (i.e. as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or alien whose deportation was being withheld) and who later converted to LPR status.

In addition, the five-year bar to eligibility for HealthPAC MCE and HCCI does not apply to

- Members of a Federally-recognized Indian tribe, as defined in 25 U.S.C. 450b(e); and
- American Indians born in Canada to whom §289 of the Immigration and Nationality Act applies.

Following are the **verification procedures** for determining that an individual is exempt from the five-year bar:

- *Exemptions based on immigration status.* Five of the exemptions from the five-year bar apply to immigrants in a specific immigration status: refugees, asylees, Cuban and Haitian entrants, aliens whose deportation is being withheld and Amerasian immigrants. Immigrants in any of these groups should possess an immigration document establishing their status, which can be verified with the INS in accordance with the procedure generally followed by the state to verify immigration status. Verification of immigration status is discussed in §3212 of the State Medicaid Manual.
- *Exemption based on veteran or active duty status.* Verification of honorable discharge status or active duty requires presentation of an original or notarized copy of the veteran's discharge certificate or current orders showing "Honorable"

discharge from or active duty in the Army, Navy, Air Force, Marine Corps or Coast Guard. Neither discharge “Under Honorable Conditions” nor service in the National Guard satisfies this exemption. States should contact the local Veterans Affairs (VA) regional office if an applicant presents (1) documentation showing honorable discharge from, or active duty in, any other branch of the military; (2) documentation showing any other type of duty (e.g. “active duty for training”) or (3) the state has any other reason to question whether or not an applicant satisfies the requirements for this exemption. Verification of veteran or active duty status is discussed in §3212.5 of the State Medicaid Manual. States may also consult Exhibit B to Attachment 6 of the Interim Guidance at 62 Federal Register 61413-61414.

- *Exemption for certain Native Americans.* For purposes of HealthPAC MCE and HCCI eligibility, American Indians born in Canada to whom §289 of the INA applies and members of a Federally-recognized tribe also are exempt from the five-year bar. Some American Indians born in Canada to whom §289 of the INA applies may have documentation establishing legal permanent residence status, which can be verified in accordance with the procedure generally followed by the state to verify immigration status. Alternatively, an applicant claiming to fall under this exemption could present a letter or other tribal document certifying at least 50% Indian blood, as required by §289 of the INA, combined with a birth certificate or other evidence of birth in Canada.

Applicants can establish membership in a Federally-recognized tribe by presenting a membership card or other tribal document demonstrating membership in an Indian tribe. If the applicant has no documentation, the state can verify membership by contacting the tribe in question.

Verifying Native American status is discussed in §3212.6 of the State Medicaid Manual as well as in §104.62 and §104.63 of the proposed regulations published by the Department of Justice on August 4, 1998 at 63 Federal Register 41685.

- *Victims of Trafficking.* The Office of Refugee Resettlement (ORR) of the U.S. Department of Health and Human Services has been given authority to certify that an individual is a victim of a severe form of trafficking. ORR issues a letter to all individuals so certified. Thus, to verify an immigrant’s status as a victim of a severe form of trafficking, so as to establish an exemption from the five-year bar, the immigrant should present a certification letter from ORR. The letter will contain a certification date, which can be treated as the date of entry for eligibility purposes, as well as an expiration date. Additional information on the eligibility of trafficking victims for benefits can be found in a letter on the Trafficking Victims Protection Act of 2000 from the ORR dated May 3, 2001.



HealthPAC

Health Program of Alameda County

Alameda County Health Care Services Agency

POLICY AND PROCEDURE

Policy Name	Hearings and Appeals
Department Owner	HealthPAC Administrator
Lines of Business	LHP – MCE / HCCI
Effective Date	6/30/2011

HEARINGS AND APPEAL PROCESS

I. Definitions

A. An "action" is:

1. A denial, termination or reduction of eligibility for Medicaid Coverage Expansion (MCE) or Health Care Coverage Initiative (HCCI).
2. A denial or limited authorization of a requested HealthPAC service, including the type or level of service.
3. A reduction, suspension, or termination of a previously authorized service.
4. A failure to provide HealthPAC services in a timely manner pursuant to the Special Terms and Conditions of the California Bridge to Reform Demonstration for the LHP.
5. A failure of the HealthPAC to act within the timeframes for grievances and appeals as outlined herein.

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

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

II. Processes

A. A process for internal resolution of HealthPAC applicants and enrollees grievances and appeals of actions; and

B. A process for HealthPAC applicants and enrollees appeal of actions to a State fair hearing.

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

- A. For those individuals whose HealthPAC eligibility is determined by the State, the State assumes the responsibility and accountability for the resolution process. For those individuals whose HealthPAC eligibility is determined by the county, the State delegates to the county responsibility for the resolution process.
- B. Exhaustion of the internal appeal process will be required of a HealthPAC applicant or enrollee prior to filing a request for a State fair hearing to appeal an action. (42 C.F.R. 438.402.)
- C. Grievances will not be appealable to a State fair hearing.

