

Solicitation 10-87242

Recovery Audit Contractor

State of California

Bid 10-87242 Recovery Audit Contractor

Bid Number	10-87242
Bid Title	Recovery Audit Contractor
Bid Start Date	Oct 18, 2011 1:30:59 PM PDT
Bid End Date	Dec 22, 2011 4:00:00 PM PST
Question & Answer End Date	Oct 18, 2011 4:00:00 PM PDT
Bid Contact	Vince Tancreto AISA/Procurement Consultant / Webmaster
Pre-Bid Conference	Nov 18, 2011 10:00:00 AM PST Attendance is optional Location: Department of Health Care Services 1500 Capitol Avenue, First Floor Auditorium Sacramento, CA 95814
Standard Disclaimer	The State of California advises that prospective bidders periodically check the websites, including but not limited to Bidsync, and/or other state department links for modifications to bid documents. The State of California is not responsible for a prospective bidder's misunderstanding of the bid solicitation or nonresponsive bid due to failure to check these websites for updates or amendments to bid documents, and/or other information regarding the bid solicitations. Failure to periodically check these websites will be at the bidder's sole risk. The information published and/or responded to on these websites is public information. Confidential questions/issues/concerns should be directed to the contact on the ad.

Description

Audits & Investigations (A&I) has been charged with the administration and maintenance of the RAC Program. The mission of Audits and Investigations (A&I) is to ensure that fiscal integrity of the health programs administered by the Department of Health Care Services (DHCS) and ensure quality of care provided to the beneficiaries of these programs. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers. To carry out its mission A&I will:

- Perform special audits as needed by DHCS program managers, executive staff, Health and Human Services, or the Governor's Office.
- Perform internal audits of DHCS organizations to ensure that various internal controls are operating and effective.
- Perform medical reviews of Medi-Cal and public health providers.
- Provide technical assistance (financial and medical) in the development and expansion of the Managed Care program.
- Identify and investigate Medi-Cal beneficiary and provider fraud and abuse, emphasizing fraud prevention.
- Participate in the development or modification of DHCS policies.

* Please note that the Expected Expenditure amount is shown as \$1.00 as a required placeholder only. An actual amount cannot be indicated since this contract will be paid on a contingency basis.

This RFP release is an electronic release only, and may also be viewed and/or downloaded from the DHCS/OMCP website located at: http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPHomePage.aspx.

All questions should be submitted directly to DHCS/OMCP per the instructions in the RFP. Do NOT submit questions to the BidSync website.



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

October 18, 2011

Dear Interested Party,

Notice to Prospective Proposers

Prospective Proposers are invited to review and respond to the attached Request for Proposal (RFP) Number 10-97242 entitled, "Recovery Audit Contractor". When preparing and submitting a proposal, compliance with the instructions found herein is imperative.

Prospective Proposers can view and download the Recovery Audit Contractor RFP from the following Internet site:

http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPhcocpHome.aspx

If any prospective Proposer is unable to obtain the RFP via the Internet, please contact the Office of Medi-Cal Procurement (OMCP) at (916) 552-8006 or e-mail OMCP at omcprfp1@dhcs.ca.gov to request a CD-R version.

All agreements entered into with the State of California will include, by reference, General Terms and Conditions (GTC) and Contractor Certification Clauses (CCC) that may be viewed and downloaded at this Internet site: <http://www.ols.dgs.ca.gov/StandardLanguage/default.htm>. If any prospective proposer lacks Internet access, a hard copy can be obtained by contacting the person signing this letter.

If a discrepancy occurs between the information in the advertisement appearing in the California State Contracts Register and the information herein, the information in this notice and in the attached RFP shall take precedence.

I. Proposal Submission Deadline

Regardless of postmark or method of delivery, the Department of Health Care Services' Office of Medi-Cal Procurement (OMCP) must receive proposal packages no later than **4:00 p.m. on December 22, 2011**. Refer to the attached RFP for detailed submission requirements.

II. Voluntary Non-Binding Letter of Intent

In this procurement, prospective proposers are asked to voluntarily submit a non-binding Letter of Intent. See the attached RFP for detailed Letter of Intent submission instructions.

III. Proposer Questions

In the opinion of DHCS this Request for Proposal is complete and without need of explanation. However, if questions arise or there is a need to obtain clarifying information, put all inquiries in writing and mail, email or fax them to DHCS according to the instructions in the RFP section entitled, "Proposer Questions".

Thank you for your interest in our Department's service needs.

Sincerely,

Original Signed by *Kevin Morrill*

Kevin Morrill, Chief
Office of Medi-Cal Procurement
Attachment



Recovery Audit Contractor (RAC)

Request for Proposal 10-87242

Department of Health Care Services
Office of Medi-Cal Procurement
MS Code 4200
1501 Capitol Avenue, Suite 71.3041
P. O. Box 997413
Sacramento, CA 95899-7413

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Attachment 3	Business Information Sheet
Attachment 4	Client References
Attachment 5	RFP Clause Certification
Attachment 6	CCC 307 - Certification
Attachment 7	Payee Data Record

Attachment #	Attachment Name
Attachment 8	Follow-on Consultant Contract Disclosure
Attachment 9	Darfur Contracting Act Certification
Attachment 10	Voluntary Letter of Intent
Attachment 11	Request for Inclusion on Mailing List
Attachment 12	Proposer Response Guide
Attachment 13	Conflict of Interest

U. Sample Contract Forms / Exhibits

Exhibit #	Exhibit Name
Exhibit A1	Standard Agreement
Exhibit A	Scope of Work
Exhibit B	Payment Provisions
Exhibit C – View on-line.	General Terms and Conditions (GTC 610). View or download at this Internet site http://www.ols.dgs.ca.gov/Standard_Language/default.htm .
Exhibit D(F)	Special Terms and Conditions
Exhibit E	Additional Provisions
Exhibit F	HIPAA Business Associate Addendum Conflict of Interest Compliance Certificate
Exhibit G	HIPAA Business Associate Addendum Security Controls

V. Program Appendices

Appendix #	Appendix Name
Appendix 1	Hand Delivery Map

A. Purpose, Background and Description of Services

1. Purpose

The California Department of Health Care Services (DHCS) is soliciting proposals from firms that are able to review, detect and assist in collection of overpayment or underpayment of fee for services Medi-Cal payments. The Proposer must be able and willing to report fraudulent and/or criminal activities. Proposer must develop or assist in developing the implementation of actions that will prevent future improper payments.

Proposals must address all of the services described in Exhibit A entitled, "Scope of Work".

This contract includes the following tasks, which are defined in detail in subsequent sections of this contract:

- Identifying Medi-Cal claims that contain underpayments for which payment was made under Section 1902(a) of the Social Security Act.
- Identifying Medi-Cal claims that contain overpayments for which payment was made under Section 1902(a) of the Social Security Act.
- For any Recovery Auditor Contractor (RAC) identified overpayment that is appealed by the provider, the RAC shall provide support to DHCS throughout the administrative appeals process and, where applicable, a subsequent appeal to an appropriate court.
- The RAC will need to perform the necessary provider outreach to notify provider communities of the RAC's purpose and direction.

Note: The proactive education of providers about Medi-Cal coverage and coding rules is NOT a task under this RAC scope of work. DHCS has tasked ACS State Healthcare, LLC (ACS) with the task of proactively educating providers about how to avoid submitting a claim containing a request for an improper payment.

In meeting these contractual requirements, DHCS intends to make a single contract award to the most responsive and responsible firm earning the highest score. This procurement is open to all eligible firms and/or individuals that meet the qualification requirements, including commercial businesses, nonprofit organizations, State or public universities (including auxiliary organizations) and other entities.

2. Background

The Medi-Cal Program

Medi-Cal is the name of the Medicaid program in the State of California. It is jointly administered by the California State Department of Health Care Services (DHCS) and the Center for Medicare and Medicaid Services (CMS), operating as a Medical Assistance Program under Title XIX of the Social Security Act.

This public health insurance program provides needed health care services for low-income individuals including families with children, seniors, persons with disabilities, foster care, pregnant women and low income people with specific diseases such as tuberculosis, breast cancer or HIV/AIDS. Medi-Cal is financed equally by the State and federal government.

Department of Health Care Services

The Department of Health Care Services' (DHCS) mission is to preserve and improve the health status of all Californians. DHCS works closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income population.

DHCS finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children's Services program, Child Health and Disability Prevention program and Genetically Handicapped Persons Program. DHCS also helps maintain the financial viability of critical specialized care services, such as burn centers, trauma centers and children's specialty hospitals. In addition, DHCS funding helps hospitals and clinics located in underserved areas and those serving underserved populations.

Audits & Investigations

Audits & Investigations (A&I) has been charged with the administration and maintenance of the RAC Program.

The mission of Audits and Investigations (A&I) is to ensure that fiscal integrity of the health programs administered by the Department of Health Care Services (DHCS) and ensure quality of care provided to the beneficiaries of these programs. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers. To carry out its mission A&I will:

- Perform special audits as needed by DHCS program managers, executive staff, Health and Human Services, or the Governor's Office.
- Perform internal audits of DHCS organizations to ensure that various internal controls are operating and effective.
- Perform medical reviews of Medi-Cal and public health providers.
- Provide technical assistance (financial and medical) in the development and expansion of the Managed Care program.
- Identify and investigate Medi-Cal beneficiary and provider fraud and abuse, emphasizing fraud prevention.
- Participate in the development or modification of DHCS policies.

Statutory Requirements

Section 6411 (a) of the Affordable Care Act (ACA) amends and expands on section 1902 (a) (42) of the Social Security Act (the Act). It will now require States to contract with one or more RACs for the purpose of auditing Medicaid claims and identifying underpayments and overpayments and recouping overpayments.

Office of Medi-Cal Procurement

Assisting A&I in the Request for Proposal (RFP) and evaluation process is the Office of Medi-Cal Procurement (OMCP). OMCP will be the point of contact for all Proposers during the procurement or evaluation period. Please direct all questions to OMCP unless specifically direct to do otherwise either by OMCP or the RFP instructions.

B. Proposer Notice for Document Delivery

This notice is in reference to, but not limited to, the submission of the following: Proposer Questions; Requests for Inclusion on the Mailing List; Letters of Intent; and Completed Proposals.

When submitting documents to DHCS, please consider the following:

1. DHCS' internal processing of U.S. Mail may add forty-eight (48) hours or more to the delivery time. If packages are mailed, consider using certified or registered mail and request a receipt upon delivery.
2. All hand deliveries must have a preset appointment by contacting OMCP at (916) 552-8006. **Deliveries will not be accepted without an appointment.** For hand deliveries, allow sufficient time to locate on street metered parking and to sign-in at the security desk. If detained at the security desk, ask security personnel to call OMCP at (916) 552-8006 to arrange for pickup and receipt issuance. Proposers are warned not to surrender any deliverables in the care of any person other than an OMCP staff member.
3. Courier service personnel must sign-in at the security station and must obtain an access key card. Couriers will then be able to access pre-determined areas. If detained at the security desk, ask security personnel to call OMCP at (916) 552-8006 to collect the package and to issue a receipt.
4. When faxing documents, please confirm delivery by calling OMCP at (916) 552-8006.

Proposals must be delivered via U.S. Mail or hand delivery to the address shown below. Proposals may not be faxed or e-mailed. All other submissions may be mailed, hand delivered, faxed or e-mailed, using the addresses shown below:

U.S. Mail, Hand Delivery or Overnight Express:	Fax:
Questions - RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Nathan Greve or Subran Singh 1501 Capitol Ave. Suite 71.3041 MS 4200 P.O. Box 997413 Sacramento, CA 95899-7413	Questions - RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Nathan Greve or Subran Singh Fax: (916) 440-7369
Email: omcprfp1@dhcs.ca.gov	

C. Time Schedule

Below is the tentative time schedule for this procurement.

Event	Date	Time (If applicable)
RFP Released	October 18, 2011	
Questions Due	November 18, 2011	5:00 p.m.
Request to be included on Mailing List	November 18, 2011	5:00 p.m.
Voluntary Pre-Proposal Conference	November 18, 2011	10:00 a.m.
Voluntary Non-Binding Letter of Intent	November 18, 2011	5:00 p.m.
Proposal Due Date	December 22, 2011	4:00 p.m.
Notice of Intent to Award Posted	February 1, 2012	
Protest Deadline	February 9, 2012	5:00 p.m.
Contract Award Date	February 10, 2012	
Proposed Start Date of Agreement	March 1, 2012 or until approved by DGS whichever is later	

D. Contract Term

The term of the resulting agreement is expected to be twenty-four (24) months from the contract award date with potentially three one (1) one-year extensions exercised at the sole discretion of DHCS. The agreement term may change if DHCS makes an award earlier than expected or if DHCS cannot execute the agreement in a timely manner due to unforeseen delays. DHCS reserves the right to extend the term of the resulting agreement via an amendment as necessary to complete or continue the services. Contract extensions are subject to satisfactory performance, funding availability, and possibly approval by the Department of General Services.

The resulting contract will be of no force or effect until it is signed by both parties and approved by the Department of General Services, if required. The Contractor is hereby advised not to commence performance until all approvals have been obtained and the Contractor is advised by DHCS to begin work. If performance commences before all approvals are obtained, said services may be considered to have been volunteered until all approvals are obtained.

E. Proposer Questions

Immediately notify DHCS if clarification is needed regarding the services sought or questions arise about the RFP and/or its accompanying materials, instructions, or requirements. Put the inquiry in writing and transmit it to DHCS as instructed below. At its discretion, DHCS reserves the right to contact an inquirer to seek clarification of any inquiry received.

Proposers that fail to report a known or suspected problem with the RFP and/or its accompanying materials or fail to seek clarification and/or correction of the RFP and/or its accompanying materials shall submit a proposal at their own risk. In addition, if awarded the contract, the successful Proposer shall not be entitled to additional compensation for any additional work caused by such problem, including any ambiguity, conflict, discrepancy, omission, or error.

1. What to include in an inquiry

- a. Inquirer's name, name of firm submitting the inquiry, mailing address, email address, area code and telephone number, and fax number.
- b. A description of the subject or issue in question or discrepancy found.
- c. RFP section, page number or other information useful in identifying the specific problem or issue in question.
- d. Remedy sought, if any.

A prospective proposer that desires clarification about specific RFP requirements and/or whose inquiry relates to sensitive issues or proprietary aspects of a proposal may submit individual inquiries that are marked "Confidential". The Inquirer must include with its inquiry an explanation as to why it believes questions marked "Confidential" are sensitive or surround a proprietary issue.

2. Question deadline

Proposers are encouraged to submit written inquiries about this RFP to DHCS no later than two (2) working days before the Pre-Proposal Conference date so answers can be prepared in advance. Notwithstanding the initial question submission deadline, DHCS will accept written or faxed inquiries received by **4:00 p.m. on the date of Pre-Proposal Conference**. At its discretion, DHCS may contact an inquirer to seek clarification of any inquiry received.

Notwithstanding the initial question submission deadline, DHCS will accept questions or inquiries about RFP errors or irregularities if such inquiries are received prior to the proposal submission deadline.

Verbal Questions

Verbal inquiries are discouraged. DHCS reserves the right not to accept or respond to verbal inquiries. **Spontaneous verbal remarks provided in response to verbal inquiries are unofficial and are not binding on DHCS unless later confirmed in writing.**

Direct all verbal requests for DVBE assistance to DHCS' DVBE Coordinator at (916) 650-0205 up to the proposal deadline.

F. Data Library

Data Library for the sole use of Proposers will be available on the release date of this RFP. The entire contents of the Data Library will be accessible in an electronic format for the duration of this procurement and longer if deemed necessary by DHCS. Data Library materials will not be

supplied in hard copy, unless doing so is necessary to meet a reasonable accommodation request. Additional methods for accessing the contents of the Data Library are discussed below. The Data library may be accessed at

http://www.dhcs.ca.gov/ProvGovPart/rfa_rfp/Pages/OMCPHomePage.aspx

1. Electronic Data Library Contents

The Data Library contains various documentation and information that Proposers will find or may find beneficial in the preparation of their proposal responses. Data Library materials may be periodically updated and additional documents may be added during this procurement. Interested parties that have requested access to the Data Library or copies of Data Library documents will be notified of the additions and/or changes by way of written notice.

2. Electronic Data Library Access

Proposers may view, download, or access Data Library documents:

- a. All or part of the Data Library documents may be downloaded from the links supplied on the OMCP's website:
http://www.dhcs.ca.gov/ProvGovPart/rfa_rfp/Pages/OMCPHomePage.aspx as of the RFP release date.

G. Voluntary Pre-Proposal Conference will be held.

A voluntary Pre-Proposal Conference will be held.

DHCS will conduct a voluntary Pre-Proposal Conference in Sacramento, California on November 8, 2011 beginning 10:00 am at the following location at 1500 Capitol Ave 1st Floor Auditorium.

Prospective proposers that intend to submit a proposal are encouraged to attend the voluntary Pre-Proposal Conference. It shall be each prospective proposer's responsibility to attend the Pre-Proposal Conference promptly at 10:00 am. DHCS reserves the right not to repeat information for participants that join the conference after it has begun. If a potential prime contractor is unable to attend the voluntary Pre-Proposal Conference, an authorized representative of its choice may attend on its behalf.

The voluntary Pre-Proposal Conference is a public event or meeting and anyone can attend.

The purpose of the conference is to:

1. Allow prospective Proposers to ask questions about the services sought or RFP requirements and/or instructions.
2. Share the answers to general questions and inquiries received before and during the conference.

Please note, spontaneous verbal remarks provided in response to questions/inquiries are unofficial and are not binding on DHCS unless later confirmed in writing.

Carefully review this RFP before the conference date to become familiar with the qualification requirements, scope of work and proposal content requirements. Conference attendees are encouraged to have their copy of this RFP available for viewing during the conference.

Refer to the RFP section entitled, "Proposer Questions" for instructions on how to submit written questions and inquiries before the conference date.

