ARTICLE I. PROGRAM DEFINITIONS

A. **Accomplishments** mean tasks that were accomplished during this reporting period.

B. **Agreement or Contract** is a subaward as described in 45 CFR 75.351 and means the Standard Agreement (Std. 213), Exhibits A, B, C, D and E, an approved Budget Display as identified in Exhibit B, and if applicable, a Work Plan or Budget Summary, which are hereby incorporated by reference, amendments, and any other documents incorporated by reference; unless otherwise provided for in this Article.

C. **Cal MediConnect** (formerly the Dual Eligible Demonstration Project) means a demonstration program that coordinates health care services for people with Medicare and Medi-Cal through an integrated system of health care delivery, including medical, behavioral, and long-term support. Cal MediConnect is authorized by Section 1115A of the Social Security Act (added by Section 3021 of the Patient Protection and Affordable Care Act, PL 111-148), and it is a key element of California's Coordinated Care Initiative (CCI). The CCI was authorized pursuant to SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012), and reauthorized in the 2017-18 California Budget.

D. **Centers for Medicare & Medicaid Services (CMS)** mean the federal Medicare/Medicaid Agency.

E. **Contractor** is a sub-recipient as described in 45 CFR 75.351 and means the Area Agency on Aging (AAA) awarded funds under this Agreement and is accountable to the State and/or federal government for use of these funds and is responsible for executing the provisions for services provided under this Agreement.

F. **Dual Eligible Beneficiaries** mean individuals 21 years of age or older who are enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for medical assistance under the Medi-Cal State Plan.

G. **Eligible Service Population** means dual eligible beneficiaries eligible for, enrolled in, or targeted for enrollment into a Cal MediConnect Health Plan, or beneficiaries' designated representative.

H. **Enhanced Outreach** means outreach activities above and beyond routine activities planned in response to other funding (e.g., F2-1718, State Health Insurance Assistance Program (SHIP) Funds, and Medicare Improvements for Patients and Providers Act (MIPPA) Funds), tailored to the specific needs of dual eligible beneficiaries eligible for, enrolled in, or targeted for enrollment into a Cal MediConnect Health Plan.

ARTICLE I. PROGRAM DEFINITIONS (Continued)

I. **Enrollment Brokers** mean third-party entities that enroll beneficiaries into Cal MediConnect plans chosen by the beneficiary.

J. **Financial Alignment (FA) Model** means the model the State is using to enroll dual eligible beneficiaries in managed care plans that integrate benefits and align financial incentives between Medicare and Medi-Cal.

K. **Health Insurance Counseling and Advocacy Program (HICAP)** means a program designed to provide Medicare beneficiaries and those imminent of becoming eligible for Medicare with counseling and advocacy about Medicare, private health insurance, and related health care coverage plans for the purpose of preserving service integrity on a Statewide basis. [Welf. & Inst. Code § 9541]

L. **Indirect Costs** mean costs incurred for a common or joint purpose benefitting more than one cost objective and not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

M. **Long Term Services and Supports (LTSS)** are Medi-Cal programs that provide assistance with Activities of Daily Living, and include a range of home and community based services, such as: In-Home Supportive Services; Community-Based Adult Services; and Multipurpose Senior Services Program, in addition to care in nursing facility services when needed.

N. **Milestones** mean high-level goals that define the phases of this Project.

O. **One-on-one Counseling** means the provision of local counseling and informational resources that enable dual eligible beneficiaries to make informed decisions about options they have for receiving Medicare and Medi-Cal benefits that best meet their health and Long Term Services and Supports needs.

P. **Program Income** means revenue generated by the Contractor or Subcontractor from contract-supported activities. Program income includes:

1. Voluntary contributions received from a participant or responsible party as a result of the service(s)

2. Income from usage or rental fees of real or personal property acquired with funds provided under this Agreement

3. Royalties received on patents and copyrights from contract-supported activities

4. Proceeds from the sale of items fabricated under a contract agreement

ARTICLE I. PROGRAM DEFINITIONS (Continued)

Q. **State Health Insurance Assistance Program** (SHIP) is a program designed to provide Medicare beneficiaries and those imminent of becoming eligible for Medicare with counseling and advocacy as to Medicare, private health insurance, and related health care coverage plans, on a Statewide basis. [Welf. & Inst. Code §9541]. In California, SHIP is the same program as the Health Insurance Counseling and Advocacy Program (HICAP). This term may be used interchangeably with HICAP.

R. **Statewide HICAP Automated Reporting Program (SHARP)** means the State's proprietary database for reporting HICAP data to the Centers for Medicare and Medicaid Services (CMS).

S. **Social Security Act Section 1115A** means the section added by Section 3021of the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) that authorizes the CMS Innovation Center to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and the Children's Health Insurance Program while preserving or enhancing quality of life.