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

- A. The sole issue is one of Federal or State law or policy, LIHP protocols approved under the Demonstration Standards, Terms and Conditions (STC). (42 C.F.R. 431.230(1).)
- B. The establishment of and any adjustments to the upper income limit made by the LIHP, in accord with STC 58(b).
- C. The establishment by a LIHP of enrollment caps of HCCL, and if as the result of such cap the HCCL is completely closed, establishment of enrollment caps for MCE. (STC 58(c).)
- D. The establishment by a LIHP of wait lists as a result of enrollment caps created in accord with STC 58(c). (STC 58(d).)
- E. The requirement that a LIHP make a timely eligibility determination is waived with respect to individuals' eligibility for a capped program while those individuals are placed on a county wait list for that program. The County's determination to place individuals on a wait list, rather than enrolling them in the capped program directly, is not subject to appeal. Nothing in this provision shall preclude those individuals from appealing the County's determination of eligibility for other programs.

V. Grievance and Appeals Process

A. Notice of Grievance and Appeal Rights

- 1. HealthPAC applicants will be informed of their right to file an internal grievance or appeal and the procedures for exercising this right, as well as the right to appeal an action as identified herein to a State fair hearing upon exhaustion of the internal process. Such information shall be made available in languages in addition to English as outlined in 42 CFR 438.10(e).
- 2. Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all HealthPAC enrollees at the same time that a Notice of Action is issued (as generally required in B.,(below), and in B.2 and B.3., specifically).

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

B. Notice of Action

1. Format - the notice of action will be in writing, and available in languages in addition to English as outlined in 42 C.F.R. 438.10(c).
2. Notice to Applicants – notice will be provided upon completion of an eligibility determination.
3. Timing of Notice for LIHP enrollees – a notice of action will be mailed to HealthPAC enrollees at least 10 calendar days before the date of the action. Exceptions to such notice will follow 42 C.F.R. 431.213.
 - a. Notices regarding standard authorization of service that deny or limit services will be provided as expeditiously as the HealthPAC enrollee's health condition requires and within 14 calendar days following receipt of the request for service. (42 C.F.R. 438.210(d)(1).) The timeframe may be extended for up to 14 additional calendar days if the HealthPaC enrollee or provider requests the extension, and the HealthPaC justifies (to the State agency upon request) a need for additional information and how the extension is in the HealthPAC enrollee's interest. Failure to timely reach authorization decisions constitute a denial and an adverse action, and notice must be provided on the date the timeframe expires. (42 C.F.R. 438.404(c)(5).)
 - b. When the HealthPAC determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that following the standard timeframe in (a), above, could seriously jeopardize the HealthPAC enrollee's life or health or ability to attain, maintain, or regain maximum function, the HealthPAC must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the HealthPAC enrollee's health condition requires and no later than 3 working days. The 3 working days time period may be extended by up to 14 calendar days if the HealthPAC enrollee requests an extension or if the HealthPAC justifies (to the State agency upon request) a need for additional information and how the extension is in the HealthPAC enrollee's interest.
 - c. The requirement for advance notice may be shortened to 5 calendar days in case of probable fraud by HealthPAC enrollees where the agency has facts indicating probable fraud and those facts have been verified, if possible, through secondary sources. (42 CFR 431.214.)
4. Content of Notice - the intended action; the reasons for the action (including statutory and regulatory references, if applicable); the

effective date of the action; the program requirements that support the action; the HealthPAC enrollee's right to file an appeal; the procedures for exercising these rights; the circumstances under which expedited resolution is available and how to request it, and the circumstances under which benefits are continued and how to request it. (42 CFR 438.404.)

C. The Internal Grievance and Appeal Requirements

1. For both grievances and appeals

- a. The HealthPAC will provide any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY-TDD and interpreter capability (42 C.F.R. 438.406.) for all stages of the grievance and appeal processes, at no cost to applicants or HealthPAC enrollees.
- b. HealthPAC applicants and enrollees must file an internal grievance within 60 calendar days of the incident giving rise to the grievance, and must file an appeal of action within 60 calendar days of the date of the notice of action.
- c. The HealthPAC will acknowledge receipt in writing of each grievance and appeal.
- d. The decision maker must not be involved in any previous level of review or decision making.
- e. The decision maker in the following cases must be a health care professional with the appropriate clinical expertise in treating the HealthPAC enrollee's condition or disease:
 - i. An appeal of a denial based on lack of medical necessity.
 - ii. A grievance regarding denial of expedited resolution of an appeal.
 - iii. Grievance or appeal that involves clinical issues.

2. Requirements for appeals of actions

- a. Oral inquiries seeking to appeal an action will be treated as an appeal and confirmed in writing by the HealthPAC unless the applicant, HealthPAC enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.
- b. Applicants, HealthPAC enrollees and their representatives will have the opportunity, before and during the appeals process:

- i. To examine the HealthPAC's position statement related to the reason services are delayed, denied or withdrawn by the HealthPAC, the HealthPAC enrollee's case file, including medical records, and any other documents under consideration in the appeal, and
 - ii. To confront and cross-examine adverse witnesses.
 - c. HealthPAC applicants and enrollees and their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses, in person, in writing, or by telephone if requested by the individual.
 - d. In regard to the option for HealthPAC applicants and enrollees and their representatives to present evidence via the telephone, hearings can be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings conducted in this manner must meet the following criteria:
 - i. Telephonic hearings may be requested by the individual, at any stage of the appeals process, free of charge,
 - ii. The individual must receive a written notice that a hearing can be conducted by telephone or video conference in lieu of an in-person hearing. Such notice must contain information about the process for an individual to review the records, submit evidence, and receive reimbursement for costs in accordance with (3) through (7) of this section C.2.d.
 - iii. HealthPAC applicants and enrollees and their representatives must have the opportunity, before, and during the appeals process, to examine the HealthPAC's position statement, the HealthPAC enrollee's case file, including medical records, and any other documents under consideration in the appeal.
 - iv. HealthPAC applicants and enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal.
 - v. The record must be kept open for 15 calendar days to permit HealthPAC applicants and enrollees and their representatives to submit evidence and any other documents for consideration in the appeal after the hearing has concluded.
 - vi. HealthPAC applicants and enrollees and their representatives must be able to obtain reimbursement of HealthPAC enrollee's costs in order to attend an in-person hearing, i.e. transportation.

vii. Change in Process

- a. At any point prior to or during a telephone or video conference hearing, at the request of either party or the decision maker, an in-person hearing can be ordered.
- b. If an individual has an in person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.