If DHCS is unable to respond to all inquiries received before and/or during the conference, DHCS will share written responses shortly thereafter. DHCS reserves the right to determine which inquiries will be answered during the conference and which will be answered later in writing.

After the conference, DHCS intends to summarize all general questions and issues raised before and during the conference and mail, email, or fax the summary and responses to all persons who received this RFP and to those who attended/participated in the conference. In lieu of mailing, emailing, or faxing a summary of questions/responses to all RFP recipients and conference attendees, DHCS may opt to post the summary of general questions and responses on the Internet at the Department of General Services' Contract Register Ad site where this RFP was posted.

In response to inquiries that appear to be unique to a single firm or that are marked "Confidential", DHCS will mail, email, or fax a response only to the inquirer if DHCS concurs with the inquirer's claim that the inquiry is sensitive or proprietary in nature. If DHCS does not concur, the inquiry will be answered in the manner described herein for general questions and the inquirer will be so notified. Inquiries and/or responses that DHCS agrees should be held in confidence shall be held in confidence only until the Notice of Intent to Award is posted.

To the extent practical, inquiries shall remain as submitted. However, DHCS may consolidate and/or paraphrase similar or related inquiries.

Conference attendees are responsible for their costs to attend/participate in the conference. Those costs cannot be charged to DHCS or included in any cost element of a Proposer's price offering.

H. Request for Inclusion on the RFP Mailing List

DHCS recognizes that not all parties are interested in continuing to receive updates concerning the RFP. In addition, the printing and mailing of updates such as Administrative Bulletins and Addenda to all interested parties on the mailing list is costly to DHCS. DHCS will continue to provide updates concerning the RFP only to prospective Proposers who have submitted a Request for Inclusion on Mailing List form, Attachment 11. Regardless of delivery method, the Request for Inclusion on Mailing List form is due by 4:00 p.m. on 11/18/2011, after which only those who have submitted Attachment 11 shall receive procurement updates.

Please note that OMCP will continue to accept the Request for Inclusion on Mailing List form up to the due date for proposals. Failure to provide a Request for Inclusion **does not** preclude a Proposer from submitting a proposal.

It is incumbent upon any Proposer who has not submitted a Request for Inclusion on the Mailing List form, but intends to bid on this contract, to monitor the OMCP website at omcprfp1@dhcs.ca.gov for any Administrative Bulletins, addenda, and/or other updates to the RFP.

A Proposer may also contact Nathan Greve or Subran Singh at OMCP at (916) 552-8006 to request any Administrative Bulletins, addenda, and/or other updates to the RFP.

I. Scope of Work

See Exhibit A entitled, "Scope of Work" that is included in the Sample Contract Forms and Exhibits section of this RFP. Exhibit A contains a detailed description of the services and work to be performed as a result of this procurement.

J. Qualification Requirements

Failure to meet the following requirements by the proposal submission deadline will be grounds for DHCS to deem a proposer nonresponsive. Evaluators may choose not to thoroughly review or score proposals that fail to meet these requirements. In submitting a proposal, each proposer must certify and prove that it possesses the following qualification requirements.

1. Experience requirements

At least three consecutive years of experience of the type(s) listed below. All experience must have occurred within the past ten years. It is possible to attain the experience types listed below during the same time period. Proposers must have experience:

- a) Prior experience in the health care industry, utilization review firm or health care claims processing organization. This experience should include coding error detection and established processes for corrective action.
- b) Knowledge of the Medi-Cal program especially in coverage and payment rules.
- c) Experience in working with physician groups or beneficiary organizations.

2. Compliance with Contract Terms and Conditions

Proposers must certify they have read and are willing to comply with all proposed terms and conditions addressed in the RFP section entitled, "Contract Terms and Conditions", including the terms appearing in the referenced contract exhibits.

3. **[Corporations]** Corporations must certify they are in good standing and qualified to conduct business in California.

4. **[Nonprofit Organizations]** Non-profit organizations must certify their eligibility to claim nonprofit status.

5. Past Business Practice

Proposers must have a past record of sound business integrity and a history of being responsive to past contractual obligations.

6. Financial Stability

Proposers must certify they are financially stable and solvent and have adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State.

7. Follow-on Consultant Contract Disclosure

Proposers must certify their proposal response is not in violation of Public Contract Code (PCC) Section 10365.5 and, if applicable, must identify previous consultant services contracts that are related in any manner to the services, goods, or supplies being acquired in this solicitation. Detailed requirements are outlined in **Attachment 8**.

PCC Section 10365.5 generally prohibits a person, firm, or subsidiary thereof that has been awarded a consulting services contract from submitting a bid for and/or being awarded an agreement for, the provision of services, procurement of goods or supplies, or any other related action that is required, suggested, or otherwise deemed appropriate in the end product of a consulting services contract.

PCC Section 10365.5 does not apply to any person, firm, or subsidiary thereof that is awarded a subcontract of a consulting services agreement that totals no more than 10 percent of the total monetary value of the consulting services agreement. Consultants and employees of a firm that provides consulting advice under an original consulting contract are not prohibited from providing services as employees of another firm on a follow-on contract, unless the persons are named contracting parties or named parties in a subcontract of the original contract.

PCC Section 10365.5 does not distinguish between intentional, negligent, and/or inadvertent violations. A violation could result in disqualification from bidding, a void contract, and/or imposition of criminal penalties.

8. Darfur Contracting Act Certification

Proposers that currently have or within three years prior to the bid submission date have had business activities or other operations outside of the United States must certify that the bidding entity is either (A) not a scrutinized company; or (B) a scrutinized company that has been granted permission by the Department of General Services to submit a proposal in response to this solicitation. A "scrutinized" company is defined in Public Contract Code Section 10476. Detailed certification requirements appear in **Attachment 9**.

If the Proposer does not currently have and has not, within three years prior to the bid submission date, had any business activities or other operations outside of the United States, there is no need to complete or submit Attachment 9.

9. Liability Insurance Requirement

The winning Proposer must supply, before contract execution, proof of liability insurance that meets the requirements of Exhibit E, 14.

10. Conflict of Interest Certification

- a) Any firm that intends to submit a proposal is required to submit **Attachment 13** certifying:
 - i. Whether the proposing firm is currently involved with or connected to any Contractor or subcontractor (including consultant) that is contracted with any Medi-Cal Managed care health plan, provider, or billing agent for Medi-Cal services; and,
 - ii. That the proposing firm is not currently involved with or connected to the current or proposed Fiscal Intermediary for Medi-Cal services, or any of their subcontractors; and,
 - iii. That the proposing firm understands that the conflict of interest requirements shall remain in effect for the entire term of the resulting agreement.

- b) If a conflict of interest is exist or appears to exist, the proposer must submit a plan to mitigate the conflict to which DHCS has sole discretion to accept or reject.
- c) If a conflict of interest is determined to exist that cannot be resolved to the satisfaction of DHCS, before the award of the contract, the conflict will be grounds for deeming a proposal nonresponsive.
- d) Proposers must assess their own situation according to the Conflict of Interest Compliance Certification information in Attachment 13 complete, sign, and attach any required documentation according to the instructions on the attachment. **Place Attachment 13 and any accompanying documentation in the Appendix Section of the proposal.**

11. Proposer Response Guide

To insure that each proposal is evaluated on the full merits of the information provided, please complete the Proposer Response Guide, as provided. (Attachment 12 and accompanying instructions)

K. Proposal Format and Content Requirements

1. General instructions

- a. Each firm or individual may submit only one proposal consisting of a technical proposal with narrative content and a cost proposal section.

For the purposes of this paragraph, “firm” includes a parent corporation of a firm and any other subsidiary of that parent corporation. If a firm or individual submits more than one proposal, DHCS will reject all proposals submitted by that firm or individual.

A firm or individual proposing to act as a prime contractor may be named as a subcontractor in another Proposer’s proposal. Similarly, more than one proposer may use the same subcontractors and/or independent consultants.

- b. Develop proposals by following all RFP instructions and/or clarifications issued by DHCS in the form of question and answer notices, clarification notices, Administrative Bulletins or RFP addenda.
- c. Before submitting a proposal, seek timely written clarification of any requirements or instructions that are believed to be vague, unclear or that are not fully understood.
- d. In preparing a proposal response, all narrative portions should be straightforward, detailed and precise. DHCS will determine the responsiveness of a proposal by its quality, not its volume, packaging or colored displays.
- e. Arrange for the timely delivery of the proposal package(s) to the address specified in this RFP. Do not delay until shortly before the deadline to submit the proposal.

2. Format requirements

- a. Submit one (1) original proposal, five (5) copies or sets, and one accompanying CD.
 - 1) Write “**Original**” on the original proposal set. Place the accompanying CD in a protective sleeve that bears the RFP number.

- 2) The CD-ROM must be identical to and contain copies of everything included in the proposal hard copy. The original hard copy submission remains the official submission.
- b. Format the narrative portion of the Technical proposal as follows:
 - 1) Use one-inch margins at the top, bottom, and both sides.
 - 2) Use a font size of not less than 11 points.
 - 3) Print pages single-sided on white bond paper.
 - 4) Sequentially paginate the pages in each section. It is not necessary to paginate items in the Forms Section or Appendix Section.
 - c. Bind each proposal set in a way that enables easy page removal. Loose leaf or three-ring binders are acceptable.
 - d. All RFP attachments that require a signature must be signed in ink, preferably in a color other than black. Signatures may be omitted from the accompanying CD.
 - 1) Have a person who is authorized to bind the proposing firm sign each RFP attachment that requires a signature. Signature stamps are not acceptable.
 - 2) Place the originally signed attachments in the proposal set marked "Original".
 - 3) The RFP attachments and other documentation placed in the extra proposal sets may reflect photocopied signatures.
 - e. Do not mark any portion of the proposal response, any RFP attachment, or other item of required documentation as "Confidential" or "Proprietary". DHCS will disregard any language purporting to render all or portions of a proposal confidential.

3. Content requirements

This section specifies the order and content of each proposal. Assemble the materials in each proposal set in the following order:

- a. Proposal Cover Page

A person authorized to bind the Proposer must sign the Proposal Cover Page (**Attachment 1**). If the proposer is a corporation, a person authorized by the Board of Directors to sign on behalf of the Board must sign the Proposal Cover Page.

- b. Table of Contents

Properly identify each section and the contents therein. Paginate all items in each section with the exception of those items placed in the Forms Section and Appendix Section.

c. Executive Summary Section

This section must not exceed ten (10) pages in length. Evaluators may not review or evaluate excess pages.

In preparing the Executive Summary, do not simply restate or paraphrase information in this RFP. Describe or demonstrate, in the Proposer's own words, the following information.

- 1) An understanding of DHCS' needs and the importance of this project.
- 2) The tangible results that are expected to be achieved.
- 3) A sincere commitment to perform the Scope of Work in an efficient and timely manner.
- 4) How this project will be effectively integrated into the proposing firm's current obligations and existing workload.
- 5) Why the proposing firm should be chosen to undertake this work at this time.

d. Proposing Firm's Capability Section

- 1) Include a brief history of the proposing firm, including:
 - a) A discussion of the organizational structure of the Proposer and how that structure supports the goals and requirements of this RFP. Also include a history of the organization, the Parent Corporation and /or subsidiaries and partnership arrangements detailing any assistance those entities are expected to provide in meeting the requirements of this RFP.
 - b) Date of establishment. If applicable, explain any changes in business history (i.e., name change, ownership, partnership arrangements, etc.) or organizational structure that will assist DHCS in determining the qualifications of the proposing firm.
 - c) A description of the proposing firm's business activities that are relevant or closely related with purpose of this contract.
 - d) Indicate any relevant past experience with Medicaid, Medicare, and/or other health organizations in providing audit, billing error detection or discovery of billing issues.
- 2) Please provide (if any) a description of your firm's prior experience with a public or governmental agency in which the Proposer has been directly engaged in the activities required by the Scope Of Work (SOW) including the identification under or over payment of medical billings.
- 3) Please provide (if any) a description of your firms prior experience with a public or governmental agency that the Contractor has been directly engaged in a Scope Of Work (SOW) including the development and implementation of corrective actions or training of billing parties to control billing errors.

- 4) Please provide (if any) a discussion of any services that are similar to, or relevant to, the services requested in this RFP not previously discussed.
- 5) Please provide a detailed discussion of any previous relationships with governmental programs in which an audit or audit type scope of work existed as part of the services provided in the last ten (10) years.
- 6) Please provide an in-depth discussion of how your prior experience qualifies your firm to undertake this project.
- 7) Please describe (if any) your firm's current billing review operations. Please include in the discussion of the operational size, staffing levels, expertise and any other relevant information.
- 8) Describe in detail the staffing levels and total staff hours used in each of the historical projects identified. Where appropriate, identify and discuss the staff assigned to those historical projects that will be assigned to this project in either significant managerial roles or in significant subject matter expert roles.
- 9) Describe the controls and reporting methods used to report, manage or convey your findings to your clients at the appropriate level and time.
- 10) Briefly describe accounts or work projects begun and/or completed in the past ten (10) years that involved services similar in nature or closely related to the SOW in this RFP. For each account or project listed, include the following information:
 - a) Name of agency or firm for whom services were performed,
 - b) Identification of a contact person
 - c) Duration or length of the project,
 - d) Total of identified over or underpayments discovered.
 - e) Indicate if the account or project is "active/open",
 - f) If the SOW of this contract was not the primary function of the contract under discussion, what percentage of the contract can be attributed to error identification and/or over or under billing? Please include a percentage attributable to error identification or over or under billing and total dollar amount paid or earned on error identification or over or under billing.
 - g) Describe briefly the type and nature of any additional services performed under the contract. .
 - h) Specify if you were the prime contractor or subcontractor.
- 11) Briefly describe any experience that demonstrates the proposing firm's ability to establish and maintain effective working relationships with government entities, local community based organizations, providers or provider organizations.
- 12) Briefly describe any experience that demonstrates the proposing firm's ability to maintain effective working relationships with a fiscal intermediary contractor while providing services for the contracting entity.
- 13) Briefly describe the firm's recruiting capabilities and retention policies that demonstrates its ability to provide qualified staff for this contract
- 14) Identify three (3) client references specific to the Proposer's firm, serviced within the past ten (10) years that can confirm their satisfaction with the Proposer's services. Client references should be able to confirm that the Proposer provided timely and effective services and/or deliverables. Use the Client References Form

(Attachment 4) for this purpose and place the completed forms in the Forms Section of the Proposal.

- 15) While not required as a client reference, identify any client for any qualifying experience discussed in detail under RFP Main J. 3.d.2 above which is listed as a reference on Attachment 4.

DHCS **will** contact references to validate the information provided by the Proposer to determine the client's overall satisfaction with the services provided. Please be sure your points of contact for the selected references are current. Please be sure the references are prepared to confirm the information provided and that the reference will be available during the period of time that DHCS will be validating references (shortly following the submission of the final proposal). **References that fail to respond to the State will not be considered a reference and may result in determining a Proposer to be found non-responsive.**

e. Work Plan Section

1) Overview

- a) The contractor should describe in their own words their understanding of the project's objectives and DHCS' expectations of the work activities.
- b) DHCS is interested in proposals that provide well-organized, comprehensive, and technically sound business solutions. Vague explanations will undermine the proposing firm's credibility and will result in reduced proposal scores.
- c) The Work Plan must include an in-depth discussion and description of the methods, approaches, and step-by-step actions that will be carried out to fulfill all Scope of Work requirements.
- d) If Proposer is unable to specifically delineate or explain in-depth methods and procedures for a task or function (e.g., if specific methods or procedures are presently unknown due to dependence upon a future action or where multiple approaches may be used), explain the probable methods, approaches, or procedures that will be used to accomplish the task or function. Also, describe, in this instance, how the proposing firm will propose the ultimate strategies and detailed plans to DHCS for full consideration and approval before proceeding to carry out the project.

2) Rejection of Tasks, Activities or Functions

The Proposer may not reject any task, activity or function required by this proposal. Any language discovered during the evaluation by DHCS that states a task, activity or function is rejected may be grounds to deem a Proposer non-responsive, at DHCS' sole discretion. Upon execution of the contract the Proposer may not assert that any part, section or language of their proposal rejected a task, activity or function.

3) Work Plan content

- a) Please provide a synopsis explaining or describing the overall approach and/or methods that will be used to accomplish the scope of work.

- b) Explain why the particular approaches and methods that are proposed were chosen (e.g., proven success or past effectiveness, etc.).
- c) Please identify and describe the methodology your firm intends to employ in meeting the requirement of this project.
- d) If your firm believes the methodology is unique or superior to other known methodologies, please describe the why you believe these methodologies or approaches to be superior.
- e) If any major complications or delays are envisioned at any stage of performance, describe those complications or delays and include a proposed strategy for overcoming those issues. Likewise, indicate if no major complications or delays are anticipated.
- f) Please explain or describe the "Internal Guidelines" process or procedures to be used in reviewing claims for coverage and coding issues.
- g) When addressing the SOW as it relates to any Automated Reviews process identify the specific tasks/activities and functions that will be performed in the order they are likely to occur. Include an in-depth discussion of the steps and procedures needed to perform each task/activity or function in the work plan:
- h) Indicate who will have primary responsibility for performing each major task/activity or function. Identify the position and number of staff that will perform the work.
- i) Include a performance time line for each major task/activity or function.

If desirable, proposers may use other terms such as start-up, on-going, continuous, take-over, turn-over, etc. to describe the performance time line. In doing so, proposers must define the meaning of each unique term that is used.
- j) Explain/describe how the proposer intends to measure or prove successful completion of each major task, function, or activity.
- k) If applicable, identify the key events or outcomes that will signify completion or identify of potential Automated Reviews process.
- l) When addressing Complex Reviews identify the specific tasks/activities and functions that will be performed in the order they are likely to occur. Include the following in-depth information for each task/activity or function in the work plan:
 - i. Indicate who will conduct the field work for these Complex Reviews, including qualification, the experience and credentials required to conduct this work for your firm.
 - ii. Please provide a detail discussion of the step or process expected to be followed by the field auditor in conducting a Complex Review.
 - iii. Explain what procedures the field auditor will follow for obtaining additional opinions or expertise from your firm while in the field and/or after leaving the Provider's offices.