ARTICLE II. SCOPE OF WORK

A. General Provisions

1. The Scope of Work shall be performed by the Contractor and/or its HICAP Subcontractor.

2. All contract and subcontract activities must be separate, distinct, over and above those related activities provided through other funding sources (e.g., the F2-1718, State Health Insurance Assistance Program (SHIP), and Medicare Improvements for Patients and Providers Act (MIPPA) Funds) and must meet CDA and CMS performance requirements.

3. Contractor must expend first year funds by December 22, 2018. If available, second year funds must be expended by December 21, 2019.

B. Contractor, if providing services directly or through a subcontract, shall:

1. Ensure statutory requirements of HICAP [Welf. & Inst. Code §9541] are met. Services shall be provided in accordance with all applicable laws, regulations, this Agreement, the HICAP Program Manual, and any other subsequent California Department of Aging (CDA) Program Memos (PM), provider bulletins or similar instructions issued by federal or State agencies during the term of this Agreement.

ARTICLE II. SCOPE OF WORK (Continued)

2. Ensure that the Eligible Service Population, as defined in Exhibit A, Article I, G, is provided with services in a manner that:

    - Is fair, objective, timely, complete and impartial;
    - Empowers consumers to make informed decisions about selecting plans that best meet their health and LTSS needs, and continues to meet their needs;
    - Refers consumers and their families to other resources as needed;
    - Culturally and linguistically appropriate; and
    - Complies with accessibility and non-discrimination laws and regulations as they apply to Project activities (including the Americans with Disabilities Act, Sections 504 and 510 of the Rehabilitation Act of 1973, and Section 1557 of the Affordable Care Act).

3. Ensure that the Eligible Service Population, as defined in Exhibit A, Article I, G, is provided with enhanced outreach activities, materials, and one-on-one counseling on coverage options for their Health and LTSS benefits under Cal MediConnect and alternatives. Outreach materials and one-on-one counseling activities should be health literate, culturally/linguistically appropriate, and specific to the needs of the Eligible Service Population.

4. Ensure that individuals in the Eligible Service Population have access to information and counseling to empower them to make informed decisions about selecting plans that best meet their health and LTSS needs. This information and counseling shall be fair, objective, accurate, timely, complete and impartial. It shall include, but not be limited to, all available health coverage options, implementation activities and timelines, appeal rights, and options for participating in the program.

5. Ensure the provision of additional outreach services and materials to partners, beneficiary caregivers, providers, and other aging network and disability partners (e.g., Information and Assistance, Aging and Disability Resource Centers (ADRC), county Medi-Cal offices, county Independent Living Centers, the Cal MediConnect Ombudsman and other not-for-profit agencies) regarding Cal MediConnect and the availability of HICAP one-on-one counseling for the Eligible Service Population, and refer beneficiaries to other resources as needed.

6. Ensure outreach and one-on-one counseling activities are enhanced to reach Dual Eligible sub-populations, such as beneficiaries with Limited English Proficiency, intellectual and developmental disabilities, severe and persistent mental illness, those with behavioral and cognitive disabilities, and other demonstration sub-populations.

ARTICLE II. SCOPE OF WORK (Continued)

7. Ensure that the services provided are separate, distinct, above and beyond those performed under the F2-1718 Contract, and/or services authorized under other Federal initiatives. These services include, but are not limited to:

   a. Staying apprised of the status of the Cal MediConnect demonstration, including plan participation, enrollment schedules, and outreach campaigns;

   b. Developing and providing HICAP Counselors with the information, training, and tools they will need to effectively and efficiently help dual eligible beneficiaries;

   c. Conducting outreach to educate the eligible service population about their coverage options, including those available through the Cal MediConnect demonstration;

   d. Partnering with stakeholders and other entities such as, local Medi-Cal offices, participating health plans, enrollment brokers, and the Cal MediConnect Ombudsman, to conduct beneficiary outreach and education;

   e. Providing one-on-one counseling for the eligible service population in determining what forms of coverage best meet their individual health and LTSS needs. These choices could include:

      - Selecting a different Cal MediConnect plan;
      - Enrolling in a Medicare Managed Care plan and a Medi-Cal Managed Care plan;
      - Choosing fee-for-service Medicare with a Medi-Cal Managed Care plan; and
      - Enrolling in Program of All-Inclusive Care for the Elderly (PACE) if eligible.

   f. Assisting the eligible service population with enrollment and disenrollment assistance, including referrals to the state enrollment broker, when applicable.

   g. Referring beneficiaries, as appropriate, to other organizations, including Demonstration Ombudsman Programs and other service organizations.