D. Timeframe for resolution of appeals and grievances

1. Standard disposition of grievances – Oral or written notice must be mailed within 60 calendar days of receipt of the grievance.
2. Standard resolution of appeals – HealthPAC must mail written notice within 45 calendar days of receipt of the appeal.
3. Expedited resolution of appeals – HealthPAC must mail written notice within 3 working days of receipt of the appeal. In addition, reasonable efforts to provide oral notice will be made.
4. Timeframes on the above may be extended by up to 14 calendar days if either the HealthPAC enrollee requests it, or the HealthPAC can show (to the satisfaction of the State DHCS upon its request) that there is a need for additional information and how the delay is in the HealthPAC enrollee's interest.
5. Written notice of the reason for the delay under (4.), above, must be provided, unless requested by the HealthPAC enrollee.
6. If a request for expedited resolution of an appeal is denied, the appeal must be treated under the standard resolution timeframe. In addition, reasonable efforts to give prompt oral notice of the denial must be made, and follow up with written notice within 2 calendar days must be provided.

E. Content of Notice of Appeals resolution

1. Written notice of the resolution must include:
 - a. The results of the resolution process and the date it was completed.
 - b. Be available in languages in addition to English as outlined in 42 C.F.R. 438.10(c)
 - c. For appeals not resolved wholly in favor of the HealthPAC enrollee:
 - i. The right to request a State fair hearing and how to do so and the date by which the request of a State fair hearing must be made to be considered timely;

- ii. If applicable, the right to request to receive benefits while the hearing is pending, and how to make the request; and
- iii. That the HealthPAC enrollees may be held liable for the cost of those benefits if the hearing decision upholds the HealthPACs action.

F. State Fair Hearing

- 1. A State fair hearing may be requested within 90 calendar days of the date of the Notice of Resolution of the internal appeal of an action.
- 2. The State will take final administrative action in accord with 42 CFR 431.244(f)(1), or 431.244(f)(2), if applicable.
- 3. The HealthPAC will be a party to the State fair hearing.

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

- 1. The HealthPAC enrollee's benefits must be continued if:
 - a. A HealthPAC enrollee's eligibility is terminated or reduced;
 - b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - c. The services were ordered by an authorized provider;
 - d. The original period covered by the original authorization has not expired;
 - e. The HealthPAC enrollees or provider (on behalf of the HealthPAC enrollees) timely files an appeal; and
 - f. The HealthPAC enrollee requests extension of benefits.
- 2. "Timely filing" as used in this section means filing on or before the later of either:
 - a. Ten (10) calendar days from the mailing of the notice of action
 - b. The intended effective date of the proposed action.
 - c. In the case of a State fair hearing, 10 calendar days from the date of the internal appeal decision.
- 3. Benefits that are continued under this section shall be continued until:
 - a. The HealthPAC enrollees withdraw the appeal;
 - b. Ten (10) calendar days pass after the mailing of a notice resolving the internal appeal adverse to the HealthPAC

enrollees, unless the HealthPAC enrollees requests a State fair hearing with continuation of benefits within 10 calendar days of the issuance of the internal appeal decision;

- c. A State fair hearing decision adverse to the HealthPAC enrollees is issued,
 - d. As ordered by the Administrative Law Judge at the State fair hearing, in limited permissible circumstances, such as 431.230(a)(1); or
 - e. The time period or service limits of a previously authorized service has been met.
4. If the final resolution of the internal appeal or the state fair hearing is adverse to the HealthPAC enrollees, the HealthPAC may recover the cost of the services furnished to the HealthPAC enrollees while the appeal is pending, to the extent they were furnished solely because of the requirements of this section of the procedures.
 5. If services were not furnished pending the internal appeal or the State fair hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the HealthPAC must provide the disputed services promptly, and as expeditiously as the HealthPAC enrollee's health condition requires.
 6. If the HealthPAC enrollee received disputed services while the internal appeal or the State fair hearing was pending, and the resolution reverses a denial of services, the HealthPAC must cover such services.