- iv. Include a discussion on methods, technics, staff training or other measures that will limit the disruption to Providers while conducting a Complex Review. At a minimum this should include a discussion of policies, training, work reviews and policies for dealing with Provider concerns.
 - m) Please explain or describe how your firm intends to monitor or audit the conduct of auditors in the field and the appropriateness of the work conducted.
 - n) Please describe the database how your firm intends use to track information on underpayments, overpayments, appeals, correspondents with providers, and any other information useful for DHCS during appeals and/or other audits. Please include sample report or other related documents or samples, if available.
- f. Management Plan Section
- 1) Describe how your firm will effectively coordinate, manage, and monitor the efforts of the assigned staff, including subcontractors and/or consultants, if any, to ensure that all tasks, activities, and functions are completed effectively and in a timely manner.
 - 2) Describe the accounting processes and controls that will be employed to ensure claims are forwarded to the Department in accurate and timely manner. Include at a minimum, a brief description of all of the following:
 - a) Describe in detail how your firm will track progress and statutes of limitations to ensure that payments or recovers are not lost to lapses in time.
 - b) How claims sent to DCHS as under or over payments will be tracked under this project. Include a discussion of the process for flagging pending statutes of limitations issues that may arise while claims are in the possession of DHCS for processing.
 - c) Processes for tracking payments received and identifying any duplicate payment received in error.
 - d) The procedures for tracking and storing all documentation that will be retained as the case file for each claim submitted.
 - e) Detailed description of the processes to be used in purging investigational information or records for providers that did not result in any claims adjustment.
 - 3) Include an organization chart. The organization chart must show the distinct lines of authority between and among the divisions that will perform the project work and the primary reporting relationships within the Proposer's organization. Show the relationships between management, key decision makers, supervisory personnel and subcontractors and/or independent consultants, if any.
 - 4) If your organization is a subsidiary, please provide an organizational chart detailing your position in relationship to any upstream entities to your parent organization.
 - 5) Include financial statements, as required. Instructions are explained in the Appendix Section. **Place the financial statement in the Appendix Section of the proposal.**
 - 6) Please describe in detail Quality Assurance plan your firm with use to monitor the this contract as required by the SOW

g. Project Personnel Section

- 1) RAC contractor shall employ one FTE Medical Director on staff. The Medical Director shall be a board certified physician licensed to practice medicine in California and the United States, who has relevant utilization review work and educational experience. The RAC shall arrange for an alternate when the Medical Director is unavailable for extended periods. Multiply part time individual's time cannot be combined to meet the one (1) FTE minimum.

Relevant Work Experience

- a) Experience practicing medicine as a board certified doctor of medicine or doctor who is currently licensed.
 - b) Prior experience in the health care industry, utilization review firm or health care claims processing organization.
 - c) Knowledge of the Medi-Cal program especially in coverage and payment rules.
 - d) Experience in working with physician groups or beneficiary organizations.
- 2) Other Required Staff
 - a) Certified Coders
 - b) Registered Nurses
 - 3) For each of the positions above in J., 3., g., 2), please describe what other special or unique characteristic(s) each of the required positions is expected to possess, if any. Include in your discussion why those characteristics are important to this project.
 - 4) Other Suggested Staff
 - a) Auditors
 - b) Research Analysts
 - c) Statistician
 - 5) For any of the positions above in J. 3.g.4) your firm has identified as needed or to be provided as part of your workplan, please describe what other special or unique characteristic(s) each of those staff for that position(s) is expected to possess, if any. Include in your discussion why those characteristics are important to this project.
 - 6) Please describe your planned staffing level for this project. At minimum include a discussion on the number personnel for each identified position you intend to employee.
 - 7) Please describe the provisions within your workplan you have made to accommodate the difficulties arising from dealing with a state of the size or geographic girth of California.
 - 8) Please provide a narrative of the administrative policies or procedures will be used to ensure that the proposing firm will recruit and select well-qualified, competent, and experienced in-house staff, subcontractors and/or independent consultants.
 - 9) Please describe your employee recruitment/selection policies or procedures and how those policies or procedures apply to this contract.

- 10) Please state whether incentive payments in the form of increased salaries, bonuses payments or other forms of remuneration shall be paid to Certified Coders, Registered Nurses, Auditors or other review members based on the dollars identified as in error and/or recovered from Providers.

If such an incentive program is used, describe how your firm shall monitor your staff to insure that such payments do not bias the findings or judgment of the staff.

If your firm offers no such incentive plan describe how your firm shall monitor your staff to insure that an inappropriate bias to assessment culture does not develop within the reviewing staff.

- 11) Briefly, describe the processes or procedures that will be used to ensure that vacancies are filled expeditiously and that services are continued despite the presence of vacancies.
- 12) It is preferred that a résumé not exceed 4 pages in length. **Place all résumés in the Appendix Section of your proposal.** To the extent possible, résumés should not include personal information such as a social security number, home address, home telephone number, marital status, sex, birth date, age, etc.
- 13) If subcontractors (including independent consultants) will be used to perform contract services, proposers must do the following at the time of proposal submission:
- a) Indicate if the Proposer has pre-identified any firms/persons to perform the work or if the Proposer will recruit them later.
 - i. For each pre-identified subcontractor and independent consultant include:
 - A. Full legal name.
 - B. A job description or duty statement that outlines the duties and functional responsibilities that will be assigned to the subcontracted firm or independent consultant.
 - C. A brief explanation as to why the subcontracted firm or independent consultant was chosen. Stress things such as applicable skills, knowledge, capabilities, past experience or accomplishments, availability, reasonableness of rates, notoriety in a field or specialty, etc.
 - D. It is preferred that a résumé not exceed 4 pages in length for each pre-identified subcontractor and independent consultant. **Place all subcontractor and/or consultant résumés in the Appendix Section of your proposal.** To the extent possible, résumés should not include personal information such as a social security number, home address, home telephone number, marital status, sex, birth date, age, etc.
 - E. A letter of agreement, signed by an official representative of each subcontracted firm or independent consultant, acknowledging their intended participation/availability and confirmation that they have read or been made aware of the terms and conditions of the proposed contract. **Place all subcontractor and/or consultant letters of agreement in the Appendix Section.**

Specific subcontractor and/or independent consultant relationships proposed in response to this RFP (i.e., identification of pre-identified subcontractors and independent consultants) shall not be changed during the procurement process or prior to contract execution. The pre-identification of a subcontractor or independent consultant does not affect DHCS' right to approve personnel or staffing selections or changes made after the contract award.

- ii. For subcontractors and/or independent consultants that cannot be identified when the proposal is submitted to DHCS or are to be determined (TBD) after the contract is executed, include:
 - A. An identification of the functions, activities, and responsibilities that will be assigned to each subcontractor and/or independent consultant.
 - B. A description of the process that will be used to obtain DHCS approval of each subcontractor and/or independent consultant selected.

h. Facilities and Resources Section

- 1) Please identify the office location for this procurement within the State of California, as required by the SOW.
- 2) Please explain why and how the facilities you have acquired or have access to for this contract support and enhance your ability to execute this contract.

i. Appendix Section

Place the following documentation in the Appendix Section of the proposal in the order shown below.

1) **Proof of Corporate Status**

If the Proposer is a Corporation, submit **either** a copy of the proposing firm's most current Certificate of Status issued by State of California, Office of the Secretary of State **or** submit a downloaded copy of the proposing firm's on-line status information from the California Business Portal website of California's Office of the Secretary of State. Include an explanation if this documentation cannot be submitted. **Do not submit copies of your firm's Bylaws or Articles of Incorporation, as proof.**

2) **Proof of Nonprofit Status**

Nonprofit organizations must prove they are legally eligible to claim "nonprofit" and/or tax-exempt status by submitting a copy of an IRS determination letter indicating nonprofit or 501 (3) (c) tax-exempt status. Submit an explanation if this documentation cannot be supplied.

3) **An Organization Chart**

Please place the organization chart as requested in J. 3.F.3 of this RFP in the appendix. .

4) Financial Statements

Submit copies of financial statements for the past two years or most recent twenty-four (24) month period.

- a) Annual income statement(s), and
- b) Annual balance sheets

Audited statements are preferred, but not required. If audited financial statements are supplied please include the opinion statement or auditor's report for each year provided. All noted audit exceptions must be explained or justified, in full.

DHCS will accept financial statements prepared by a Proposer's financial accounting department, accounting firm or an auditing firm.

Be advised that in order to safeguard the interest of the State an assessment of the Proposer's financial capacity to complete this contract will be conducted. Additional information, requirements or actions up to and including removal of the Proposer as financially unqualified for a proposal of this size may be taken by the Department.

- a) If your financials presented for the most recent fiscal year ending is greater than 18 months old from the due date of proposals, please explain why a more recent fiscal year is not presented.
- b) The Chief Financial Officer shall provide a signed statement that financial statements provided fairly represent the current financial position of the firm or a detailed statement of how the firm's financial position has changed.
- c) If the Proposer is a subsidiary of any other legal entity and the financial resources of the Parent Corporation might be used to support the subsidiary do to State budget issues or extend period for payment, please submit the two most recent fiscal years of the Parent Company for which Financial Statements have been prepared. Financial Statements at a minimum shall include a balance sheet and an income statement for each year. Publicly traded companies should provide copy of their annual audit reports as presented to the public.
- d) If, as a subsidiary and on review of the RFP requirements, the Proposer believes that their financial position may result the State finding the Proposer unqualified to perform under this proposal due to financial concerns, the proposer may qualify under a parent corporation's financials. To use the parent financials for additional support, please provide two years of annual reports from the parent corporation (as describe below) and a statement from an officer of the parent corporation committing the parent corporation to financial support, as needed.
 - i. Financial Statements as describe above in Section J.i.4)a)-d) or Audited annual financial statements for the last two (2) fiscal years, accompanied by an independent certified public accountant's report, certificate or Opinion Statement.
 - ii. Interim financial statements for the interim period from the end of the last full fiscal year up to and including the month prior to submission of proposals. The State does not require submittal of interim statements for the last two (2) fiscal years for which annual reports are submitted.

- iii. A projected pro forma financial statement and statement of changes in financial position for the next three (3) years predicated upon operation without the award of this Contract.
 - iv. A detailed financial plan and proposed cash flow budget demonstrating the availability and source of sufficient funds to cover the Proposer's projected operational cost without risk of insolvency should the Proposer be selected to provide the contractual services.
 - v. All financial data submitted in the Financial Stability Plan in connection with this RFP shall be accompanied by a signed statement from the Proposer's or parent corporation's Chief Executive Officer and Chief Financial Officer or Representative, certifying that the data is current, accurate and complete.
 - vi. Proposers must include an organization history of claims of bankruptcy, receivership, questioned cost, repayment of funds, failure to fulfill contract requirements and criminal or civil legal actions that name the organization or administrative/supervisory staff that have occurred during the past five (5) years. If you supply audited financial statements, all noted audit exceptions must be explained.
- e) In lieu of the above Section requirements, Proposers may provide the following:
- i. Proposers two (2) most recent annual certified financial statements accompanied by an independent certified public accountant's Unqualified Audit Report or Opinion Statement (Unqualified/Clean Opinion); Any noted audit exceptions of the audited financial statements must be explained in full and;
 - ii. An organization history of claims of bankruptcy, receivership, questioned cost, repayment of funds, failure to fulfill contract requirements and criminal or civil legal actions that name the organization or administrative/supervisory staff that have occurred during the past five (5) years.
 - iii. Parent Corporations

Subsidiary may use the parent financial statements to qualify under this section by providing the parent information required in Section J.i.4)e).
 - iv. The Chief Financial Officer shall provide a signed statement that financial statements provided fairly represent the current financial position of the firm or a detailed statement of how the firm's financial position has changed.
 - v. Either
 - A. Evidence of capital contributions and retained earnings equal to an amount greater than \$5,000,000 (five million dollars), as identified in the annual financial statements.
 - Or
 - B. Evidence of tangible assets under control greater than \$10,000,000 (ten million dollars), as identified in the annual financial statements.

f) **Certification**

Under either submission criteria, all financial data submitted in connection with this RFP shall be accompanied by a signed statement from the Proposer or parent corporation(s) Chief Executive Officer, Chief Financial Officer or designee certifying that the financial statements are accurate, complete and reflect the current financial position of the firm.

5) **Staff Résumés**

It is preferred that a résumé not exceed 4 pages in length per person and should not include personal information such as a social security number, home address, home telephone number, home email address, marital status, sex, birth date, age, etc.

6) **Subcontractor/Consultant Résumés**

Submit a résumé for any pre-identified subcontractor or independent consultant, used to meet any required staffing position. You may also submit the résumé for any pre-identified subcontractor or independent consultant in support of your abilities or expertise to execute this contract.

It is preferred that a résumé not exceed 4 pages in length per person and should not include personal information such as a social security number, home address, home telephone number, home email address, marital status, sex, birth date, age, etc.

7) **Subcontractor/Consultant Letters of Agreement**

For each pre-identified subcontractor and independent consultant that will be used to perform services under the resulting contract, submit a letter of agreement to work on this project.

A letter of agreement must be signed by an official representative of each subcontracted firm or independent consultant, acknowledging their intended participation/availability to work on this project and acknowledging they have read or been made aware of the terms and conditions of the proposed contract. Include an explanation if a letter of agreement cannot be obtained from each pre-identified subcontractor and consultant and indicate when a letter of agreement will be forthcoming.

8) **Conflict of Interest Compliance Certificate**

Any firm that intends to submit a proposal is required to submit **Attachment 13** certifying:

- a) Whether the proposing firm is currently involved with or connected to any Contractor or subcontractor (including consultant) that is contracted with any Medi-Cal Managed care health plan, provider, or billing agent for Medi-Cal service;
- b) That the proposing firm is not currently involved with or connected to the current Fiscal Intermediary for Medi-Cal services, or any of their subcontractors and, shall remain so for the duration of this contract;
- c) That the proposing firm understands that the conflict of interest requirements shall remain in effect for the entire term of the resulting agreement.

- d) If a conflict of interest is determined to exist that cannot be resolved to the satisfaction of DHCS, before the award of the contract, the conflict will be grounds for deeming a proposal nonresponsive.
- e) Proposers must assess their own situation according to the Conflict of Interest Compliance Certification information in **Attachment 13**. Complete, sign, and attach any required documentation according to the instructions on the attachment. Place Attachment 13 and any accompanying documentation in the Appendix Section of the proposal.

9) Proposer Response Guide

To insure that each proposal is evaluated on the full merits of the information provided, please complete the Proposer Response Guide, as provided. (Attachment 12 and accompanying instructions.)

h. Forms Section

Complete, sign, and include the forms/attachments listed below. When completing the attachments, follow the instructions in this section and any instructions appearing on the attachment. After completing and signing the applicable attachments, assemble them in the order shown below.

Attachment #, Name, or Documentation	Instructions
2 - Required Attachment / Certification Checklist	1) Check each item with "Yes" or "N/A", as applicable, and sign the form. If necessary, explain the choices. 2) If a proposer marks "Yes" or "N/A" and makes any notation on the checklist and/or attaches an explanation to the checklist to clarify their choice, DHCS considers this a "qualified response". Any "qualified response", determined by DHCS to be unsatisfactory or insufficient to meet a requirement, may cause a proposal to be deemed nonresponsive.
3 - Business Information Sheet	Completion of the form is self-explanatory.
4 - Client References	Identify three (3) clients serviced within the past ten years that can confirm their satisfaction with the Proposer's services and confirm that the Proposer provided timely and effective services or deliverables. If possible, identify clients whose needs were similar in scope and nature to the services sought in this RFP. List the most recent first.
5 - RFP Clause Certification	Complete and sign this form indicating a willingness and ability to comply with the contract certification clauses appearing in the RFP section entitled, "Bid Requirements and Information," subsection "Bidding Certification Causes".

Attachment #, Name, or Documentation	Instructions
6 – CCC 307 – Certification	Complete and sign this form indicating a willingness and ability to comply with the Contractor Certification Clauses appearing in this Attachment. The attachment supplied in this bid represents only a portion of the contractor information in this document. Visit this web site to view the state's Standard Contract Language: http://www.ols.dgs.ca.gov/StandardLanguage/default.htm .
7 - Payee Data Record	Complete and return this form, <u>only</u> if the proposing firm has not previously entered into a contract with DHCS. If uncertain, complete and return the form.
8 - Follow-on Consultant Contract Disclosure	Complete and sign this form. If applicable, attach to this form the appropriate disclosure information.
9 – Darfur Contracting Act Certification	If applicable, complete, sign and return this form and the required documentation if applicable. Detailed completion instructions appear on the cited attachment.
11 - Proposer Response Guide	See the instruction with the attachment
12 - Conflict of Interest	Complete and sign as appropriate.

i. Cost Section

1) Limitations as a Contingent Fee Contract

- a. As a contingent fee based contract, all cost associated with these contract are the sole responsibility of the contractor. DHCS disclaims any and all expenses incurred by the contractor in the execution of the contract, except as may be specifically acknowledged as the responsibility of the DHSC in this contract.
- b. The contractor will be paid for any recovered funds of an overpayment or of a duplicate payment by the provider at a rate of 12.5% (twelve and one half percent) of any identified overpayment or duplicate payment that is recovered from a provider either as cash or as an offset of payments to the provider. It should be clear that payment to the contractor will only be made after collection from the provider has been made by the Department.
- c. The contractor will be paid for any underpayment the provider identified as refundable to a provider at a rate of 10.0% (ten percent) of any identified underpayment that is credited or refunded a provider. It should be clear that payment to the contractor will only be made after the refund has been authorized by the Department and based the amount refunded to the provider

2) Reimbursement Timing

The Department expects a significant period of time to elapse between the beginning of an audit and ultimate payment by the Department for services rendered. Proposers are advised to carefully review their financial position and ability to operate for the prolonged periods without compensation from this contract.

