PROVIDER NETWORK

1. Network Capacity

Contractor shall maintain a provider network adequate to serve sixty percent (60%) of all Eligible Beneficiaries in the proposed county and provide the full scope of benefits. Contractor will increase the capacity of the network as necessary to accommodate enrollment growth beyond the sixty percent (60%). However, after the first twelve months of operation, if Enrollments do not achieve seventy-five (75%) of the required network capacity, the Contractor's total network capacity requirement may be renegotiated.

2. Network Composition

Contractor shall maintain an adequate number of inpatient Facilities, Service Sites, professional, allied, specialist and supportive paramedical personnel within their network to provide Covered Services to its Members.

3. Provider to Member Ratios

A. Contractor shall ensure that networks continuously satisfy the following full-time equivalent provider to Member ratios:

1.	Primary Care Physicians	1:2,000
2.	Total Physicians	1:1,200

B. If Non-Physician Medical Practitioners are included in Contractor's provider network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/patient caseload of one provider per 1,000 patients.

4. Physician Supervisor to Non-Physician Medical Practitioner Ratios

Contractor shall ensure compliance with Title 22, CCR, Section 51241, and that full-time equivalent Physician Supervisor to Non-Physician Medical Practitioner ratios do not exceed the following:

A.	Nurse Practitioners	1:4
B.	Physician Assistants	1:2

C. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three nurse midwives or two Physician assistants.

5. Emergency Services

Contractor shall have as a minimum a designated emergency service facility, providing care on a 24-hour-a-day, 7-day-a-week basis. This designated emergency service facility will have one or more Physicians and one Nurse on duty in the facility at all times.

6. Specialists

Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22, CCR, Section 53853(a).

7. Federally Qualified Health Center (FQHC) Services

Contractor shall meet federal requirements for access to FQHC services, including those in 42 United States Code Section 1396 b(m) and Medicaid Regional Memorandum 93-13. Contractor shall reimburse FQHCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 6. If FQHC services are not available in the provider network of either the Local Initiative (LI) Health Plan in the county or Contractor, Contractor shall reimburse FQHCs for services provided out-of-plan to Contractor's Members at the FQHC rate determined by DHS. If FQHC services are not available in Contractor's provider network, but are available within DHS' time and distance standards for access to Primary Care for Contractor's Members in the LI Health Plan's provider network in the county, Contractor shall not be obligated to reimburse FQHCs for services provided out-of-plan to Members (unless authorized by Contractor).

8. Time and Distance Standard

Contractor shall maintain a network of Primary Care Physicians which are located within thirty (30) minutes or ten (10) miles of a Member's residence unless the Contractor has a DHS approved alternative time and distance standard.

9. Plan Physician Availability

Contractor shall have a plan Physician available 24 hours per day, seven days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize medically necessary post-stabilization services, and for general communication with emergency room personnel.

10. Provider Network Report

Contractor shall submit to DHS on a quarterly basis, in a format specified by DHS, a report summarizing changes in the provider network. The report shall identify provider deletions and additions and the resulting impact to: 1) geographic access for the Members; 2) cultural and linguistic services including provider and provider staff language capability; 3) the targeted percentage of Traditional and Safety-Net providers; and 4) the number of Members assigned to each Primary Care Physician and the percentage of Members assigned to Traditional and Safety-Net providers. Contractor shall submit the report thirty (30) days following the end of the reporting quarter.

11. Plan Subcontractors

Contractor shall submit to DHS, a quarterly report containing the names of all direct subcontracting provider groups including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their subcontracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. The report must be sorted by sub-subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect subcontractors. The

report shall be submitted within 30 days following the end of the reporting quarter.

12. Ethnic and Cultural Composition

Contractor shall ensure that the composition of Contractor's provider network meets the ethnic, cultural, and linguistic needs of Contractor's Members on a continuous basis. Contractor shall ensure that any contract terminations do not adversely impact the ethnic composition of the provider network.