VI. LIHP Monitoring Reporting

CMS expects LIHP's to maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process. To demonstrate the efficacy of the State's grievance and appeals process, the State Medicaid agency will provide to CMS the following data by LIHP program on a quarterly basis:

- A. Time Period(s) Covered
- B. Average Number of LIHP enrollees in the time period
- C. Total number of appeal and the total number of grievance cases received by the LIHP and the State in the period;
- D. Rate of Appeals and the rate of grievances per 1000 LIHP
- E. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of;
 1. Number and percent decided in fully favor of the LIHP enrollee
 2. Number and percent decided partially in favor of the LIHP enrollee

3. Number and percent not decided in favor of the LIHP enrollee
4. Number and percent withdrawn by the LIHP enrollee;
5. Number and percent of cases resolved through the fair hearing process, using telephonic procedures
 - a. Number and percent decided in fully favor of the LIHP enrollee using telephonic procedures
 - b. Number and percent decided partially in favor of the LIHP enrollee using telephonic procedures
 - c. Number and percent not decided in favor of the LIHP enrollee using telephonic procedures
 - d. Number and percent withdrawn by the LIHP enrollee using telephonic procedures;
- F. Issues involved in all cases.
- G. Time it takes to resolve the cases (upper and lower limits, median/mean)
 1. Number and percent of these cases involving expedited processing; and
- H. Quality Improvement activities related to issues identified through the County's LIHP.

Signature



Alex Briscoe

Date: 6/30/11

Director, Alameda County Health Care Services Agency

Appendix H:

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
Health Program of Alameda County (HealthPAC)

HealthPAC Statement of Income and Residency

I, (1) _____, and (2) _____,
(Print Full Name) (Print Full Name)

residing at _____,
(Street address-Do not use a P.O. Box) (City) (State) (Zip code)

declare under the penalty of perjury that the following information is true and correct to the best of my/our knowledge and belief: (Check all that apply)

_____ I am/We are currently unemployed and have no source of income.

_____ I am/We are currently residing with a relative/friend who is providing free room and board.

_____ I am/We are currently living off my/our savings account (please provide most recent bank statement).

_____ I am/We are currently a student receiving a student grant/loan/scholarship.

_____ I /We receive free room and board in lieu of managing an apartment.

_____ I /We receive rental income. I receive \$ _____ monthly.

_____ I am /We are currently homeless in Alameda County (currently residing in a shelter or lacking adequate night time residence).

_____ Other (Specify) _____.

_____ I/We am/are currently receiving cash payment for work performed as follows:

CASH INCOME	
<i>NOTE: DO NOT USE THIS FORM IF YOU RECEIVE: Check stubs; Social Security; Unemployment; Disability; Pensions or are Self-Employed. Refer to Appendix E for acceptable verifications.</i>	
<u>TYPE OF WORK:</u>	<u>PAYMENT FREQUENCY:</u>
_____ Day Care Provider	_____ \$ _____ Daily
_____ Beauty Salon	_____ \$ _____ Weekly
_____ General Labor	_____ \$ _____ Bi-Weekly (every other week)
_____ House Cleaning	_____ \$ _____ Semi-Monthly (twice a month)
_____ Waiter/Waitress	_____ \$ _____ Monthly
_____ Other (Specify) _____	_____ \$ _____ Other (Specify)

_____ DATE

_____ SIGNATURE

APPENDIX I: HEALTH PROGRAM OF ALAMEDA COUNTY LIABILITY SCHEDULE

**ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
ALAMEDA COUNTY MEDICAL CENTER / COMMUNITY BASED ORGANIZATION
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) LIABILITY SCHEDULE
EFFECTIVE, April 1, 2012**

The total cost for a family in a year can NOT exceed 5 percent of the family's income.

% OF POVERTY LEVEL	HealthPAC CO-PAYMENT					***MAXIMUM GROSS MONTHLY INCOME PER FAMILY SIZE***										FOR EACH ADD'L MEMBER ADD:
	Emergency Co-Pay	Inpatient Co-Pay	Outpatient Co-Pay	Pharmacy Co-Pay ¹	Special Procedure ² Co-Pay	1	2	3	4	5	6	7	8	9	10	
0-133%	0	0	0	0	0	1238	1677	2116	2555	2994	3433	3871	4310	4749	5188	439
133.01 - 150%	0	75	0	3	75	1396	1891	2386	2881	3376	3871	4366	4861	5356	5851	495
150.01 - 200%	0	125	0	3	125	1862	2522	3182	3842	4502	5162	5822	6482	7142	7802	660
Over 200%	PATIENTS WHOSE GROSS MONTHLY INCOME IS OVER 200% OF THE FEDERAL POVERTY INCOME GUIDELINES SHALL BE CONSIDERED PRIVATE PAY.															

¹ Pharmacy charge \$3 per prescription drug with \$36 per visit maximum.

² Examples of special procedures include:

- bronchoscopy
- cat scans
- cholecystectomy
- EKG
- EMG (electromyography)
- endoscopy
- holler monitor
- hysteroscopy
- implantation of pumps
- pacemakers
- stimulators or other devices
- IV infusion/chemotherapy (co-pay to cover duration of treatment plan)
- laparoscopy
- MRI (Magnetic Resonance Imaging)
- myelography
- nuclear med
- thoracscopy
- venous/arterial catheter placement



Quality Measurement and Improvement Plan

QUALITY IMPROVEMENT PROGRAM GOALS AND SCOPE

The purpose of the HealthPAC Quality Improvement (QI) Program, overseen by the Alameda County Health Care Services Agency (HCSA), is to objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to members of HealthPAC. The QI Program is structured to continuously pursue opportunities for improvement and problem resolution. Settings and types of care to examine are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

The QI program is designed to ensure that:

- High quality, safe, and appropriate care that meets professionally recognized standards of practice is delivered to all enrollees.
- The plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings.
- Activities to improve processes by which care and services are delivered are developed, implemented, evaluated and reassessed.
- Quality of care problems are identified and corrected for all provider entities.
- Physicians and other appropriate licensed professionals are an integral part of the QI program.
- Appropriate care consistent with professionally recognized standards of practice is not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
- The plan does not pressure institutions to grant privileges to health care providers that would not otherwise be granted.
- The plan does not pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the QI Program is comprehensive and encompasses major aspects of care and service in the HealthPAC delivery system, and the clinical/non-clinical issues that affect its membership. These include:

- Availability and access to care, clinical services, and care management.
- Cultural and linguistic issues
- Special needs populations such as persons with chronic conditions, homeless individuals, individuals with serious mental illness, the re-entry population, and others.
- Patient safety

- Member and Provider satisfaction
- Member and Provider education
- Continuity and coordination of care
- Utilization trends including over- and under-utilization
- Clinical practice guideline development, compliance, and revision
- Acute, chronic, and preventive care services for adults
- Primary, specialty, emergency, inpatient, and ancillary care services
- Case review of suspected instances of poor quality
- Credentialing and recredentialing activities

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITY

Overview

HCSA is responsible for oversight of the QI program. The program will utilize and build upon existing quality assurance and improvement structures and activities already taking place among members of the Alameda County Safety Net Council. In addition, HCSA contracts with the Alameda Alliance for Health (Alliance) to perform certain quality management functions as articulated later in this document.

Alameda County Health Care Services Safety Net Council

The Safety Net Council is comprised of Health Care Services Agency leadership (director, finance director, HealthPAC administrator, Public Health Director, Public Health Officer, Behavioral Health Care Services Director and Medical Director); the Alameda Alliance for Health leadership (Chief Executive Officer, Medical Officer); ACMC leadership (Chief Executive Officer, Chief Strategy & Integration Officer, Chief Financial Officer); all HealthPAC clinic Chief Executive Officers; the Alameda Health Consortium Executive Director.

The Safety Net Council and its members provide executive level input and oversight into the HealthPAC Quality Improvement (QI) Program; however, the HCSA director is ultimately responsible for making decisions about the program. The Safety Net Council duties include:

- Annually review, update and approve the Quality Improvement Program description, defining the scope, objectives, activities, and structure of the program.
- Review annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assess QI program's effectiveness and direct modification of operations as indicated.
- Provide oversight and guidance of the work of the Clinical Quality Improvement Workgroup.
- Designate a member of senior management within their organizations that has the authority and responsibility for the overall operation of the quality improvement program within their organization.

HealthPAC Clinical Implementation Workgroup (CIWG)

The Clinical Implementation Workgroup is responsible for the development, implementation, oversight, and monitoring of quality improvement activities within HealthPAC with a focus on priority areas as identified by the Safety Net Council. This workgroup meets at least quarterly, and as often as needed, to follow-up on findings and required actions. This group includes key administrative and clinical staff members that represent the range of providers.

CIWG responsibilities include:

- Approve selection, design, and schedule for studies and improvement activities.
- Designs standards of care such as panel management standards, care management standards, and other best practice models.
- Review results of established quality measures, annual site visit assessments, and improvement and intervention activities.
- Provides on-going reporting to the Safety Net Council.
- Meets at least quarterly and maintains minutes of all committee meetings.
- Review member grievance and appeals information.
- Review utilization management results.
- Provides guidance to staff on quality management priorities and projects.
- Monitors progress in meeting quality improvement goals.
- Annually evaluates the effectiveness of the Quality Improvement Program.
- Review and approve QI policy and procedure revisions, and annual QI Program description, work plan, and evaluation.

HealthPAC Contract with the Alameda Alliance for Health

The County delegates responsibility for aspects of the Quality Improvement Program. The Alliance will perform the following quality measurement and monitoring functions for the HealthPAC program:

- Provide a representative to the CIWG,
- Credential participating providers,
- Quarterly reports on HEDIS-like quality measures,
- Provide ad-hoc quality reports as requested by HCSA and/or the CIWG,
- Provide reports on utilization trends, and
- Report on the number of grievances and appeals received, upheld and overturned.

Alameda County Behavioral Health Care Services

The Behavioral Health Care Services (BHCS) department of HCSA participates in the aforementioned groups with designated staff members and provides additional quality improvement data and support to the HealthPAC QI effort. BHCS performs the following functions:

- Ensure appropriate credentialing of specialty mental health participating providers;
- Quarterly reports on mutually identified measures;

- Provide ad-hoc quality reports as requested by HCSA and/or the QI,
- Provide reports on utilization trends, and
- Report on the number of grievances and appeals received, upheld and overturned

Alameda County Public Health Medical Officer

The Alameda County Public Health Medical Officer is a physician who is responsible for, and oversees the Quality Improvement Program. The Medical Officer provides leadership to the Quality Improvement Program through oversight of QI study design, development, and implementation. The Medical Officer makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the Safety Net Council.

HealthPAC Quality Coordinator

The HealthPAC Quality Coordinator is a nurse and HCSA employee who coordinates the HealthPAC Quality Improvement Program. The HealthPAC Quality Coordinator conducts site visits, does assessments, collects data and presents information to the QI Workgroup. The HealthPAC Quality Coordinator works with the Workgroup to identify training needs at service delivery sites and provides hands on training to staff.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, and sub-contractors of the HealthPAC maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QI activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QI activities must submit a written request to the Medical Officer. Release of all information will be in accordance with state and federal laws.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QI meeting material and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

METHODS AND PROCESSES FOR QUALITY IMPROVEMENT

The Quality Improvement Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any service or product for which it seems relevant.