L. Proposal Submission

1. General Instructions

- a. Assemble the accompanying CD on top of the paper copies. Package an original and three (5) copies of the proposal together. Place the proposal set marked "Original" on top, followed by the three (5) extra paper copies.
- b. If possible, place all proposal copies and accompanying CD in a single envelope or package. Seal the envelope, package, carton, or box.

If more than one envelope, package, carton, or box is submitted, carefully label each one as instructed below, and mark on the outside of each envelope or package "1 of X", "2 of X", etc.
- c. Mail or arrange for hand delivery of the proposal sets and accompanying CD to the Department of Health Care Services' Office of Medi-Cal Procurement. Proposals may not be transmitted electronically by fax or email.
- d. The Office of Medi-Cal Procurement must receive the proposal sets and accompanying CD, regardless of postmark or method of delivery, by **4:00 p.m. on December 22, 2011.** Late proposals will not be reviewed or scored.
- e. Label and submit the proposal sets and accompanying CD using one of the following methods.

Hand Delivery or Overnight Express:	U.S. Mail:
Proposal - RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Nathan Greve or Subran Singh 1501 Capitol Ave. Suite 71.3041 MS 4200 P.O. Box 997413 Sacramento, CA 95899-7413	Proposal - RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Nathan Greve or Subran Singh 1501 Capitol Ave. Suite 71.3041 MS 4200 P.O. Box 997413 Sacramento, CA 95899-7413

2. Proof of Timely Receipt

- a. DHCS staff will log and attach a date/time stamped slip or bid receipt to each proposal package/envelope received. If a proposal envelope or package is hand delivered, DHCS staff will give a bid receipt to the hand carrier upon request.
- b. To be timely, DHCS' Contract Management Unit must receive each proposal at the stated delivery address **no later than 4:00 p.m.** on the proposal submission due date. Neither delivery to the department's mailroom, or to the DHCS program that issued this RFP, or a U.S. postmark will serve as proof of timely delivery.
- c. DHCS will deem late proposals nonresponsive.

3. Proposal Costs

Proposers are responsible for all costs of developing and submitting a proposal. Such costs cannot be charged to DHCS.

M. Evaluation and Selection

A multiple stage evaluation process will be used to review and/or score technical proposals. DHCS will reject any proposal that is found to be nonresponsive at any stage of evaluation. A separate evaluation committee will be used for all stages during the evaluation and selection process. The evaluation committee is comprised of four (4) groups:

The **Preliminary Review Committee** (PRC) consists of team leads from OMCP and Audits and Investigate and conducts the Stage 1 review.

The **Evaluation Scoring Committee** (ESC) consists of Audits and Investigate staff, and DHCS staff working in other areas of the Medi-Cal program. The ESC conducts the review of the proposals and scoring of the proposals.

The **Rating Review Committee** (RRC) consists of OMCP management staff, and members of the PRC. The RRC will interact with the ESC throughout the evaluation process.

The **Executive Review Committee** (ERC) consists of DHCS Executive management officials. The ERC acts as a final decision-making authority for Proposal evaluation issues without knowledge of any Proposer to which the issue applies. The ERC assures all appropriate processes have been followed. Additionally, the ERC may seek independent review or advice from individuals, including internal auditors, from within DHCS or elsewhere regarding issues including, but not limited to, procurement policy matters, Narrative Proposal and/or Cost Proposal deficiencies, and acceptability. Finally, the ERC provides final approval of the procurement process in order to determine the awardee.

1. Stage 1 – Required Attachment / Certification Checklist review

- a. Shortly after the proposal submission deadline, DHCS staff will convene to review each proposal for timeliness, completeness, and initial responsiveness to the RFP requirements. This is a pass/fail evaluation.
- b. In this review stage, DHCS will compare the contents of each proposal to the claims made by the Proposer on the Required Attachment / Certification Checklist to determine if the Proposer's claims are accurate.
- c. If deemed necessary, DHCS may collect additional documentation (i.e., missing forms, missing data from RFP attachments, missing signatures, etc.) from a Proposer to confirm the claims made on the Required Attachment / Certification Checklist and to ensure that the proposal is initially responsive to the RFP requirements.
- d. If a Proposer's claims on the Required Attachment / Certification Checklist cannot be proven or substantiated to DHCS' satisfaction, the proposal may be deemed nonresponsive and rejected from further consideration.

A multiple stage evaluation process will be used to review and/or score technical proposals. DHCS will reject any proposal that is found to be nonresponsive at any stage of evaluation.

2. Stage 2 – Narrative Proposal Evaluation/Scoring

- a. Proposals that appear to meet the basic format requirements, initial qualification requirements and contain the required documentation, as evidenced by passing the Stage 1 review, will be submitted to a rating committee.

Raters will individually and/or as a team review, evaluate and numerically score proposals based on each proposal's adequacy, thoroughness, and the degree to which it complies with the RFP requirements.

- b. DHCS will use the following scoring system to assign points. Following this chart is a list of the considerations that raters may take into account when assigning individual points to a technical proposal.

Points	Interpretation	General basis for point assignment
0	Inadequate	Proposer does not include a response and/or supporting information for the requirement(s) or does not commit to meet the RFP requirement(s).
1	Barely Adequate	Response and/or supporting information just meets the RFP requirement(s) and/or the information is unclear. Response provides very minimal descriptive information to support the Proposer's claim that they understand and intend to meet the requirement(s).
2	Adequate	Response and/or supporting information meets the basic RFP requirement(s) and demonstrates an understanding of, and the ability and intent to meet the requirement(s). There may be omission(s), flaw(s) and/or defect(s) but they are inconsequential and acceptable.
3	More than Adequate	Response and/or supporting information demonstrates a thorough, detailed and complete understanding of the requirement(s), demonstrates the ability and intent to meet the requirement(s), provides evidence of current ability to comply, and/or provides detailed plans or methodologies to further assure compliance with the requirement(s). The response is not considered excellent or outstanding but is above average and has no flaw(s), omission(s) or defect(s).
4	Excellent or Outstanding	Response and/or supporting information demonstrates a thorough, detailed and complete understanding of the requirement(s). Response demonstrates the ability and intent to <u>exceed</u> the requirement(s), provides evidence of current ability to comply, and proposes detailed plans or methodologies that further assure how the requirement(s) will be exceeded.

- c. In assigning points for individual rating factors, raters may consider issues including, but not limited to, the extent to which a proposal response:
- 1) Is lacking information, lacking depth or breadth or lacking significant facts and/or details, and/or

- 2) Is fully developed, comprehensive and has few if any weaknesses, defects or deficiencies, and/or
 - 3) Demonstrates that the Proposer understands DHCS' needs, the services sought, and/or the contractor's responsibilities, and/or
 - 4) Illustrates the Proposer's capability to perform all services and meet all scope of work requirements, and/or
 - 5) If implemented, will contribute to the achievement of DHCS' goals and objectives, and/or
 - 6) Demonstrates the Proposer's capacity, capability and/or commitment to exceed regular service needs (i.e., enhanced features, approaches, or methods; creative or innovative business solutions).
- d. Below are the point values and weight values for each rating category that will be scored.
- 1) Proposals, excluding the Cost Section, will be scored on a scale of 0 to 225.40 points, as follows:

Rating Category	Points	X	Weight	=	Total
Executive Summary	20	X	0.25	=	5.0
Proposing Firm's Capability	36	X	1.60	=	57.6
Work Plan	48	X	1.60	=	76.8
Management Plan	32	X	0.75	=	24.0
Project Personnel	32	X	1.75	=	56.0
Facilities and Resources	8	X	0.75	=	6.0
Possible Narrative Proposal Total 225.40 Points					

3. Stage 3 – Adjustments to Score Calculations for Bidding Preferences/Incentives

- a. DHCS will determine which firms, if any, are eligible to receive a bidding preference (i.e., small business or non-small business subcontractor preference, etc.
- b. To confirm the identity of the highest scored responsive Proposer, DHCS will adjust the total score for applicable claimed preference(s)/incentives for eligible Proposers. DHCS will apply preference adjustments to eligible Proposers according to State regulations following verification of eligibility with the appropriate office of the Department of General Services. More information about the allowable bidding preferences appears in the RFP section entitled, "Preference and Incentive Programs".

4. Stage 4 – Final Score Calculation

The final shall be the narrative score plus and bidding preferences/Incentives earned.

N. Narrative Proposal Rating Factors

Raters will use the following criteria to score the narrative portion of each proposal.

1. Executive Summary

#	Executive Summary Rating Factors	Max. Points
1	To what extent did the Proposer express, in its own words, its understanding of DHCS' needs and the importance of this project? Assign 1 point or 0 points if the Proposer restates or paraphrases information in the RFP.	4
2	To what extent did the Proposer's delineated expected tangible results reflect the goals of this procurement? Assign 1 point or 0 points if the Proposer restates or paraphrases information in the RFP.	4
3	To what extent did the Proposer express a sincere commitment to perform this work in an efficient and timely manner?	4
4	To what extent did the Proposer demonstrate that it can effectively integrate this project into its current obligations and existing workload?	4
5	To what extent did the proposer adequately explain why it should be chosen to undertake this project at this time?	4
Executive Summary Score		Points earned X .25 = Section Points Earned

2. Proposing Firm's Capability

	Proposing Firm's Capability Rating Factors	Max. Points
6	Upon reviewing the Proposer's description of its business history, to what extent are the Proposing firm's goals relevant, closely related, and do their business activities complement this project?	4
7	From the experience described in its proposal, to what extent does the Proposer possess experience in audit recovery activities or recovery type activities to support a claim to successfully execute a proposal of this of the size and scope?	4
8	Did the Proposer identify any qualifying experience under RFP Main J. 3.d.2 as a client reference, in Attachment 4? If yes award 4 points, if no award 0 points.	4
9	From the experience described in its proposal, to what extent does the Proposer demonstrate experience directly engaged in the identification of billing error detection or discovery of medical or others billing issues for government agencies?	4
10	From the experience described in its proposal, to what extent does the Proposer's have prior experience with a public or governmental agency that has been directly engaged in the identification under or over payment of medical billings?	4

	Proposing Firm's Capability Rating Factors	Max. Points
11	From the experience described in its proposal, to what extent does the Proposer have audit or audit type scope of work experience with a government agency?	4
12	From the in-depth discussion of the Proposer's experience qualifying them to undertake this project, to what extent does the Proposer's experience qualify them for this contract?	4
13	From the experience describing the firm's current billing review operations, to what extent the Proposer's discussion of the operational size, staffing levels, expertise and any other relevant information indicate current knowledge, expertise or other desirable attributes as contractor?	4
14	To what extent did the Proposer's controls and reporting methods used to report, manage or convey your findings to the client at the appropriate level and time?	4
Proposing Firm's Capability Score Points earned X 1.60 = Section Points Earned		

3. Work Plan

	Work Plan Rating Factors	Max. Points
15	To what extent is the Proposer's synopsis explaining or describing their overall approach and/or methods for accomplishing the scope of work well planned, feasible and appropriate as related to the SOW?	4
16	To what extent are the "Internal Guidelines" process or procedures to be used in reviewing claims for coverage and coding issues appropriate in meeting the goals of the SOW?	4
17	To what extent are the Automated Reviews processes appropriate for achieving success in executing the SOW?	4
18	To what extent are the proposed procedures, methods and approaches for tracking successful completion of major task appropriate and reasonable?	4
19	To what extent are the Proposer's processes or procedures for conducting Complex Reviews appropriate and conducive to a successful Complex Review?	4
20	To what extent is the personnel chosen by Proposer to perform and conduct the field work for Complex Reviews logical and appropriate in meeting the needs of a Complex Review and the requirements of the SOW?	4
21	To what extent are process expected to be followed by the field auditor in conducting a Complex Review appropriate in meeting the needs of a Complex Review and the requirements of the SOW?	4
22	To what extent are the procedures for obtaining additional opinions or expertise for the filed auditor while in the field and/or after leaving the Provider's offices appropriate in meeting the needs of a Complex Review and the requirements of the SOW?	4

	Work Plan Rating Factors	Max. Points
23	To what extent are the methods, techniques, staff training or other measures that will limit the disruption to Providers while conducting a Complex Review appropriate in mitigating the disruption to Providers that will occur?	4
24	To what extent are the methods, techniques, staff training or other measures that will limit the disruption to Providers while conducting a Complex Review appropriate in mitigating the disruption to Providers that will occur?	4
25	To what extent are the firm's monitoring or auditing techniques of the conduct of auditors in the field and the appropriateness of the work conducted substantial and meaningful?	4
26	To what extent are the firm's database used to track information on underpayments, overpayments, appeals, correspondents with providers, and any other information useful for DHCS during appeals and/or other audits appropriate and functional?	4
Work Plan Score		Points earned X 1.60 = Section Points Earned

4. Management Plan

	Management Plan Rating Factors	Max. Points
27	To what extent has the Proposer demonstrated its capability to effectively coordinate, manage and monitor the efforts of assigned staff (including subcontractors and consultants) to ensure that work is effectively completed and timely?	4
28	To what extent has the Proposer's developed an effective fiscal accounting processes to ensure claims are forwarded to the Department in accurate and timely manner?	4
29	To what extent has the Proposer's developed an effective method to track under or over payments of this project?	4
30	To what extent has the Proposer's developed an effective system for storing all documentation that will be retained as the case file for each claim submitted?	4
31	To what extent has the Proposer's developed an effective tracking system for all stored documentation that will be retained as the case file for each claim submitted?	4
32	To what extent has the Proposer's developed an effective process for purging investigational information or records for providers that did not result in any claims adjustment?	4
33	To what extent is the Proposer's organization chart distinct in showing clear lines of authority between and among the divisions that will perform the project work. Within that analysis, what are the primary reporting relationships within the Proposer's organization supportive of the SOW of the project?	4
34	To what extent is the Proposer's Quality Assurance plan to monitor this contract as required by the SOW appropriate?	4
Management Plan Score		Points earned X .75 = Section Points Earned

5. Project Personnel

	Project Personnel Rating Factors	Max. Points
35	Upon reviewing the qualifications of the Proposer's Medical Director, to what extent are those qualifications likely to enhance the goals and requirements of the proposal?	4
36	Upon reviewing the Proposer's staffing plan, to what extent has the Proposer allocated a sufficient number of staff in the appropriate position levels or classifications to perform the requirements of project?	4
37	Upon reviewing the proposed staffing qualification for each position identified as needed or required to what extent are the proposed qualifications appropriate and in line with the SOW required and proposed plan for executing the RFP?	4
38	Upon reviewing the Proposer's plans for dealing with the difficulties arising from dealing with a state of the size or geographic girth of California, to what extent are those plans reasonable and appropriate for this contract?	4
39	Upon reviewing the Proposer's administrative policies and procedures, to what extent will the policies/procedures lead to the recruitment and selection of qualified, competent and experienced staff, subcontractors and/or independent consultants for this project?	4
40	Upon review of the discussion on recover based incentives and/or the control of inappropriate bias to what extent has the Proposer shown an appropriate plan for controlling and monitoring it staff as it relates to this issue?	4
41	Upon reviewing the employee recruitment/selection policies or procedures of the Proposer to what extent are those policies or procedures appropriate for this project?	4
42	Upon reviewing the job descriptions and résumés of the proposed staff <i>[excluding the project director(s)/administrator(s) or project coordinator(s)]</i> , to what extent do the proposed personnel possess the qualifications and expertise needed to perform the assigned duties?	4
Project Personnel Score		Points earned X 1.75 = Section Points Earned

6. Facilities and Resources

	Facilities and Resources Rating Factors	Max. Points
43	Does the Proposer have access to office facilities in California as required? (4 points if Yes, 0 point if No.)	4
44	To what extent does the Proposer's access or acquired facilities support and enhance the ability of Proposer to successfully execute this procurement?	4
Facilities and Resources Score		Points earned X 0.75 = Section Points Earned

O. Bid Requirements and Information

1. Nonresponsive proposals

In addition to any condition previously indicated in this RFP, the following occurrences **may** cause DHCS to deem a proposal nonresponsive.

- a. Failure of a Proposer to:
 - 1) Meet proposal format/content or submission requirements including, but not limited to, the sealing, labeling, packaging and/or timely and proper delivery of proposals.
 - 2) Pass the Required Attachment / Certification Checklist review (i.e., by not marking "Yes" to applicable items or by not appropriately justifying, to DHCS' satisfaction, all "N/A" designations).
 - 3) Submit a **mandatory** Conflict of Interest Compliance Certificate in the manner required.
- b. If a Proposer submits a proposal that is conditional, materially incomplete or contains material defects, alterations or irregularities of any kind.
- c. If a Proposer supplies false, inaccurate or misleading information or falsely certifies compliance on any RFP attachment.
- d. If DHCS discovers, at any stage of the bid process or upon contract award, that the Proposer is unwilling or unable to comply with the contract terms, conditions and exhibits cited in this RFP or the resulting contract.
- e. If other irregularities occur in a proposal response that is not specifically addressed herein (i.e., the Proposer places any conditions on performance of the scope of work, submits a counter proposal, etc.).

2. Proposal modifications after submission

- a. All proposals are to be complete when submitted. However, an entire proposal may be withdrawn and the Proposer may resubmit a new proposal.
- b. To withdraw and/or resubmit a new proposal, follow the instructions appearing in the RFP section entitled, "Withdrawal and/or Resubmission of Proposals".

3. Proposal mistakes

If prior to contract award, award confirmation, or contract signing, a proposer discovers a mistake in their proposal and/or cost offering that renders the proposer unable or unwilling to perform all scope of work services as described in its proposal response for the price/costs offered, the proposer must immediately notify DHCS and submit a written request to withdraw its proposal following the procedures set forth below.

4. Withdrawal and/or Resubmission of Proposals

- a. Withdrawal deadlines

A proposer may withdraw a proposal at any time before the issuance of the Notice of Intent to Award.

b. Submitting a withdrawal request

- 1) Submit a written withdrawal request, signed by an authorized representative of the Proposer.
- 2) Label and submit the withdrawal request using one of the following methods.

