ARTICLE I. PROGRAM DEFINITIONS

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

B. **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.

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

D. **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.

E. **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.

F. **Enhanced Outreach** means outreach activities above and beyond routine activities planned in response to other funding (e.g., FA-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.

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

H. **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.

I. **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]

ARTICLE I. PROGRAM DEFINITIONS (Continued)

J. **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.

K. **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.

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

M. **Options 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.

N. **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

O. **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.

P. **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).

ARTICLE I. PROGRAM DEFINITIONS (Continued)

Q. **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 FA-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 all funds by April 30, 2018.

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.

2. Ensure that the Eligible Service Population, as defined in Exhibit A, Article I, E, is provided with enhanced outreach activities, materials, and options counseling regarding Cal MediConnect and alternatives. Outreach materials and counseling activities should be health literate, culturally/linguistically appropriate, and specific to the needs of the Eligible Service Population regarding Cal MediConnect benefits and options.

ARTICLE II. SCOPE OF WORK (Continued)

3. Ensure that individuals in the Eligible Service Population have access to information and counseling to empower them to make informed decisions about Medicare and Medi-Cal benefit options. This information and counseling shall be unbiased, timely, accurate, and consumer-friendly. 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.

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

5. Ensure that the services provided are separate, distinct, above and beyond those performed under the FA-1718 Contract. These services may include, but are not limited to:

    a. Increase training of Cal MediConnect HICAP staff to perform additional Cal MediConnect counseling, outreach, and community education, as necessary to assure that program capability is adequate to meet the needs of the Eligible Service Population;

    b. providing outreach and community education services to Cal MediConnect-eligible beneficiaries and sub-populations that may not have been reached with the funding from the FA-1316 Contract and FA-1516 Contracts;

    c. providing outreach and/or education to providers, including physician groups, board and care providers, and non-profit agencies who were not reached with the funding from the first contract to:
        - address problems related to provider non-participation in the Project; and
        - assist beneficiaries who have continuity of care issues that could result in beneficiaries opting-out of the Project;

    d. providing options counseling to beneficiaries eligible for Cal MediConnect who were not reached with the funding from FA-1316 Contract and FA-1516 Contracts;

ARTICLE II. SCOPE OF WORK (Continued)

e. providing counseling to beneficiaries who opted-out of Cal MediConnect regarding other coverage options available under Medicare and Medi-Cal;

f. providing options counseling to beneficiaries who were passively enrolled in a Cal MediConnect plan and are experiencing problems with Plan. These problems may include, but are not limited to, continuity of care concerns; balance-billing problems; and provider, formulary or other plan-related issues. Beneficiaries will be provided information on options regarding other health plan choices. 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;
   - enrolling in Program of All-Inclusive Care for the Elderly (PACE) if eligible;

g. expanding existing partnerships and developing new community partnerships.

6. Provide to CDA, prior to release of funds, a detailed F2-1718 Work Plan outlining performance goals, measurable outcomes, major objectives, key tasks, and time frames (start and end dates). Work plans must also ensure coordination with the State's enrollment brokers and vendor(s), Work Plan shall include use of CCI Project appeals mechanisms including, but are not limited to referrals to the Cal MediConnect Ombudsman Program. The approved F2-1718 Work Plan is hereby incorporated by reference as part of this Agreement.

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

8. Develop and implement a customer satisfaction process that ensures program quality prior to submitting the first year-end report. Report results to CDA in mid-term, year-end and final narrative reports, as specified in Exhibit E, Article II of this agreement, with a corrective action plan, if necessary, and assure that the related corrective action plan is implemented.

9. Prepare and submit the F2-1718 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.

ARTICLE II. SCOPE OF WORK (Continued)

10. Prepare and submit mid-term, annual and final F2-1718 narrative reports as specified by CDA in Exhibit E, Article II of this contract.

11. Prepare and submit the F2-1718 Budget Narrative as instructed by CDA.

12. 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.

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

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

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

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

17. 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.

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

19. 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.

ARTICLE II. SCOPE OF WORK (Continued)

20. 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.

21. Submit mid-term, year-end, and final report data to CDA as specified in Exhibit E, Article II of this Agreement.

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.