Identification of Important Aspects of Care

HealthPAC uses several methods to identify aspects of care that are the focus of QI activities. Some studies are initiated based on performance measured as part of contractual requirements and member demographics, utilization patterns, and risk areas. Other studies are initiated based on analyses of the assessments performed during site visits. Population based information captured by the Public Health Department is also used to set priorities.

Data Sources

Data sources include, but are not limited, to the following:

- Claim and encounter submissions.
- Disease registry information.
- Credentialing, medical record review, and audit findings.
- Member and provider grievance and appeal data.
- Potential Quality Issue tracking/trending data.
- Other clinical or administrative data.
- Public health department population data.

Data Collection, Analysis, and Reporting

HealthPAC has the capability to design sound studies of clinical and service quality that produce meaningful data. Data collection and coordination activities are performed primarily through the Clinical Implementation Workgroup.

ACTIONS TAKEN AS RESULT OF QUALITY IMPROVEMENT ACTIVITIES

Action plans are developed and implemented when problems or opportunities for improvement are identified. Each corrective action plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

TYPES OF QI MEASURES AND ACTIVITIES

HEDIS-LIKE Measures

A subset of HEDIS- like (Health Effectiveness Data Information Set) as agreed upon by the CIWG are calculated and reported annually. Additional quality measures as defined by the HealthPAC implementation workgroup are also assessed and reported on annually.

Annual Site Assessments

The HealthPAC Quality Coordinator conducts annual site visits to all medical homes for HealthPAC. During the site visits the Coordinator conducts assessments of the clinics progress in meeting panel management and care management standards. From the assessment, the Coordinator develops a HealthPAC report summarizing the findings. From the findings the Clinical Implementation Workgroup develops a training plan.

Trainings

The HealthPAC Quality Coordinator and designated staff from behavioral health care services organize trainings each year that all of the providers in the network can participate in. At least four trainings are offered each year. The content of the trainings is developed based on the findings in the site visit assessments and with input from the CIWG. In addition, the HealthPAC Quality Coordinator provides site based trainings as needed.

Patient Safety and Quality of Care

The HealthPAC QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for plan members. Quality of care and patient safety are monitored through review of the following:

- Complaint and grievance processes.
- Iatrogenic events reported on claims and encounter submissions.
- Concurrent review of inpatient admissions.
- Investigation of reported and/or identified potential quality of care issues.
- Credentialing and re-credentialing review of malpractice, license suspension registries, loss of hospital privileges.

Access and Availability

The QI Program monitors access and availability of care including member wait times and access to providers for routine, urgent, emergent, and preventive, specialty, and after-hour care. Access to health care is ensured by monitoring compliance with wait time standards for provider office appointments, telephone calls, and appointment availability. HCSA (including public health and behavioral health) and Alliance staff review the member complaints about access and make recommendations for intervention. The CIWG provides input into the recommendations and how to implement changes.

Disease Management and Practice Guidelines

Healthcare homes maintain responsibility for basic case management, including preventive health care and disease management. The QI Program includes a process to review, develop and/or adopt and update clinical practice guidelines that assist providers in the delivery of preventive, acute, and chronic care, and disease management. Approved guidelines are: 1) consistent with standards and recommendations of professional organizations, and/or scientific evidence, clinical trials, validated studies, or published reports; 2) consider the needs of HealthPAC members; 3) are adopted in consultation with Healthcare homes; and 4) are periodically updated when appropriate.

COMMUNICATION

The County's contracts with its providers foster open communication and cooperation with QI activities. Contract language specifically addresses:

- Provider cooperation with QI activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.

- Open provider-patient communication about treatment alternatives for medically necessary or appropriate care.

Provider involvement in the QI program occurs through membership in standing and ad-hoc committees, and attendance at CIWG and Safety Net Council meetings. Providers and members may request copies of the QI program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies and those that focus on improving aspects of member care. Additionally, provider feedback on surveys and questionnaires is encouraged as a means of continuously improving the QI Program.

EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The QIWG reviews a written evaluation of the overall effectiveness of the Quality Improvement program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Resources allocated to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and on-going QI activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or limitations.
- Recommendations for goals, targets, activities, or priorities in subsequent Quality Improvement Work Plan

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIWG, Medical Officer, Director of Health Care Services Agency, or Safety Net Council. The CIWG's recommendations for revision are incorporated into the Quality Improvement Program description, as appropriate, which is reviewed by the Safety Net Council and submitted to DHCS on an annual basis.

ANNUAL WORK PLAN

A Quality Improvement Work Plan is received and approved annually by the Safety Net Council. The work plan describes the quality management goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as the need is identified. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.

QI DOCUMENTS

In addition to this program description, the annual evaluation and work plan, other additional documents important in communicating QI policies and procedures are:

- The contracts provide detail about the expectations of each partners roles and responsibilities.
- The "HealthPAC Plan" provides information about eligibility, scope of services, and general responsibilities of each partner.

Appendix J

- The “HealthPAC operations manual” documents policies and procedures under the Alameda County HealthPAC.
- Monthly e-mail blasts to the HealthPAC providers will give program updates.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners.