U.S. Mail, Hand Delivery or Overnight Express:	Fax:
Withdrawal - RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Nathan Greve MS 4200 1501 Capitol Ave Suite 71.3041 P.O. Box 997413 Sacramento, CA 95899-7413	Withdrawal - RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Nathan Greve Fax: (916) 440-7369

- 3) **[For faxed requests]** Proposers must call DHCS' OMCP at (916) 552-8006 to confirm receipt of a faxed withdrawal request. Follow-up the faxed request by mailing or delivering the signed original withdrawal request within 24 hours after submitting a faxed request.

An originally signed withdrawal request is generally required before DHCS will return a proposal to a Proposer. DHCS may grant an exception if the Proposer informs DHCS that a new or replacement proposal will immediately follow the withdrawal.

c. Resubmitting a proposal

After withdrawing a proposal, Proposers may resubmit a new proposal according to the proposal submission instructions. Replacement proposals must be received at the stated place of delivery by the proposal due date and time. **Proposals withdrawn after the proposal due date may not be resubmitted.**

a. Contract award

- 1) Award of the contract, if awarded, will be to the responsive and responsible Proposer, who earns the highest total score. The highest scored proposal will be determined after DHCS adjusts Proposer scores for applicable bidder preferences and/or incentives.
- 2) DHCS shall award the contract only after DHCS posts a Notice of Intent to Award for five (5) working days. DHCS expects to post the Notice of Intent to Award before the close of business on February 1, 2012 in a Contract Award Notices Binder which will be available for viewing by the public during normal business hours, at the following location:

Department of Health Care Services
 Office of Medi-Cal Procurement
 1501 Capitol Avenue, First Floor Guard Station
 Sacramento, CA 95814

- 3) DHCS will mail, email, or fax a written notification and/or a copy of the Notice of Intent to Award to all firms that submitted a proposal.
- 4) DHCS will confirm the contract award to the winning Proposer after the protest deadline, if no protests are filed or following the Department of General Service's resolution of all protests. DHCS staff may confirm an award verbally or in writing.

b. Settlement of ties

- 1) In the event of a precise total high score tie between a responsive proposal submitted by a certified small business or microbusiness and a responsive proposal submitted by a certified DVBE that is also a certified small business, the contract will be awarded to the DVBE firm per Government Code Section 14838(f) et seq.
- 2) In the event of a precise total high score tie between a responsive proposal submitted by a firm that was granted non-small business subcontractor preference and a responsive proposal submitted by a certified small business or microbusiness, the contract will be awarded to the certified small business or microbusiness.
- 3) In the event of a precise total high score between a responsive proposal submitted by a nonprofit veteran service agency (NVSA) that is a certified small business and a responsive proposal submitted by a certified DVBE that is also a certified small business, the contract will be awarded to the certified DVBE.
- 4) In the absence of a California law or regulation governing a specific tie, DHCS will settle all other precise total high score ties by making an award to the Proposer who earns the highest narrative or Technical Proposal score. If narrative or Technical Proposal scores are also tied, DHCS will settle the tie in a manner that DHCS determines to be fair and equitable (e.g., coin toss, lot drawing, etc.). In no event will DHCS settle a tie by dividing the work among the tied Proposers.

c. Protests

- 1) Who can protest

Any proposer who submits a proposal may file protest if the Proposer believes its proposal is responsive to all RFP requirements.

- 2) Grounds for protests

Protests are limited to the grounds described in Public Contract Code (PCC) Section 10345. DHCS will not make an award until all protests are withdrawn by the protestant, denied, or resolved to the satisfaction of the Department of General Services (DGS).

- 3) Protest time lines

- d. If an eligible Proposer wishes to protest the intended contract award, the Proposer must file a "Notice of Intent to Protest" with both DHCS and the Department of General Services within five working days after DHCS posts the Notice of Intent to Award. The Notice of Intent to Protest may be quite brief. Any Notice of Intent to Protest filed more than five working days after DHCS posts the Notice of Intent to Award shall be untimely.

- e. Within five calendar days after filing a "Notice of Intent to Protest", the protestant must file with both DHCS and the Department of General Services a full and complete written protest statement identifying the specific grounds for the protest. The statement must contain, in detail, the reasons, law, rule, regulation, or practice that the protestant believes DHCS has improperly applied in awarding the contract.

4) Submitting a protest

Protests must be filed with **both** the Department of General Services and the Department of Health Care Services. Proposers may hand deliver, mail or fax a protest.

Label, address, and submit the initial protest notice and detailed protest statement using one of the following methods.

U.S. Mail, Hand Delivery or Overnight Express:	Fax:
Protest to DHCS RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement MS 4200 P.O. 997413 1501 Capitol Avenue, Suite 71.3041 Sacramento, CA 95899-7413	Protest to DHCS RFP 10-87242 Department of Health Care Services Office of Medi-Cal Procurement Fax: (916) 440-7369
Protest to DHCS RFP 10-87242 Department of Health Care Services Contract Management Unit Mail Station 1403 P.O. Box 997413 1501 Capitol Avenue, Suite 71.5195 Sacramento, CA 95899-7413	Protest to DHCS RFP 10-87242 Department of Health Care Services Contract Management Unit Fax: (916) 650-0111
Protest to DHCS RFP 10-87242 Dept. of General Services Office of Legal Services Attention: Protest Coordinator 707 Third Street, 7 th Floor, Suite 7-330 P.O. Box 989052 West Sacramento, CA 95798-9052	Protest to DHCS RFP 10-87242 Dept. of General Services Office of Legal Services Fax: (916) 376-5088

For faxed protests

Faxed protests must be followed-up by sending an original signed protest, with all supporting material, within seven (7) calendar days of submitting the faxed protest.

Call the telephone numbers below to confirm receipt of a fax transmission:

Department of General Services-DGS	(916) 376-5080
Department of Health Care Services-CMU	(916) 650-0150
Department of Health Care Services-OMCP	(916) 552-8006

5. Disposition of Proposals

- a. All materials submitted in response to this RFP will become the property of the Department of Health Care Services and, as such, are subject to the Public Records Act (GC Section 6250, et seq.). DHCS will disregard any language purporting to render all or portions of any proposal confidential.
- b. Upon posting the Notice of Intent to Award, all documents submitted in response to this RFP and all documents used in the selection process (e.g., review checklists, scoring sheets, letters of intent, etc.) will be regarded as public records under the California Public Records Act (Government Code Section 6250 et seq.) and are available to the public. However, these documents shall be held in the strictest confidence until the Notice of Intent to award is posted.
- c. DHCS may return a proposal to a Proposer at their request and expense after DHCS concludes the bid process.

6. Public Release of Proposal Material

a. Who Can Inspect

Any person or member of the public can inspect or obtain copies of any proposal materials. The following materials are made available to the public:

- 1) After the Pre-Proposal Conference, the sign-in or attendance sheet is a public record and will be available as an Administrative Bulletin that will be posted on the OMCP website.
- 2) On or after the date DHCS posts the Notice of Intent to Award, all proposals, Proposer Lists, conference sign-in/attendance sheet, letters of intent, checklists and/or scoring/evaluation sheets become public records and our part of the Bidder's Package. The Bidder's Package will be available on CD upon request.

b. Obtaining CD copies of proposal materials

Persons wishing to obtain CD copies of Proposal materials may call DHCS or e-mail a written request to DHCS office identified below. The requestor must identify the items they wish to receive.

Persons requesting CD copies must provide replacement CD's.

Request for Copies - RFP 10-87242

Attn: Subran Singh or Nathan Greve
Department of Health Care Services
Office of Medi-Cal Procurement
Subran Singh or Nathan Greve
MS 4200
1501 Capitol Avenue, Suite 71.3041
P.O. Box 997413
Sacramento, CA 95899-7413

7. Verification of Proposer information

By submitting a proposal, Proposers agree to authorize DHCS to:

- a. Verify any and all claims made by the Proposer including, but not limited to verification of prior experience and the possession of other qualification requirements, and
- b. Check any reference identified by a Proposer or other resources known by DHCS to confirm the Proposer's business integrity and history of providing effective, efficient and timely services.

8. Inspecting or obtaining copies of proposals

- a. Who can inspect or copy proposal materials

Any person or member of the public can inspect or obtain copies of any proposal materials.

- b. What can be inspected / copied and when

On or after the date DHCS posts the Notice of Intent to Award, all proposals, Proposers Lists, RFP download lists, conference sign-in/attendance sheet, letters of intent, checklists and/or scoring/evaluation sheets become public records. These records shall be available for review, inspection and copying during normal business hours.

- c. Inspecting or obtaining copies of proposal materials

Persons wishing to view or inspect any proposal or award related materials must identify the items they wish to inspect and must make an inspection appointment by contacting Nathan Greve at (916) 552-8006.

Persons wishing to obtain copies of proposal materials may visit DHCS or mail a written request to the DHCS office identified below. The requestor must identify the items they wish to have copied. Materials will not be released from State premises for the purposes of making copies.

Unless waived by DHCS, a check covering copying and/or mailing costs must accompany the request. Copying costs, when applicable, are charged at a rate of **ten cents** per page. DHCS will fulfill all copy requests as promptly as possible. Submit copy requests as follows:

Request for Copies - RFP 10-87242

Attn: Nathan Greve or Subran Singh
Department of Health Care Services
Office of Medi-Cal Procurement
[O. 997413
1501 Capitol Avenue, Suite 71.3041
Sacramento, CA 95899-7413

9. Verification of Proposer information

By submitting a proposal, Proposers agree to authorize DHCS to:

- a. Verify any and all claims made by the Proposer including, but not limited to verification of prior experience and the possession of other qualification requirements, and

- b. Check any reference identified by a Proposer or other resources known by DHCS to confirm the Proposer's business integrity and history of providing effective, efficient and timely services.

10. DHCS Rights

In addition to the rights discussed elsewhere in this RFP, DHCS reserves the following rights.

a. RFP Corrections

- 1) DHCS reserves the right to do any of the following up to the proposal submission deadline:
 - a) Modify any date or deadline appearing in this RFP or the RFP Time Schedule.
 - b) Issue clarification notices, addenda, alternate RFP instructions, forms, etc.
 - c) Waive any RFP requirement or instruction for all proposers if DHCS determines that the requirement or instruction was unnecessary, erroneous or unreasonable.
 - d) Allow Proposers to submit questions about any RFP change, correction or addenda. If DHCS allows such questions, specific instructions will appear in the cover letter accompanying the document.
- 2) If deemed necessary by DHCS to remedy an RFP error or defect that is not detected in a timely manner, DHCS may also issue correction notices or waive any unnecessary, erroneous, or unreasonable RFP requirement or instruction after the proposal submission deadline.
- 3) If this RFP is clarified, corrected, or modified, DHCS will mail, email, or fax written clarification notices, Administrative Bulletins, and/or RFP addenda to all persons/firms to whom DHCS sent this RFP and to any persons that specifically make a request to receive materials that announce changes to the RFP.

If DHCS decides, just before or on the proposal due date, to extend the submission deadline, DHCS may choose to notify potential proposers of the extension by fax, email, or by telephone. DHCS will follow-up any verbal notice in writing by fax, email, or by mail.

b. Collecting Information from Proposers

- 1) If deemed necessary, DHCS may request a Proposer to submit additional documentation during or after the proposal review and evaluation process. DHCS will advise the Proposers orally, by fax, email, or in writing of the documentation that is required and the time line for submitting the documentation. DHCS will follow-up oral instructions in writing by fax, email, or mail. Failure to submit the required documentation by the date and time indicated may cause DHCS to deem a proposal nonresponsive.
- 2) DHCS, at its sole discretion, reserves the right to collect, by mail, email, fax or other method; the following omitted documentation and/or additional information.
 - a) Signed copies of any form submitted without a signature.
 - b) Data or documentation omitted from any submitted RFP attachment/form.

- c) Information/material needed to clarify or confirm certifications or claims made by a Proposer.
 - d) Information/material or form needed to correct or remedy an immaterial defect in a proposal.
 - e) Information, material, facts, or data needed to justify or substantiate any proposed budgeted costs of the Proposer or a subcontractor including any DVBE supplier.
- 3) The collection of proposer documentation may cause DHCS to extend the date for posting the Notice of Intent to Award. If DHCS changes the posting date, DHCS will advise the Proposers, orally, via email, or in writing, of the alternate posting date.

c. Immaterial Proposal Defects

- 1) DHCS may waive any immaterial defect in any proposal and allow the Proposer to remedy those defects. DHCS reserves the right to use its best judgment to determine what constitutes an immaterial deviation or defect.
- 2) DHCS' waiver of an immaterial defect in a proposal shall in no way modify this RFP or excuse a Proposer from full compliance with all bid requirements.

d. Correction of Clerical or Mathematical Errors

- 1) DHCS reserves the right, at its sole discretion, to overlook, correct or require a Proposer to remedy any obvious clerical or mathematical errors occurring in the narrative portion of a proposal, on a Cost Proposal form or on a Budget Detail Work Sheet.
- 2) If the correction of an error results in an increase or decrease in the total price, and a unit price pursuant to d 4) is not provided, DHCS shall give the Proposer the option to accept the corrected price or withdraw their proposal.
- 3) Proposers may be required to initial corrections to costs and dollar figures on the Cost Proposal form or a Budget Detail Work Sheet if the correction results in an alteration of the annual costs or total cost offered.
- 4) If a mathematical error occurs in a total or extended price and a unit price is present, DHCS will use the unit price to settle the discrepancy.

e. Right to Remedy Errors

DHCS reserves the right to remedy errors caused by:

- 1) DHCS office equipment malfunctions or negligence by agency staff,
- 2) Natural disasters (i.e., floods, fires, earthquakes, etc.).

f. No Contract Award or RFP Cancellation

The issuance of this RFP does not constitute a commitment by DHCS to award a contract. DHCS reserves the right to reject all proposals and to cancel this RFP if it is in the best interests of DHCS to do so.

g. Change or Loss of Funding

If full funding does not become available, is reduced, or DHCS determines that it does not need all of the services described in this RFP; DHCS reserves the right to offer an amended contract for reduced services.

h. Contract Amendments after Award

As provided in the Public Contract Code governing contracts awarded by competitive bid, the DHCS reserves the right to amend the contract after DHCS makes a contract award.

i. Proposed Use of Subcontractors and/or Independent Consultants

Specific subcontract relationships proposed in response to this RFP (i.e., identification of pre-identified subcontractors and independent consultants) shall not be changed during the procurement process or prior to contract execution. The pre-identification of a subcontractor or independent consultant does not affect DHCS' right to approve personnel or staffing selections or changes made after the contract award.

j. Staffing Changes after Contract Award

DHCS reserves the right to approve or disapprove changes in key personnel that occur after DHCS awards the contract.

k. Reference Issues

Should the RRC determine that significant issues are raised during the client reference checks, those issues may be elevated to the ERC. The ERC may request additional information, deem the issues immaterial or find issue material and significant and deem the Proposer non-response, at their sole discretion.

P. Bidding Certification Clauses

1. Debarment and Suspension Certification

- a. The 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) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - 3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph a.2) of this certification; and
 - 4) Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

- 5) It shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - 6) It will include a clause entitled "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- b. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the program funding this contract.

2. Lobbying Restrictions and Disclosure

- a. The Contractor certifies, to the best of its knowledge and belief, that:
- 1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
 - 2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
 - 3) The Contractor shall require that the contents of this certification be collected from the recipients of all subawards, exceeding \$100,000, at all tiers (including subcontracts, subgrants, etc.) and shall be maintained for three years following final payment/settlement of those agreements.
- b. This certification is a material representation of fact upon which reliance was placed when this contract was made and/or entered into. The making of the above certification is a prerequisite for making or entering into this contract pursuant to 31 U.S.C. 1352 (45 CFR 93). Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.
- c. The Standard Form-LLL may be obtained from various federal agencies, federally sponsored World Wide Web Internet sites, DHCS upon request or may be copied from Exhibit D(F) entitled, Special Terms and Conditions.

Q. Preference and Incentive Programs

To confirm the identity of the highest scored responsive Proposer, DHCS will adjust the total point score for applicable claimed preference(s). Bidding preferences shall not be applied to proposals that fail to pass the Checklist Review or fail to earn a minimum passing score during the narrative proposal scoring process. DHCS will apply preference adjustments to eligible

Proposers according to State regulations following on-line or personal verification of eligibility with the appropriate office of the Department of General Services.

1. Small Business / Microbusiness Preference

- a. A responsive California small business or microbusiness proposer claiming preference and verified as a certified small business or microbusiness in a relevant business category or type will be granted a preference of five percent (5%) of the total point score earned by the responsive/responsible proposer with highest combined score, if the highest scored proposal is submitted by a non-small business. Non-small business means a responsive/responsible proposer that is not certified by the California Department of General Services as a California small business or microbusiness in a relevant business category or type. The "service" category or business type will most likely apply to this procurement. Nonprofit Veteran Service Agencies (NVSA) are to view the instructions in provision 3 of this section (Preference Programs).
- b. To be certified as a California small business or microbusiness and eligible for a bidding preference the business must meet the State's eligibility requirements and must have applied for small business status no later than 5:00 p.m. on the proposal submission deadline.
- c. Firms desiring small/micro business certification must follow the Department of General Services certification instructions and apply for certification. Prospective bidding firms desiring small business certification assistance may contact the Department of General Services by the following means:
 - 1) (916) 375-4940 (Small business assistance) or (800) 559-5529 (live operator Central receptionist), or
 - 2) Internet address: <http://www.dgs.ca.gov/pd/Programs/OSDS.aspx> or
 - 3) Fax: (916) 375-4950, or
 - 4) Email: OSDShelp@dgs.ca.gov

2. Nonprofit Veteran Service Agency (NVSA) Small Business Preference

- a. Pursuant to Military and Veteran Code Section 999.50 et seq., responsive/responsible nonprofit veteran service agencies (NVSAs) claiming small business/microbusiness preference and verified as such in the relevant category or business type prior to the proposal submission due date will be granted a preference up to five percent (5%) of the highest score, if the highest scored responsive proposal is submitted by a proposer not certified as a small business/microbusiness. The "service" category is the business type that will most likely apply to this procurement.
- b. To be eligible for the NVSA small business preference, the business concern must:
 - 1) Request small business preference at the time of proposal submission, and
 - 2) Become certified as a small business by the appropriate office of the California Department of General Services (DGS) prior to the proposal submission due date.
- c. Refer to the RFP section entitled, "Settlement of ties" to learn how tied proposals will be resolved.