ARTICLE II. SCOPE OF WORK (Continued)

8. Provide to CDA, prior to release of funds, a detailed FA-1718 Work Plan outlining projected goals, measurable outcomes, major objectives, key tasks, key staff and positions, and time frames (start and end dates). Work plans must also ensure coordination with the State's enrollment brokers and vendor(s), Work Plans shall include use of CCI Project appeals mechanisms including, but are not limited to referrals to the Cal MediConnect Ombudsman Program. The approved FA-1718 Work Plan is hereby incorporated by reference as part of this Exhibit. Updates to the approved Work Plan and documentation of progress towards reaching projected goals shall be included with Semi-Annual reports, as specified by CDA in Exhibit E. Article II of this contract.

9. Ensure adequate staffing to cover all contract requirements and timelines.

10. Prepare and submit the FA-1718 Budget to the CDA Fiscal Team for approval, prior to release of funds. The approved Budget is hereby incorporated by reference as part of this Agreement.

11. Prepare and submit Semi-Annual and Final FA-1718 narrative reports as specified by CDA in Exhibit E, Article II of this contract.

12. Prepare and submit the FA-1718 Budget Narrative as instructed by CDA.

13. Monitor, on an ongoing basis, all use of contract funds through reporting, regular contact, or other means to provide reasonable assurance that the contract funds are administered in compliance with laws, regulations, and the provisions of the contract and that performance goals are achieved [2 CFR Part 200.331]. Conduct annual program and fiscal monitoring. Provide support and technical assistance to subcontractors and respond in writing to all subcontractors' written requests for direction and guidance.

14. As notified by CDA, the Contractor and Sub-Contractors shall cooperate in any site visits conducted by CMS or its designee(s), in technical assistance provided by ACL, and with CMS contractors supporting the implementation of the demonstration, including the independent evaluator, actuarial rate setting services contractor, and operations support contractor.

15. Ensure that all responsible persons have access to up-to-date materials, standards, policies, and procedures relevant to Cal MediConnect.

16. Ensure all applicable provisions required within this Agreement are included in any subcontract entered into by the Contractor pursuant to this Agreement.

ARTICLE II. SCOPE OF WORK (Continued)

17. Review, approve, and monitor on an ongoing basis subcontractor budgets and expenditures and any subsequent amendments and revisions to budgets.

18. Ensure, to the extent feasible, that all budgeted funds are expended by the end of each fiscal year.

19. Provide training, support and technical assistance to the Subcontractor as needed and respond in writing to all written requests from subcontractors for guidance, and interpretation of instructions.

20. Monitor, evaluate and document subcontractor performance and compliance with this Agreement.

21. Provide timely notice to CDA of any changes to the program or changes in the status of the Contractor that could restrict the operations of, or access to, FA services. Require the Subcontractor to provide timely notice to the Contractor of any changes to the program or changes in the status of the Subcontractor that could restrict operation of, or access to, FA services. These changes include, but are not limited to: personnel changes, phone number changes, headquarters office address changes, and mailing address changes. If subcontracted, the Contractor will forward the updated information to the CDA HICAP team.

22. Collect, verify, approve, and report all required monthly data to CDA using the State HICAP Automated Reporting System (SHARP), as specified in Exhibit E, Article II of this Agreement.

23. CDA has established Financial Alignment performance measures to be used in assessing progress for meeting target penetration counts for the eligible service population. The Contractor and Subcontractor shall use the progress towards the Financial Alignment performance measures to evaluate efforts to reach the eligible service population, and for reference in completing Semi-Annual, Final, and Ad hoc reports as specified in Exhibit E, Article II of this Agreement.

24. Submit Semi-Annual and Final report data to CDA as specified in Exhibit E, Article II of this Agreement.

25. Ensure the submission of program information and support documentation, to CDA, for the development of the applications for continued funding.

ARTICLE II. SCOPE OF WORK (Continued)

C. Other Provisions and Assumptions

1. The Contractor shall:

a. Ensure that Project staff and volunteers neither engage in the solicitation of insurance nor endorse the services of any insurer or managed care plan, claims processing organization, or other enterprise that could benefit from activities conducted during this Project. All Project staff and volunteers shall provide FA educational services in a manner that is objective and impartial and shall provide counseling consistent with the best interests of the clients and which preserves the independent decision-making responsibilities of the client.

b. Ensure that the Project, Project staff, and Project volunteers shall not have a conflict of interest such as, but not limited to, a business relationship with insurers, health plans, or organizations posing a conflict of interest. The Contractor shall assure that Project staff and volunteers do not accept money or gifts from any client in exchange for services in accordance with Department guidance on conflict of interest and the HICAP Program Manual.

c. Take all reasonable and necessary measures to ensure that advisors, employees, and volunteers associated with the operation of the Project agree to act in a manner that prevents the appearance of impropriety or any other act which would place in jeopardy HICAP's reputation as an independent and impartial program. The Contractor shall ensure that advisors and governing board members shall be recused from the affairs of the Project in cases of existing employment or compensation from the health insurance or managed health care industries.