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

HealthPAC NAME CHANGE FORM

I, _____ declare that my name at birth was
(FULL NAME: FIRST, MIDDLE, LAST)

_____ and I was born in
(FULL NAME: FIRST, MIDDLE, LAST)

_____. I changed my name in _____ and do not have
(US STATE OR FOREIGN COUNTY) (YEAR)
court documentation to verify this change. I understand that the HealthPAC program may verify this information against State records.

I declare under penalty of perjury that this information is true and correct to the best of my knowledge.

(SIGNATURE OF APPLICANT)

(DATE)

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

HealthPAC EVENT CHANGE FORM

I, _____ declare that I was born _____
(FULL NAME: FIRST, MIDDLE, LAST) (DATE OF BIRTH)

in _____. My name at birth was _____
(US STATE OR FOREIGN COUNTY) (FULL NAME: FIRST, MIDDLE, LAST)

and I was born a male / female. In _____ I changed my name and/or gender.
(CIRCLE) (YEAR)

I declare under penalty of perjury that this information is true and correct to the best of my knowledge.

(SIGNATURE OF APPLICANT)

(DATE)

EXHIBIT B - PAYMENT TERMS

I. Budget - Contractor Budget Summary is attached hereto as Exhibit B-1.

County is not obligated to pay actual expenses exceeding the amounts set forth in the attached Budget Summary, unless prior written approval for those expenses have been obtained and appropriate budget adjustments made so that the total budget amount is not exceeded.

II. Terms and Conditions of Payment

A. Reimbursement

1. Contractor shall invoice the County for actual expenses incurred but not to exceed \$487,932 per quarterly period without prior written approval from the County. The final and last invoice shall reflect actual expenses incurred, however, shall not exceed the remaining balance of the total contract and budget amount. Payment under the terms of this Agreement shall not exceed the total amount of \$1,951,728 for the period of the contract. Invoices shall be submitted monthly by the end of the month following the month services were performed.
2. Funds shall be used solely in support of the project's program budget. Funds may not be used for any purpose other than those specified in Exhibit A of this Agreement without prior written approval from County.
3. County will pay Contractor based on actual expenditures incurred and upon submission by the Contractor of invoices, required reports and documentation monthly verifying that services have been performed pursuant to this Contract.
4. County shall review the invoices, accompanying reports and required supporting documentation for approval and sign off on invoices for payment upon successful completion.
5. The County reserves the right to request additional information at the time an invoice is submitted, the time the quarterly progress report is submitted, or at any time thereafter. Contractor shall provide any additional information requested by County. The right of the County to request and the obligation of the Contractor to supply additional information, shall survive termination of the Agreement.
6. Acceptance of an invoice or payment for any services, does not release the Contractor from the requirement to provide information at a later time.
7. Contractor agrees to indemnify County for any costs incurred as a result of Contractor's failure to properly account for or document any expenditures and costs, including but not limited to those found in any audit by the County, the Federal Government or the State of California.

B. Invoicing Procedures

Contractor shall invoice County each month. Invoices, accompanied by the required reports and documentation, should be sent to:

Alameda County Health Care Service Agency
ATTN:HealthPAC Program Administrator
1000 San Leandro Blvd., Suite 300
San Leandro, CA 94577

Alameda Alliance for Health
 HealthPac TPA Services - County
 Fiscal Year 2013 Budget

		Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Total
Participants		75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	75,000	900,000
Personnel														
105 Healthcare Analytics/Ops.		\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$5,801	\$69,607
110 Administration		\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$1,921	\$23,054
120 Finance		\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$1,513	\$18,155
130 IT		\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$3,299	\$39,583
140 HealthPlan Services		\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$9,469	\$113,625
150 Member Services		\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$26,857	\$322,288
185 Business Operations		\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$6,509	\$78,105
190 Policy & Planning		\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$13,828	\$165,936
195 Healthplan Services Ops.		\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$1,659	\$19,904
230 General & Administrative		\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$12,885	\$154,617
240 Communications		\$242	\$242	\$242	\$242	\$242	\$242	\$242	\$242	\$242	\$242	\$242	\$242	\$2,899
Personnel Subtotal		\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$83,981	\$1,007,774
Space, Supplies & Equipment														
Based on expense per FTE	\$6,000	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$5,946	\$71,346
Administrative Systems														
EMS – Diamond Support		\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$62,304
InContact		\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$5,192	\$62,304
Support Systems Allocation		\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$100,000
Dedicated Hardware		\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$8,333	\$100,000
		\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$27,051	\$324,608
Participant Materials														
Postage		\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$14,359	\$172,310
Mailing Services		\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$8,228	\$98,734
Materials Design		\$791	\$791	\$791	\$791	\$791	\$791	\$791	\$791	\$791	\$791	\$791	\$791	\$9,494
Printing		\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$14,781	\$177,373
Translation Services		\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$3,507	\$42,089
Participant Materials Subtotal		\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$41,667	\$500,000
Medical Transportation														
Budget based on Logisticare actual		\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$4,000	\$48,000
Total Expense		\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$162,644	\$1,951,728
Per Participant Expense		\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17	\$2.17
Excluding Discharge Planning (Dept 140)														
Total Expense		\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$163,175	\$1,838,103
Per Participant Expense		\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04	\$2.04

EXHIBIT D

COUNTY OF ALAMEDA

DEBARMENT AND SUSPENSION CERTIFICATION

(Applicable to all agreements funded in part or whole with federal funds and contracts over \$25,000).