R. Contract Terms and Conditions

1. Loss Leader Clause

It is unlawful for any person engaged in business within this state (California) to sell or use any article or product as a "loss leader" as defined in Section 17030 of the Business and Professions Code.

2. Other Terms and Conditions

The winning Proposer must enter a written contract that may contain portions of the Proposer's proposal (i.e. Work Plan), Scope of Work, Scope of Work Attachments, standard contract provisions, the contract form, and the exhibits identified below. Other exhibits, not identified herein, may also appear in the resulting contract.

The exhibits identified in this section contain contract terms that require strict adherence to various laws and contracting policies. A Proposer's unwillingness or inability to agree to the proposed terms and conditions shown below or contained in any exhibit identified in this RFP may cause DHCS to deem a Proposer non-responsible and ineligible for an award. DHCS reserves the right to use the latest version of any form or exhibit listed below in the resulting agreement if a newer version is available.

The exhibits identified below illustrate many of the terms and conditions that may appear in the final agreement between DHCS and the winning Proposer. Other terms and conditions, not specified in the exhibits identified below, may also appear in the resulting agreement. Some terms and conditions are conditional and may only appear in an agreement if certain conditions exist (i.e., contract total exceeds a certain amount, federal funding is used, etc.).

In general, DHCS will not accept alterations to the General Terms and Conditions (GTC), DHCS' Special Terms and Conditions, the Scope of Work, other exhibit terms/conditions, or alternate language that is proposed or submitted by a prospective contractor. DHCS may consider a proposal containing such provisions "a counter proposal" and DHCS may reject such a proposal as nonresponsive.

3. Sample contract forms / exhibits

Exhibit Label	Exhibit Name
a. Exhibit A1	Standard Agreement http://dhcsintranet/FormsPubs/Pages/ContractForms.aspx.
b. Exhibit A	Scope of Work
c. Exhibit B	Payment Provisions
d. Exhibit C - View on-line.	General Terms and Conditions (GTC 610). View or download this exhibit at this Internet site: http://www.ols.dgs.ca.gov/Standard Language/default.htm .
e. Exhibit D(F)	Special Terms and Conditions
f. Exhibit E	Additional Provisions
g. Exhibit F	HIPAA Business Associate Addendum Conflict of Interest Compliance Certificate

Exhibit Label**Exhibit Name**

h. Exhibit G

HIPAA Business Associate Addendum Security Controls

4. Unanticipated tasks

In the event unanticipated or additional work must be performed that is not identified in this RFP, but in DHCS' opinion is necessary to successfully accomplish the scope of work, DHCS will initiate a contract amendment to add that work. All terms and conditions appearing in the final contract including the salary/wage rates, unit rates and/or other expenses appearing on the Proposer's Budget Detail Work Sheets will apply to any additional work and extension options.

5. Resolution of language conflicts (RFP vs. final agreement)

If an inconsistency or conflict arises between the terms and conditions appearing in the final agreement and the proposed terms and conditions appearing in this RFP, any inconsistency or conflict will be resolved by giving precedence to the final agreement.

Proposal Cover Page

Name of Bidding Firm *(Legal name as it will appear on the contract)*

Mailing Address *(Street address, P.O. Box, City, State, Zip Code)*

Person authorized to act as the primary contact for matters regarding this proposal:

Printed Name *(First, Last)*:

Title:

Telephone number:

Fax number:

Email address, if applicable

()

()

Person authorized to obligate this firm in matters regarding the resulting contract:

Printed Name *(First, Last)*:

Title:

Telephone number:

Fax number:

Email address, if applicable

()

()

(CORPORATIONS) Name/Title of person authorized by the Board of Directors to sign all proposal documents on behalf of the Board:

Printed Name *(First, Last)*:

Title:

Signature of Proposer or Authorized Representative

Date:

Required Attachment / Certification Checklist

Qualification Requirements. I certify that my firm meets the following requirements:		Confirmed by the State
☐ Yes ☐ N/A	My firm possesses at least three consecutive years of experience of the various service types listed in Item 1 of the RFP section entitled, "Qualification Requirements". That experience occurred within the past five years.	☐ Yes ☐ No
☐ Yes ☐ N/A	My firm has read and is willing to comply with the terms, conditions and contract exhibits addressed in the RFP section entitled, "Contract Terms and Conditions".	☐ Yes ☐ No
☐ Yes ☐ N/A	(Corporations) My firm is in good standing and qualified to conduct business in California. [Check "N/A" if not a Corporation.]	☐ Yes ☐ No
☐ Yes ☐ N/A	(Nonprofit Organizations) My firm is qualified to claim nonprofit status. [Check "N/A" if not a nonprofit organization.]	☐ Yes ☐ No
☐ Yes ☐ N/A	My firm has a past record of sound business integrity and a history of being responsive to past contractual obligations. My firm authorizes the State to confirm this claim.	☐ Yes ☐ No
☐ Yes ☐ NA	My firm is financially stable and solvent and has adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State.	☐ Yes ☐ No
☐ Yes ☐ N/A	My firm has certified via Attachment 8 that its proposal response is not in violation of Public Contract Code Section 10365.5 and has, if applicable, identified previous State consultant services contracts entered into that were related in any manner to the services, goods, or supplies being acquired in this procurement.	☐ Yes ☐ No
☐ Yes ☐ N/A	My firm will supply, before contract execution, proof of self-insurance or copies of insurance certificates proving possession of general liability and/or automobile liability insurance as stipulated in Item 9 of the RFP section entitled, "Qualification Requirements".	☐ Yes ☐ No
☐ Yes ☐ N/A	[My firm has no conflict of interest and has submitted the required certification and documentation necessary to prove this claim.	☐ Yes ☐ No
Technical Proposal format and content.		Confirmed by the State
☐ Yes ☐ N/A	My firm complied with the Technical Proposal format requirements and my firm submitted one original Technical Proposal and five (5) paper copies plus an accompanying CD. My proposal is assembled in the following order:	☐ Yes ☐ No
☐ Yes ☐ N/A	Proposal Cover Page (Attachment 1)	☐ Yes ☐ No
☐ Yes ☐ N/A	Table of Contents	☐ Yes ☐ No
☐ Yes ☐ N/A	Executive Summary Section consisting of 10 or fewer pages.	☐ Yes ☐ No
☐ Yes ☐ N/A	Proposing Firm's Capability Section	☐ Yes ☐ No
☐ Yes ☐ N/A	Work Plan Section	☐ Yes ☐ No
☐ Yes ☐ N/A	Management Plan Section	☐ Yes ☐ No
☐ Yes ☐ N/A	Project Personnel Section	☐ Yes ☐ No
☐ Yes ☐ N/A	Facilities and Resources Section	☐ Yes ☐ No

Attachment 2
Page 2

Required Attachment / Certification Checklist

Appendix Section with the following documentation:		Confirmed by the State
☐ Yes ☐ N/A	(Corporations) Attach either a copy of the Certificate of Status issued by California's Office of the Secretary of State or submit a copy of the bidding firm's <u>active</u> on-line status information downloaded from the California Business Portal website. Attach an explanation if the required documentation cannot be supplied. [Check "N/A" if not a Corporation.]	☐ Yes ☐ No
☐ Yes ☐ N/A	(Nonprofit Organizations) A copy of an IRS determination letter proving eligibility to claim nonprofit and/or 501 (3) (c) tax exempt status. [Check "N/A" if not a nonprofit organization.]	☐ Yes ☐ No
☐ Yes ☐ N/A	An organization chart.	☐ Yes ☐ No
☐ Yes ☐ N/A	Copies of financial statements for the past two years or most recent 24-month period (i.e., annual income statements and quarterly/annual balance sheets).	☐ Yes ☐ No
☐ Yes ☐ N/A	Resumes for each pre-identified subcontractor or independent consultant, if any, that will serve a major role in performing the services. [Check "N/A" if no subcontractors or consultants will be used or if none has been pre-identified.]	☐ Yes ☐ No
☐ Yes ☐ N/A	Letters of agreement, signed by each pre-identified subcontractor and independent consultant or applicable explanation. [Check "N/A" if no subcontractors or consultants will be used or if none has been pre-identified.]	☐ Yes ☐ No

Form Section with the following attachments / forms:		Confirmed by the State
☐ Yes ☐ N/A	Attachment 2, Required Attachment / Certification Checklist	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 3, Business Information Sheet	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 4, Client References	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 5, RFP Clause Certification	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 6, CCC 307 – Certification	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 7, Payee Data Record. [Check "N/A" if the Proposer has had a prior contract with DHCS.]	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 8, Follow-on Consultant Contract Disclosure. Disclosure attachment is present when applicable.	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 9, Darfur Contracting Act Certification. Proposer is to either: (1) Indicate (N/A) if it has not had any business activities or other operations outside the U.S. within three years prior to the bid submission date, <u>OR</u> (2) Indicate (Yes) noting Attachment 10 is completed, signed and attached along with proof of DGS authorization to submit a bid.	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 12, Proposer Response Guide	☐ Yes ☐ No
☐ Yes ☐ N/A	Attachment 13, Conflict of Interest	☐ Yes ☐ No

Name of Bidding Firm:

Printed Name/Title:

Signature

Date:

Attachment 3**Business Information Sheet**

A signature affixed hereon and dated certifies compliance with all bid requirements. The signature below authorizes the State to verify the claims made on this form.

Name of Bidding Firm:		CA Corp. No. (If applicable)	Federal ID Number
Name of Principal (If not an individual):	Title:	Telephone Number	Fax Number
Street Address / P.O. Box		City	State Zip Code

Type of Business Organization / Ownership (Check all that apply)

Ownership ☐ Sole Proprietor ☐ Partnership ☐ Joint venture ☐ Association	Corporation ☐ Nonprofit ☐ For Profit ☐ Private ☐ Public	Governmental ☐ City/County, California State Agency, Federal Agency, State (other than California) ☐ Other: _____	Other Type of Entity ☐ Public or Municipal Corporation, School or Water District, California State College, University of California, Joint Powers Agency ☐ Auxiliary College Foundation ☐ Other: _____
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California Certified Small Business Status ☐ N/A ☐ Microbusiness ☐ Small business ☐ NVSA

☐ Certified By DGS Certification No: _____ Expiration Date: _____

If certified, attach a copy of certification letter. If an application is pending, date submitted to DGS: _____

Small Business Type (If applicable) ☐ N/A ☐ Services ☐ Non-Manufacturer ☐ Manufacturer

☐ Contractor (Construction Type): _____ ☐ Contractor's License Type: _____

Veteran Status of Business Owner ☐ N/A (not a veteran or not certified by DGS)

☐ Disabled Veteran Certified by DGS Certification No. _____ Expiration Date: _____

If certified, attach a copy of certification letter. If an application is pending, date submitted to DGS: _____

Disadvantaged Business Enterprise Status: ☐ N/A ☐ Approved by the Cal Trans, Office of Civil Rights.

Certification number issued by Cal Trans: _____ Expiration Date: _____

Race/Ethnicity of Primary Business Owner ☐ N/A (No single owner possess more the 50% ownership)

Owner's Ethnicity (check one) ☐ Asian-Indian ☐ Black ☐ Hispanic ☐ Native American ☐ Pacific-Asian ☐ Other _____	Owner's Race (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____	If Asian, Native Hawaiian or Pacific Islander (check one): ☐ Asian-Indian ☐ Japanese ☐ Cambodian ☐ Korean ☐ Chinese ☐ Laotian ☐ Filipino ☐ Samoan ☐ Guamanian ☐ Vietnamese ☐ Hawaiian ☐ Other _____
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Gender of Primary Business Owner ☐ N/A (Not independently owned) ☐ Male ☐ Female**Indicate possession of required licenses and/or certifications (if applicable):** ☐ N/A (None required)

Contractor's State Licensing Board No. PUC License Number Required Licenses/Certifications (If applicable)

CAL-T- _____

Signature _____ **Date Signed** _____

Printed/Typed Name _____ Title _____

Public Records Information

The above information is required for statistical reporting purposes. Completion of this form is mandatory. This information will be made public upon award of the contract and will be supplied to department contract staff, Department of General Services and possibly other public agencies. To access contract related records, contact the DHCS Contract Management Unit, 1501 Capitol Avenue, Suite 71-5195, MS 1403, P. O. Box 997413, Sacramento, CA 95899-7413 or call (916) 650-0150.

Attachment 4**Client References**

List 3 clients served in the past 5-years for which the bidding firm provided similar services. List the most recent first.

REFERENCE 1

Name of Firm

Street address

City

State

Zip Code

Contact Person

Telephone number
()

Dates of service

Value or cost of service

Brief description of service provided

REFERENCE 2

Name of Firm

Street address

City

State

Zip Code

Contact Person

Telephone number
()

Dates of service

Value or cost of service

Brief description of service provided

REFERENCE 3

Name of Firm

Street address

City

State

Zip Code

Contact Person

Telephone number
()

Dates of service

Value or cost of service

Brief description of service provided

If three references cannot be provided, explain why:

Attachment 5**RFP Clause Certification**

I, the official named below, Certify Under Penalty of Perjury that I am duly authorized to legally bind the prospective Contractor to the certification clauses located in the RFP section entitled, "Bidding Certification Clauses". This certification is made under the laws of the State of California.

Name of Bidding Firm (Printed)	Federal ID Number
By (<i>Authorized Signature</i>)	
Printed Name and Title of Person Signing	
Date Executed	Executed in the County of:

Attachment 6
Page 1

CCC 307 – CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

<i>Contractor/Bidder Firm Name (Printed)</i>	<i>Federal ID Number</i>
By (Authorized Signature)	
<i>Printed Name and Title of Person Signing</i>	
<i>Date Executed</i>	<i>Executed in the County of</i>

CONTRACTOR CERTIFICATION CLAUSES

1. **STATEMENT OF COMPLIANCE:** Contractor has, unless exempted, complied with the nondiscrimination program requirements. (GC 12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)
2. **DRUG-FREE WORKPLACE REQUIREMENTS:** Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:
 - a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.
 - b. Establish a Drug-Free Awareness Program to inform employees about:
 - 1) the dangers of drug abuse in the workplace;
 - 2) the person's or organization's policy of maintaining a drug-free workplace;
 - 3) any available counseling, rehabilitation and employee assistance programs; and,
 - 4) penalties that may be imposed upon employees for drug abuse violations.
 - c. Every employee who works on the proposed Agreement will:
 - 1) receive a copy of the company's drug-free workplace policy statement; and,
 - 2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: (1) the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (GC 8350 et seq.)
3. **NATIONAL LABOR RELATIONS BOARD CERTIFICATION:** Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court which orders Contractor to comply with an order of the National Labor Relations Board. (PCC 10296) (Not applicable to public entities.)
4. **CONTRACTS FOR LEGAL SERVICES \$50,000 OR MORE- PRO BONO REQUIREMENT:** Contractor hereby certifies that contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

(Continued on next page)

**Attachment 6
Page 2****CCC 307 - CERTIFICATION**

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lesser of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with State of California.

6. SWEATFREE CODE OF CONDUCT:

- a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.
- b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph a.

7. DOMESTIC PARTNERS: For contracts over \$100,000 executed or amended after January 1, 2007, the contractor certifies that contractor is in compliance with Public Contract Code section 10295.3.

NOTE: This form represents only the certification portion of the Contractor Certification Clauses (CCC). Additional information about contracting with the State appears in the full text of the applicable CCC. Visit this web site to view the entire document: <http://www.ols.dgs.ca.gov/Standard Language/default.htm>.