13. Subcontracts

Contractor may enter into Subcontracts with other entities in order to fulfill the obligations of the Contract. In doing so, Contractor shall meet the subcontracting requirements as stated in Title 22, CCR, Section 53867 and this Contract.

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, CCR, Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22, CCR, Section 53800 et seq.; and applicable federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract shall contain:

1) Specification of the services to be provided by the subcontractor.

2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract.

3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in subparagraph C. Departmental Approval – Non-Federally Qualified HMOs, or subparagraph D. Departmental Approval – Federally Qualified HMOs.

4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.

5) Language comparable to Exhibit A, Attachment 8, Provision 13 for those subcontractor’s at risk for non-contracting emergency services.

6) Subcontractor’s agreement to submit reports as required by Contractor.

7) Subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination or copying:

a. By DHS, Department of Health and Human Services (DHHS), Department of Justice (DOJ), and Department of Managed Health Care (DMHC).

b. At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

c. In a form maintained in accordance with the general standards applicable to such book or record keeping.

d. For a term of at least five years from the close of DHS' fiscal year for the last year in which the Subcontract was in effect.

e. Including all Encounter data for a period of at least five years.

8) Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from the Contractor.

9) Subcontractor's agreement to maintain and make available to DHS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-subcontractor:

a. Make all applicable books and records available at all reasonable times for inspection, examination, or copying by DHS, DHHS, DOJ and DMHC.

b. Retain such books and records for a term of at least five years from the close of DHS' fiscal year for the last year in which the sub-subcontract is in effect.

10) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, provision 15. B. Phase out Requirements, in the event of Contract termination.

11) Subcontractor’s agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.

12) Subcontractor's agreement to notify DHS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

13) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHS.

14) Subcontractor's agreement to hold harmless both the State and Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.

15) Subcontractor’s agreement to timely gather, preserve and provide to DHS, any records in the subcontractor’s possession, in accordance with

Exhibit E, Attachment 2, provision 25, Records Related to Recovery for Litigation.

16) Subcontractor's agreement to provide interpreter services for Members at all provider sites.

17) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.

18) Subcontractor's agreement to participate and cooperate in the Contractor's Quality Improvement System.

19) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, provision 6 Delegation of Quality Improvement Activities.

20) Subcontractor's agreement to comply with all applicable requirements of the DHS, Medi-Cal Managed Care Program.

C. Departmental Approval - Non-Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, provision 6 regarding Federally Qualified Health Centers and Rural Health Clinics, a provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHS in writing, or by operation of law where DHS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within sixty (60) days of receipt. Within five (5) State working days of receipt, DHS shall acknowledge in writing the receipt of any material sent to DHS by Contractor for approval.

Subcontract amendments shall be submitted to DHS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved or disapproved by DHS, shall become effective by operation of law thirty (30) days after DHS has acknowledged receipt or upon the date specified in the Subcontract amendment, whichever is later.

D. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, provision 6, Provider Compensation Arrangements, regarding Federally Qualified Health Centers and Rural Health Clinics, Subcontracts entered into by Contractor which is a federally qualified HMO shall be:

1) Exempt from prior approval by DHS.

2) Submitted to DHS upon request.

E. Public Records

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with DHS, except as

specifically exempted in statute. The names of the officers and owners of the subcontractor, stockholders owning more than ten (10) percent of the stock issued by the subcontractor and major creditors holding more than five (5) percent of the debt of the subcontractor will be attached to the Subcontract at the time the Subcontract is presented to DHS.

14. Subcontracts with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, provision 6. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

15. Traditional and Safety-Net Providers Participation

Contractor shall establish participation standards pursuant to Title 22, CCR, Section 53800(b)(2)(C)(2) to ensure participation and broad representation of Traditional and Safety-Net Providers within a Service Area. Contractor shall maintain the percentage of Traditional and Safety-Net Provider within a Service Area submitted and approved by DHS. Federally Qualified Health Centers meet the definitions of both Traditional and Safety-Net providers.