The contractor, under penalty of perjury, certifies that, except as noted below, contractor, its principals, and any named and unnamed subcontractor:

- **Is not currently under suspension, debarment, voluntary exclusion, or determination of ineligibility by any federal agency;**
- **Has not been suspended, debarred, voluntarily excluded or determined ineligible by any federal agency within the past three years;**
- **Does not have a proposed debarment pending; and**
- **Has not been indicted, convicted, or had a civil judgment rendered against it by a court of competent jurisdiction in any matter involving fraud or official misconduct within the past three years.**

If there are any exceptions to this certification, insert the exceptions in the following space.

Exceptions will not necessarily result in denial of award, but will be considered in determining contractor responsibility. For any exception noted above, indicate below to whom it applies, initiating agency, and dates of action.

Notes: Providing false information may result in criminal prosecution or administrative sanctions. The above certification is part of the Standard Services Agreement. Signing this Standard Services Agreement on the signature portion thereof shall also constitute signature of this Certification.

CONTRACTOR: Alameda Alliance for Health

PRINCIPAL: Ingrid Lamirault

TITLE: Chief Executive Officer

SIGNATURE:  DATE: 6/12/12

Exhibit E

Business Associate Provisions relating to HIPAA Effective 4/24/2003

Definitions

Capitalized terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms are defined in 45 Code of Federal Regulations Parts 160 and 164 (the "HIPAA Privacy Rule"). In the event of an inconsistency between the provisions of this Agreement and the mandatory provisions of the HIPAA Privacy Rule, as amended, the Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Privacy Rule, but are nonetheless permitted by the Privacy Rule, the provisions of this Agreement shall control. All regulatory references in this Agreement are to HIPAA Privacy Rule unless otherwise specified.

- (a) *Business Associate*. "Business Associate" shall mean the Contractor, Alameda Alliance for Health.
- (b) *Covered Entity*. "Covered Entity" shall mean that any part of the County of Alameda Health Care Services Agency, a County of Alameda "hybrid entity", is subject to the Standards for Privacy of Individually Identifiable Health Information set forth in 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E ("County").
- (c) *Individual*. "Individual" shall have the same meaning as the term "individual" in Section 164.501 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).
- (d) *Privacy Rule*. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Part 160 and Part 164, Subparts A and E.
- (e) *Protected Health Information*. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in Section 164.501 and is limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- (f) *Required By Law*. "Required by law" shall have the same meaning as the term "required by law" in section 164.501.
- (g) *Secretary*. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.

Obligations and Activities of Business Associate

- (a) Business Associate acknowledges and agrees that all PHI that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.
- (b) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.
- (c) Business Associate agrees to use appropriate administrative, physical and technical safeguards to prevent the use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (d) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement. Mitigation includes, but is not limited to, the taking of reasonable steps to ensure that the actions or omissions of employees of Business Associate do not cause Business Associate to breach the terms of this Agreement.

Exhibit E

Business Associate Provisions relating to HIPAA Effective 4/24/2003

- (e) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information, of which it becomes aware, that is not directly related to Business Associate's performance of the Scope of Work set forth in Exhibit A of this Agreement. This includes the reporting of any security incident, of which it becomes aware, affecting the electronic protected health information.
- (f) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. Business Associate shall not subcontract with respect to this agreement without the advanced consent of Covered Entity.
- (g) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
- (h) To the extent Business Associate is required to make PHI available to an Individual pursuant to Sections 164.524 and/or 164.526, Business Associate shall do so solely by way of coordination with Covered Entity.
- (i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.
- (j) Business Associate agrees to provide to Covered Entity or an Individual, in the time and manner designated by Covered Entity, information collected in accordance with Section (h) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.

Permitted Uses and Disclosures by Business Associate

- (k) Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Exhibit A of this Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.
- (l) Business Associate may use and disclose PHI as permitted in Section 164.504.

Business Associate Obligations upon Termination or Expiration of Agreement

- (m) Covered Entity has the right to terminate this Agreement as set forth in Exhibit D (Additional provisions) and as otherwise permitted by applicable state and federal law. In the event of termination for any reason, or upon the expiration of this Agreement, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
- (n) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or

Exhibit E

Business Associate Provisions relating to HIPAA
Effective 4/24/2003

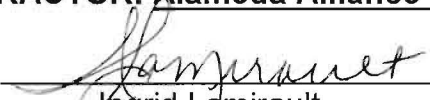
destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

Miscellaneous

- (o) *Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.
- (p) *Amendment.* The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.
- (q) *Survival.* In addition to the provisions with respect to survival as set forth in Exhibit D (Additional provisions), the following shall apply. The respective rights and obligations of Business Associate with respect to PHI in the event of termination, cancellation or expiration of this Agreement shall survive said termination, cancellation or expiration of this Agreement, and shall continue to bind Business Associate, its agents, employees, contractors and successors as set forth herein.
- (r) *Third Parties.* Except as expressly provided herein or expressly stated in the Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties.
- (s) *Preemption.* The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of PHI under the HIPAA Privacy Rule. The use and disclosure of individually identified health information is also covered by applicable California law. To the extent that California law is more stringent with respect to the protection of such information, applicable California law shall govern Business Associate's use and disclosure of confidential information related to the performance of this Agreement.
- (t) *Interpretation.* Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

CONTRACTOR: Alameda Alliance for Health

By:


Ingrid Lamirault
Chief Executive Officer
Title

Address: 1240 South Loop Road
Alameda, Ca 94502

Tax Payer I.D.# 20-3674364