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 5/06)_DHCS

1	INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this fully completed form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement. NOTE: Governmental entities, federal, state, and local (including school districts), are not required to submit this form.								
2	PAYEE'S LEGAL BUSINESS NAME (Type or Print) _____ <table style="width: 100%;"> <tr> <td style="width: 50%;">SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)</td> <td style="width: 50%;">E-MAIL ADDRESS</td> </tr> <tr> <td>MAILING ADDRESS</td> <td>BUSINESS ADDRESS</td> </tr> <tr> <td>CITY, STATE, ZIP CODE</td> <td>CITY, STATE, ZIP CODE</td> </tr> </table>			SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS	MAILING ADDRESS	BUSINESS ADDRESS	CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS								
MAILING ADDRESS	BUSINESS ADDRESS								
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE								
3 PAYEE ENTITY TYPE CHECK ONE BOX ONLY	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): - 		NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.						
	<table style="width: 100%;"> <tr> <td style="width: 30%; vertical-align: top;"> ☐ PARTNERSHIP ☐ ESTATE OR TRUST </td> <td style="width: 70%; vertical-align: top;"> CORPORATION: ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) ☐ LEGAL (e.g., attorney services) ☐ EXEMPT (nonprofit) ☐ ALL OTHERS </td> </tr> </table>		☐ PARTNERSHIP ☐ ESTATE OR TRUST	CORPORATION: ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) ☐ LEGAL (e.g., attorney services) ☐ EXEMPT (nonprofit) ☐ ALL OTHERS					
☐ PARTNERSHIP ☐ ESTATE OR TRUST	CORPORATION: ☐ MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) ☐ LEGAL (e.g., attorney services) ☐ EXEMPT (nonprofit) ☐ ALL OTHERS								
	☐ INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: - 								
	(SSN required by authority of California Revenue and Tax Code Section 18646)								
4 PAYEE RESIDENCY TYPE	☐ California resident—qualified to do business in California or maintains a permanent place of business in California. ☐ California nonresident (see reverse side)—Payments to nonresidents for services may be subject to State income tax withholding. ☐ No services performed in California. ☐ Copy of Franchise Tax Board waiver of State withholding attached.								
5	I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.								
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) _____		TITLE _____						
	SIGNATURE _____	DATE _____	TELEPHONE () _____						
6	Please return completed form to: Department/Office: <u>Department of Health Care Services</u> Unit/Section: _____ Mailing Address: _____ City/State/ZIP: _____ Telephone: () _____ FAX: () _____ E-Mail Address: _____								

PAYEE DATA RECORD**STD. 204 (Rev. 5/06) DHCS**

1	Requirement to Complete Payee Data Record, STD. 204 A completed Payee Data Record, STD. 204, is required for payments to all non-governmental entities and will be kept on file at each State agency. Since each State agency with which you do business must have a separate STD. 204 on file, it is possible for a payee to receive this form from various State agencies. Payees who do not wish to complete the STD. 204 may elect to not do business with the State. If the payee does not complete the STD. 204 and the required payee data is not otherwise provided, payment may be reduced for federal backup withholding and nonresident State income tax withholding. Amounts reported on Information Returns (1099) are in accordance with the Internal Revenue Code and the California Revenue and Taxation Code.						
2	Enter the payee's legal business name. Sole proprietorships must also include the owner's full name. An individual must list his/her full name. The mailing address should be the address at which the payee chooses to receive correspondence. Do not enter payment address or lock box information here.						
3	Check the box that corresponds to the payee business type. Check only one box. Corporations must check the box that identifies the type of corporation. The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State provide their Taxpayer Identification Number (TIN). The TIN is required by the California Revenue and Taxation Code Section 18646 to facilitate tax compliance enforcement activities and the preparation of Form 1099 and other information returns as required by the Internal Revenue Code Section 6109(a). The TIN for individuals and sole proprietorships is the Social Security Number (SSN). Only partnerships, estates, trusts, and corporations will enter their Federal Employer Identification Number (FEIN).						
4	Are you a California resident or nonresident? A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California. A partnership is considered a resident partnership if it has a permanent place of business in California. An estate is a resident if the decedent was a California resident at time of death. A trust is a resident if at least one trustee is a California resident. For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident. Payments to all nonresidents may be subject to withholding. Nonresident payees performing services in California or receiving rent, lease, or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for State income taxes. However, no withholding is required if total payments to the payee are \$1,500 or less for the calendar year. For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below: <table border="0"> <tr> <td>Withholding Services and Compliance Section:</td> <td>1-888-792-4900</td> <td>E-mail address: wscs.gen@ftb.ca.gov</td> </tr> <tr> <td>For hearing impaired with TDD, call:</td> <td>1-800-822-6268</td> <td>Website: www.ftb.ca.gov</td> </tr> </table>	Withholding Services and Compliance Section:	1-888-792-4900	E-mail address: wscs.gen@ftb.ca.gov	For hearing impaired with TDD, call:	1-800-822-6268	Website: www.ftb.ca.gov
Withholding Services and Compliance Section:	1-888-792-4900	E-mail address: wscs.gen@ftb.ca.gov					
For hearing impaired with TDD, call:	1-800-822-6268	Website: www.ftb.ca.gov					
5	Provide the name, title, signature, and telephone number of the individual completing this form. Provide the date the form was completed.						
6	This section must be completed by the State agency requesting the STD. 204.						
Privacy Statement Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and State law imposes noncompliance penalties of up to \$20,000. You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the State agency(ies) with which you transact that business. All questions should be referred to the requesting State agency listed on the bottom front of this form.							

Attachment 8**Follow-on Consultant Contract Disclosure****Background Information:**

1. PCC Section 10365.5 generally prohibits a person, firm, or subsidiary thereof that has been awarded a consulting services contract from submitting a bid for and/or being awarded an agreement for, the provision of services, procurement of goods or supplies, or any other related action that is required, suggested, or otherwise deemed appropriate in the end product of a consulting services contract.
2. PCC Section 10365.5 does not apply to any person, firm, or subsidiary thereof that is awarded a subcontract of a consulting services agreement that totals no more than 10 percent of the total monetary value of the consulting services agreement.
3. Consultants/employees of a firm that provides consulting advice under an original consulting contract are not prohibited from providing services as employees of another firm on a follow-on contract, unless the persons are named contracting parties or named parties in a subcontract of the original contract.
4. PCC Section 10365.5 does not distinguish between intentional, negligent, and/or inadvertent violations. A violation could result in disqualification from bidding, a void contract, and/or imposition of criminal penalties.

Disclosure [Mark one (1) box]:

- ☐ I hereby certify that neither my firm nor any subcontractor that my firm intends to use under the contract resulting from this procurement, is currently providing consulting services to DHCS under a state contract (or as a subcontractor providing more than 10 percent of dollar value of a consulting service contract with DHCS) or has provided such services within five (5) years prior to the release of this RFP that are related in any manner to the services, goods, or supplies being acquired pursuant to this DHCS RFP. **[Sign below.] This option is likely to apply to bidding firms that do not currently and/or never have provided consultant services to DHCS.**
- ☐ Attached is a disclosure of current and/or prior consulting services provided by my firm or a proposed subcontractor to DHCS under a state contract within five (5) years prior to the release of this DHCS RFP that may be related in some manner to the services, goods, or supplies being acquired pursuant to this DHCS RFP. **[Sign below and attach to this document a detailed disclosure.]**

Name of Bidding Firm

Signature

Date Signed

Printed/Typed Name

Title

Attachment 9**Darfur Contracting Act Certification**

Public Contract (PCC) Code Sections 10475 -- 10481 applies to any company that currently has or within the previous three years has had business activities or other operations outside of the United States. For such a company to bid on or submit a proposal for a State of California contract, the company must certify that it is either (A) not a scrutinized company; or (B) a scrutinized company that has been granted permission by the Department of General Services to submit a bid or a proposal.

A Bidding Firm that does not currently have, and has not had within the previous three years, business activities or other operations outside of the United States does not need to complete or return this form.

A “scrutinized” company is one that does business in the African nation of Sudan (of which the Darfur region is a part). As defined in PCC Section 10476, a "scrutinized company" means a company in Sudan that is involved in power production activities, mineral extraction activities, oil-related activities, or the production of military equipment, but excludes a company that can demonstrate any of the conditions specified in PCC Section 10476 subsections (a) through (g).

Completion Instructions:

1. Mark/check one (1) box to describe the Bidding Firm’s compliance with the Darfur Contracting Act.
2. Collect the signature of a person authorized to bind the Bidding Firm to the claim made below.
3. Return the completed/signed attachment with the bid/proposal response per bid instructions. If applicable, attach a copy of the written permission issued by the Department of General Services.

Bidding Firm’s Claim (Check One):

- ☐ The Bidding Firm currently has, or has had within the previous three years, business activities or other operations outside of the United States. However, the Bidding Firm claims it is not a “scrutinized” company as defined in Public Contract Code section 10476.

OR

☐ The Bidding Firm claims it is a “scrutinized” company as defined in Public Contract Code section 10476, but the bidding firm has received written permission from the Department of General Services (DGS) to submit a bid or proposal pursuant to Public Contract Code section 10477(b).
Include a copy of the written permission issued by the Department of General Services with this attachment.

Certification

I, the official named below, am duly authorized to legally bind the Bidding Firm to the claims made herein. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Printed Name of Bidding Firm		Federal ID Number
By (Authorized Signature)		Date Executed
Printed/Typed Name	Title	

Voluntary Letter of Intent

Purpose	This is a non-binding Letter of Intent whose purpose is to assist DHCS in determining the staffing needs for the proposal evaluation process and to improve future procurements.
Information requested	DHCS is interested in knowing if your firm intends to submit a proposal or your reasons for not submitting a proposal. Completion of this form is voluntary.
Action to take	Indicate your intention to submit a proposal by checking items 1 or 2 below. Follow the instructions below your selection.

1. ☐ **My firm intends to submit a proposal.**

- A. Check box number 1 if the above statement reflects your intention.
- B. Complete the bottom portion of this form and return it to DHCS as instructed in the RFP section entitled, Voluntary Non-Binding Letter of Intent".

2. ☐ **My firm does not intend to submit a proposal for this project.**

- A. Check box number 2 if the statement in item 2 reflects your intention.
- B. Indicate the reason(s) for not submitting a proposal by checking each of the following statements that apply.
- ☐ My firm lacks sufficient staff expertise or personnel resources to meet all RFP requirements.
 - ☐ My firm lacks sufficient experience (i.e., not enough or wrong type).
 - ☐ My firm believes the qualification requirements are too restrictive.
 - ☐ Insufficient time was allowed for proposal preparation.
 - ☐ Too much paperwork is required to prepare a proposal response.
 - ☐ Other commitments and projects have a greater priority.
 - ☐ My firm did not learn about the contract opportunity soon enough.
 - ☐ My firm does not provide the full range of services that DHCS is seeking.
 - ☐ My firm is only interested in becoming a subcontractor, consultant, or supplier.
 - ☐ My firm cannot meet the DVBE requirements - we do not wish to subcontract any work out.
 - ☐ Too much effort and/or paper work is required to meet California DVBE requirements.
 - ☐ Insufficient time was allowed for DVBE compliance.
 - ☐ Other reason: _____

- C. Complete the bottom portion of this form and return it to DHCS as instructed in the RFP section entitled, Voluntary Non-Binding Letter of Intent".
- D. By indicating there is no intention to submit a proposal, DHCS may elect not to send your firm RFP clarification notices, RFP addenda, proposer questions and answers, or other procurement notices.

Name of Firm: _____

Printed Name/Title: _____

Signature: _____

Date: _____

Request for Inclusion on Mailing List

The Department of Health Care Services (DHCS) will continue to provide automatic updates about RFP 10-87242 only to prospective Proposers who complete and return this form. DHCS is in the process developing a mailing list and asks Prospective Proposers interested in receiving updates and notifications about this solicitation to complete this attachment with the appropriate information in order to be added to the mailing list established for this solicitation. This mailing list is separate from the Bidders/Proposers List.

In order to continue to receive updated information relevant to the RFP identified herein, please return this form as soon as possible via mail, FAX or email using the one of the methods identified below.

It is incumbent upon any Proposer who does not submit a Request for Inclusion on Mailing List, but intends to bid on this contract, to monitor the Office of Medi-Cal Procurement website at http://www.dhcs.ca.gov/ProvGovPart/rfa_rfp/Pages/OMCPHomePage.aspx for the latest solicitation information, any Administrative Bulletins, RFP addenda updates, or other relevant information related to the RFP referenced above.

Submit this attachment to DHCS using one of the methods identified below. Confirm the submission due date by checking the RFP Time Schedule.

Name of Firm or Individual desiring Inclusion on Mailing List

Name Contact Person	Telephone number ()	Fax number
Title of Contact Person	Email address (if applicable)	

Proposer Response Guide

The Proposer Response Guide is a document which identifies where a Proposer has provided information that fully explains details or otherwise provides information that will enable evaluators to make an informed evaluation of the proposal for a specific evaluation question. Each narrative question is identified by the number corresponding to an evaluation question. Space is provided to identify the location of your response within your proposal. The Department is not dictating the format of your response, but your response should identify where the information may be found so that effective identification may be allowed. There is no limitation to the number of cites to which you direct an evaluator.

The Department recognizes that certain questions are more general to the overall information presented. It is appropriate to identify your response as a "General Response" or a "General Response of Section (i.e. L.2.a)..." as you deem appropriate.

Executive Summary

Question #

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Firm's Capability

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Work Plan

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Management Plan

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Project Personnel

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Facilities and Resources

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Conflict of Interest Compliance Certificate

- A. The Department of Health Care Services (DHCS) intends to avoid conflicts of interest or the appearance of conflicts of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information received from any source indicates the existence of a conflict of interest.
- B. Either of the following instances would be considered a "conflict of interest", including, but not limited to:
1. An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the contract.
 2. An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.
 3. Any other conflict of interest identified in federal or State statute or regulation.
- C. If the Proposer or any proposed subcontractor has a suspected or potential conflict of interest, the Proposer or proposed subcontractor shall attach to this form a description of the activity, a plan for ensuring that the activity will not adversely affect DHCS, and procedures to guard against the existence of an actual conflict of interest. Based on that information, and any other information DHCS may require, DHCS will determine whether a conflict of interest exists and whether it can be resolved to the satisfaction of DHCS.
- D. The Proposer shall place this Certificate in the Appendix Section of its proposal response. This Certificate shall bear the original signature of an official or employee of the Proposer who is authorized to bind the Proposer.
- E. This Certificate will be incorporated into the contract, if any, awarded from this RFP. It is understood that the requirements set forth in this Certificate shall be in effect for the entire term of the contract.
- F. The Contractor shall obtain a completed Certificate from any proposed subcontractor and submit it to DHCS prior to approval of the subcontractor by DHCS.

The Proposer or Contractor and each subcontractor shall notify DHCS, Administrative Services Unit, MS 4612, P.O. Box 997413, Sacramento, CA 95899-7413, within ten (10) working days of any change to the information provided on or attached to this Certificate.

- G. If DHCS becomes aware of a suspected or potential conflict of interest, the Proposer or Contractor or subcontractor will be given an opportunity to submit additional information as described in Paragraph C above or to resolve the conflict. The Proposer or Contractor or subcontractor will have five (5) working days from the date of notification of the conflict by DHCS to provide complete information regarding the conflict. If DHCS determines that a conflict of interest exists and it cannot be resolved to the satisfaction of DHCS, before or after the award of the contract, the conflict will be grounds for the proposal to be deemed non-responsive and/or termination of the contract or subcontract.

Conflict of Interest Compliance Certificate

The undersigned hereby affirms that: (check one)

- ☐ The statements above have been read and that no conflict of interest exists that would jeopardize the ability of the Proposer/Contractor to perform independently from DHCS influence.
- ☐ A suspected or potential conflict of interest does exist, and additional information (as described B.3. above) is attached along with a plan to address the possible conflict of interest.

Signed: _____ **Title:** _____ **Date:** _____

Typed or Printed Name of Authorized Representative: _____

STANDARD AGREEMENT

Sample Exhibit A1

STD 213_DHCS (1/08)

REGISTRATION NUMBER

AGREEMENT NUMBER

10-87242

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME

(Also known as DHCS, CDHS, DHS or the State)

Department of Health Care Services

CONTRACTOR'S NAME

(Also referred to as Contractor)

2. The term of this through Agreement is:

3. The maximum amount \$ of this Agreement is:

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	14 pages
Exhibit B - Attachment	3 pages
Exhibit C * – General Terms and Conditions	GTC610
Exhibit D (F) – Special Terms and Conditions	26 pages
Exhibit E – Additional Provisions	17 pages
Exhibit F HIPAA Agreement	9 pages
Exhibit G – HIPPA Business Associate Addendum	3 pages

See Provision 1 of Exhibit E for additional incorporated exhibits.

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto. These documents can be viewed at <http://www.ols.dgs.ca.gov/Standard+Language>.

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

CONTRACTOR

CONTRACTOR'S NAME (if other than an individual, state whether a corporation, partnership, etc.)

BY (Authorized Signature)

DATE SIGNED (Do not type)

PRINTED NAME AND TITLE OF PERSON SIGNING

ADDRESS

STATE OF CALIFORNIA

AGENCY NAME

Department of Health Care Services

BY (Authorized Signature)

DATE SIGNED (Do not type)

PRINTED NAME AND TITLE OF PERSON SIGNING

Karen Johnson, Chief Deputy Director, Policy and Program Support

ADDRESS

1501 Capitol Avenue, Suite 71.6001, MS 0003, P.O. Box 997413,
Sacramento, CA 95899-7413**California Department of
General Services Use Only**☐

Exempt per: W&I Code Section

**Recovery Audit Contractor
RFP# 10-87242
SAMPLE**

**EXHIBIT A
Scope of Work**

A. Purpose

The Recovery Audit Contractor (RAC) Program's mission is to reduce Medi-Cal improper payments through the efficient detection and collection of overpayments, the identification of underpayments, the reporting of fraudulent and/or criminal activities, and the implementation of actions that will prevent future improper payments.

The purpose of the contract will be to support California Department of Health Care Services (DHCS) in completing this mission. The identification of underpayments and overpayments and the recoupment of overpayments will occur for claims paid under the Medi-Cal program for services for which payment is made under Title XIX of the Social Security Act.

This contract includes the identification and recovery of claims based on improper payments.

This contract shall include the following tasks, which are defined in detail in subsequent sections of this contract:

1. Identifying Medi-Cal claims that contain underpayments for which payment was made under Section 1902(a) of the Social Security Act.
2. Identifying Medi-Cal claims that contain overpayments for which payment was made under Section 1902(a) of the Social Security Act.
3. For any RAC-identified overpayment that is appealed by the provider, the RAC shall provide support to DHCS throughout the administrative appeals process and, where applicable, a subsequent appeal to an appropriate court.
4. Performing the necessary provider outreach to notify provider communities of the RAC's purpose and direction.

Note: The proactive education of providers about Medi-Cal coverage and coding rules is not a task under this RAC Scope of Work. DHCS has tasked the Fiscal Intermediary (FI) with the proactively educating providers about how to avoid submitting a claim containing a request for an improper payment.

B. Task 1 - Specific Tasks

Independently and not as an agent of the State, the Contractor shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by the State as needed to perform the Scope of Work.

DHCS will provide minimum administrative support which may include standard system changes when appropriate, policy interpretations as necessary and other support deemed necessary by DHCS to allow the RAC to perform its tasks efficiently. DHCS will support changes it determines are necessary but cannot guarantee timeframes or constraints. In changing systems to support greater efficiencies for the State, the end product could result in an administrative task being placed on the RAC that was not

Recovery Audit Contractor
RFP# 10-87242
SAMPLE

EXHIBIT A
Scope of Work

previously noted in the contract. These administrative tasks will not constitute additional work, and will be applicable to the identification and recovery of the improper payment.

1. General Requirements

a. Project Plan

RAC key project staff (Project Director, Medical Director, key staff) shall meet with DHCS staff within four (4) weeks of the date of award to discuss the project plan. Within two (2) weeks of the meeting, the RAC will submit a formal written project plan which outlines:

- 1) Resources
- 2) Work plan
- 3) Field Audit Procedures
- 4) Outreach and Education Plan
- 5) RAC Org Chart

b. Monthly Conference Call

- 1) DHCS and RAC key project staff will participate in a monthly conference call to discuss progress of work, evaluate/identify potential problems, and discuss upcoming work plan tasks
- 2) Monthly call between key RAC staff and DHCS to discuss project findings and any suggestions for DHCS that will improve accurate claims payments.
- 3) DHCS to prepare agenda and other materials as necessary.

c. Quarterly Progress Reports

RAC will submit quarterly administrative progress reports outlining work accomplished during the previous months. Reports to include:

- 1) Complications in completing any tasks.
- 2) Update of Project Plan.
- 3) Updating Provider Plan.

d. DHCS obligations

- 1) DHCS will train RAC staff in all aspects of DHCS audit policies and procedures and rules and regulations of the Medi-Cal Program.
- 2) DHCS will designate a point of contact for the RAC contractor who will coordinate any training and.
- 3) DHCS will respond to any issues presented by RAC staff.

2. RAC Staff Requirements

RAC contractor shall employ one (1) FTE Medical Director on staff. The Medical Director must be a Doctor of Medicine or a Doctor of Osteopathy in good standing, board certified and licensed to practice medicine in California and the United States,

**Recovery Audit Contractor
RFP# 10-87242
SAMPLE**

**EXHIBIT A
Scope of Work**

who has relevant work and educational experience. The RAC shall arrange for an alternate when the Medical Director is unavailable for extended periods. More than one (1) individual's time cannot be combined to meet the one (1) FTE minimum.

a. Relevant Work Experience

- 1) Experience practicing medicine as a board certified doctor of medicine or osteopathy or doctor who is currently licensed.
- 2) Prior experience in the health care industry, utilization review firm or health care claims processing organization.
- 3) Knowledge of the Medi-Cal program especially in coverage and payment rules.
- 4) Experience in working with physician groups or beneficiary organizations.

b. Other Required Staff

- 1) Certified Coders
- 2) Registered Nurses
- 3) Statistician (If extrapolation is used.)

3. RAC Location Requirements

The RAC must maintain a functioning headquarters office within the State of California, which must be staffed by the Medical Director, Nurses, and Certified coders. Any work done for the purpose of identifying improper payments as it pertains to this contract shall be done within the jurisdiction of the United States. Work done outside of the jurisdiction of the United States will be deemed insufficient and compensation will be forfeited.

C. Data Accessibility

1. Data Scope

The RAC will receive raw claim data from DHCS for the purpose of identifying improper payments as set forth within this SOW. The scope of data received by the RAC shall be determined and amended at the sole discretion of DHCS. The RAC shall not use any data source other than provided by DHCS to identify improper payments.

The RAC will be charged with reviewing post-payment claims submitted by fee-for-service providers in the Medi-Cal program. Initially, the RAC will review claims submitted by Ambulance Service Providers, Non-Contract Hospital Providers, Optometry Providers, Podiatry Providers, and Speech Therapist Providers.

2. Data Delivery Method

The RAC will receive data sets of differing sizes on an ongoing monthly basis. The data sets may be delivered in multiple formats. The data sets may be delivered on a

Recovery Audit Contractor
RFP# 10-87242
SAMPLE

EXHIBIT A
Scope of Work

CD, a hard drive, through secure email, or through any other method agreed upon by DHCS and the RAC. The file format may consist of, but will not be limited to, Microsoft Excel, Microsoft Access, or SAP Business Objects. The RAC must have the technical capabilities to accept all data files and formats submitted by DHCS. The RAC may request, in writing, additional or reduced data submission from DHCS. Requests will be granted at the sole discretion of DHCS.

3. Health Insurance Portability and Accountability Act (HIPAA)

The transfer of information shall be in accordance with HIPAA. The RAC shall comply with the Privacy and Security Rules of HIPAA.

For more information regarding HIPAA please refer to:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html>

D. Task 2 - Identification of Improper Payments

1. Post Payment Claims

The RAC shall only review post payment claims paid to providers of services or other individuals furnishing items and services for which payment has been made under Section XIX of the Social Security Act.

2. Excluded Claims

The RAC may not attempt to identify improper payments arising from any of the following:

- a. Services provided under a program other than Medi-Cal Fee-For-Service
- b. Cost report settlement process
- c. Claims more than 3 years past the date of the initial determination

The RAC shall not attempt to identify any improper payment more than 3 years past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date.

Any improper payment inadvertently identified by the RAC before this timeframe shall be set aside. The RAC shall take no further action on these claims.

Note: DHCS reserves the right to limit the time period available for the RAC to review by region, by claim type, by provider type, or by any other reason where DHCS believes it is in the best interest of the Medi-Cal program to limit claim review. This notice will be in writing, may be by email and will be effective immediately.

- d. Claims where the beneficiary is liable for the overpayment because the provider is without fault with respect to the overpayments.

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- e. Random Claim Review selection
- f. Prior Authorization
- g. Prepayment Review
- h. Previously Reviewed Claims

3. Claim Review Process

- a. Types of Determinations a RAC may make
 - 1) Coverage Determination
 - a) Be included in one of the benefit categories described in Title XIX of the Act;
 - b) Be reasonable and necessary under Title XIX of the Act. The RAC shall consider a service to be reasonable and necessary if the RAC determines that the service is:
 - i. Safe and effective;
 - ii. Not experimental or investigational; and
 - iii. Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
 - A. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
 - B. Furnished in a setting appropriate to the patient's medical needs and condition;
 - C. Ordered and furnished by qualified personnel;
 - D. One that meets, but does not exceed, the patient's medical need; and
 - E. At least as beneficial as an existing and available medically appropriate alternative.
 - 2) Coding Determination
 - a) The RAC may find full or partial overpayment exists if the service is not covered.
 - b) The RAC may find that an improper payment exists if the service is not correctly coded.

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3) Other Determinations

a) Errors

The RAC may determine that an improper payment exists if the claim was paid twice (i.e., a "duplicate claim"), was priced incorrectly, or the claims processing contractor did not apply a payment policy.

b) Extrapolation

The RAC may use extrapolation principles in data analysis for identify potential error. However, a certified statistician must be on staff and used as part of the team developing the extrapolation principles if the RAC wishes to utilize extrapolation principles.

b. Good Cause

The RAC shall document "Good Cause" for performing a claim review.

The determination of "good cause" shall be made based upon that standard set forth here:

Good Cause means fair and honest reasons, regulated by good faith on the part of the RAC, that are not trivial, arbitrary, or capricious, and unrelated to business needs or goals. A reasoned conclusion, in short, supported by substantial evidence gathered through an adequate investigation. (Cotran v. Rollins Hudig Hall Int'l, Inc. (1998) 17 Cal.4th 93, 108)

Good Cause shall be documented and held with any other supporting documentation for the reviewed claim.

c. Medi-Cal Policies and Articles

The RAC shall comply with all Medi-Cal policies and articles.

d. Internal Guidelines

As part of its process of reviewing claims for coverage and coding purposes, the RAC shall develop detailed written review guidelines. For the purposes of this SOW, these guidelines will be called "Internal Guidelines." Internal Guidelines shall specify what information should be reviewed by reviewers and the appropriate resulting determination. The RAC must make their Internal Guidelines available to DHCS upon request. Internal Guidelines shall not create or change policy.

e. Administrative Relief from Review in the Presence of Disaster

Administrative relief from review may be given in the event of a natural disaster.

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f. Evidence

The RAC shall only identify improper payments where there is viable evidence of an improper payment. There are two ways to determine an improper payment: Automated and Complex review.

1. Automated Review

Occurs when a RAC makes a claim determination at the system level without a human review of the medical record. An Automated Review may be used when making Coverage/Coding Determinations when BOTH of the following are true:

- a) There is certainty that the service is not covered and;
- b) A written Medi-Cal policy, Medi-Cal article or Medi-Cal sanctioned coding guideline exists.

2. Complex Review

- a) Occurs when a RAC makes a claim determination using human review of medical records.
- b) The RAC may use Complex Review when the criteria for Automated Review are NOT met.
- c) Copies of the medical records will be needed to support any adverse determinations.

4. Individual Claim Determinations

The term "individual claim determination" refers to a complex review performed by the RAC in the absence of a written Medi-Cal policy, article, or coding statement. When making individual claim determinations, the RAC shall utilize appropriate medical literature and apply appropriate clinical judgment. The RAC shall consider the broad range of available evidence and evaluate its quality before making individual claim determinations. The RAC shall ensure that their Medical Director is actively involved in examining all evidence used in making individual claim determinations and acting as a resource to all reviewers making individual claim determinations.

5. Staff Performing Complex Coverage/Coding Reviews

When performing Complex Reviews the RAC shall ensure that coverage/medical necessity determinations are made by medical professionals and that coding determinations are made by certified coders.

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6. Timeframes for completing Complex Coverage/Coding Reviews

When Complex Reviews are required, the RAC will have 60 days from the receipt of medical records to make a determination. The RAC is allowed to request one (1) extension of up to 30 days for completion. The extension must be approved by DHCS staff and, if approved, the RAC shall notify the provider in writing of the extension.

7. Potential Fraud

The RAC shall report instances of potential fraud immediately, and seize all review activities.

8. Re-Opening of denied claims

DHCS may request that the RAC re-open a denied claim, if the denial is based on a failure to submit medical records.

E. Task 3 - Activities Following a Review

1. Rationale for Determination

The RAC are required to document the rationale for each determination. The rationale shall list, in detail, the review finding as well as the Medi-Cal policy or rule that was violated.

The RAC shall make the rationale documents available to any official Local, State, or Federal Agency upon request.

The RAC shall follow these Records Retention Standards when housing the rationale documents:

- a. RAC staff shall provide a document management system that meets DHCS requirements.
- b. Documents containing Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA) shall be stored in a secure location.
- c. All Rational documents must be kept for the duration of the contract. At the end of the contract all files shall be sent to DHCS.

2. Validation Process

- a. Validating the Issue

All determinations that result in an adjustment will be reviewed and approved by DHCS.

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b. Communication with Providers

The RAC must receive prior approval before initial contact is made with a provider. The RAC shall set up an entrance and exit conference with the provider. The RAC shall compile and maintain a list of provider approved points of contact. The RAC will inform DHCS ten (10) business days prior to the date of each conference. DHCS reserves the right to participate in any interaction between the RAC and a provider.

The RAC may not communicate results of the review to the provider. Any communication about determinations will be the sole responsibility of DHCS.

3. Determination of Overpayment

a. Full Denials

A full denial occurs when the RAC determines that:

- 1) The submitted service was not reasonable and necessary and no other service (for that type of provider) would have been reasonable and necessary, or
- 2) No service was provided.
- 3) The overpayment amount is the total paid amount for services in question.

b. Partial Denials

A partial denial occurs when the RAC determines that:

- 1) The submitted service was not reasonable and necessary but a lower level service would have been reasonable and necessary, or
- 2) The submitted service was upcoded (and a lower level service was actually performed) or an incorrect code (such as discharge status code) was submitted that caused a higher payment to be made.

c. RAC Claim Database

The RAC shall maintain and keep up-to-date a database to include:

- 1) The improper payment amount for each claim in question;
- 2) Line level claim detail;
- 3) Any communication with the provider
- 4) Approved provider points of contact
- 5) Any other information that may be useful during an appeal or audit

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4. Preventing Overlap

In order to minimize the impact on the provider community, it is critical that the RAC avoids situations where the RAC and another entity are working on the same claim.

a. Preventing Overlap

Preventing RAC overlap with contractors, DHCS, The Centers for Medicare and Medicaid Services (CMS), The Office of General Counsel (OGC), The Department of Justice (DOJ), The Office of the Inspector General (OIG) and/or other law enforcement entities performing potential fraud reviews.

RAC activities shall not interfere with potential fraud reviews being conducted by Local, State or Federal entities or with potential fraud investigations being conducted by law enforcement. The RAC must receive prior approval before initial contact is made to a provider. All Local, State and Federal agencies take precedence over any audit being conducted by the RAC unless otherwise stated, in writing, from any Local, State or Federal agency and with approval from DHCS.

b. DHCS Responsibilities

DHCS will provide support, as needed, in the prevention of duplicate work. DHCS will attempt to provide the RAC with the most up-to-date information in order to prevent overlapping work. It is the ultimate responsibility of the RAC to ensure that they do not interfere with any Local, State, or Federal agency performing an investigation or audit.

5. Obtaining and Storing Medical Records for reviews

- a. Whenever needed for reviews, the RAC may obtain medical records by going onsite to the provider's location to view/copy the records or by requesting that the provider mail/fax or securely transmit the records to the RAC.
- b. In an effort to limit the burden to the provider community, the RAC will have one (1) opportunity to request and obtain medical records. Any additional request for medical records from the same provider must be approved by DHCS. DHCS may allow up to two (2) more requests for medical records for the same claim. Requests must be submitted in writing to DHCS.
- c. When requesting medical records the RAC shall use discretion to ensure the number of medical records in the request is not negatively impacting the provider's ability to provide care. The RAC shall only request medical records that are necessary for an efficient review of the claims.
- d. The RAC must accept electronic medical records on CD/DVD or via facsimile at the provider's request.

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- e. If the RAC attempts an onsite visit and the provider refuses to allow access to their facility, the RAC must contact DHCS RAC Audit Coordinator immediately.
- f. When onsite review results in an improper payment finding, the RAC shall copy the relevant portions of the medical record and retain them for future use.
- g. When an onsite review results in no finding of improper payment, the RAC need not retain a copy of the medical record.

F. Task 4: Underpayments

The RAC will review claims, using automated or complex reviews, to identify potential Medi-Cal underpayments. On a monthly basis the RAC will communicate underpayment findings to DHCS. This communication shall be separate from the overpayment communications.

After receipt DHCS, along with the Fiscal Intermediary (FI), will validate all underpayment findings. If necessary, the RAC shall share any documentation supporting the underpayment determination with DHCS and the FI. DHCS will make all final underpayment determinations.

For purposes of the RAC program, a Medi-Cal underpayment is defined as those lines or payment group on a claim that was billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group. Service lines or payment groups that a provider failed to include on a claim are NOT considered underpayments for the purposes of the program.

1. Reporting Underpayments

On a monthly basis the RAC shall submit a report to DHCS listing all underpayments the RAC identified during the month. The report shall include the claim number, the provider number, the claim paid date(s), the original amount paid and the reason for the underpayment. This reporting will be separate from the reporting of overpayments.

2. RAC Claim Database

The RAC shall input the underpayment information into the RAC Claim Database. The RAC shall keep an accurate and up-to-date Database of underpayments to assist DHCS in any way necessary.

3. Provider Inquiries

The RAC will have no responsibility to accept case files from providers for an underpayment case review. If case files are received from providers that were not

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requested by the RAC, the RAC must return the files to the provider and inform them to contact DHCS for standard instructions on such requests.

4. Medical Record Requests

The RAC may request medical records for the sole purpose of identifying an underpayment. If required, the RAC will pay for all medical record requests, regardless of if an underpayment is determined.

G. Task 5: Recoupment of Overpayments

DHCS will pursue the recoupment of the Medi-Cal overpayments. DHCS will send notification to the effected provider. The RAC shall not communicate any determination to the provider.

H. Task 6: Supporting DHCS in the Medi-Cal Appeal Process

Providers are given appeal rights for the majority of Medi-Cal overpayments determined during the post payment review process. If a provider chooses to appeal an overpayment determination, the RAC shall assist DHCS with throughout all levels of the appeal.

This includes providing supporting documentation (including the medical records) with appropriate reference to Medi-Cal statutes, regulations, manuals and instructions when requested, providing assistance, and representing DHCS at any hearings associated with the overpayment when requested by DHCS.

Providers shall request an appeal through the appropriate Medi-Cal appeals process. A third party shall adjudicate all appeal requests related to provider overpayments identified by the RAC. This third party may be a third party contractor identified by DHCS, a Qualified Independent Contractor, an Administrative Law Judge, or DHCS' Departmental Appeals Board's Medi-Cal Appeals Council. Some recovery claims may eventually be appealed to the appropriate State court.

If the RAC receives a written appeal request it shall forward it to the DHCS RAC Audit Coordinator within one business day of receipt. If the RAC receives a verbal request for appeal from a provider, the RAC shall give the provider the telephone number of the appropriate DHCS contact and inform them that their verbal request does not suspend the permissible time frame for requesting an appeal as set forth in the demand letter. The appropriate third party contact will notify the RAC and DHCS of the appeal request and the outcome of each applicable appeal level.

I. Task 7: Reporting

The RAC is required to:

1. Submit an initial Project Plan within two (2) weeks of the award as stated in Task 1

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2. On a monthly basis facilitate 1 conference call as stated in Task 1
3. Submit quarterly progress reports as stated in Task 1
4. Submit a monthly report of underpayment findings as stated in Task 4
5. Create a RAC Claim Database that is up-to-date with information on underpayments, overpayments, correspondents with providers, and any other information useful for DHCS during appeals and/or other audits.

J. Task 8: Administrative and Miscellaneous Tasks

1. Administrative Functions

Once the RAC has identified an overpayment, the RAC shall send DHCS written notification with accompanying evidence.

2. Separate Reporting

The reporting and data collection/analysis of each of the major tasks must be kept separate and submitted in the appropriate format.

3. Point of Contact for RAC

The primary point of contact for the RAC shall be the DHCS RAC Audit Coordinator or his/her delegate.

4. Recalled Cases

DHCS may determine that a case should be handled by DHCS staff and may recall the case for that reason. Should DHCS recall a case, the RAC shall immediately stop all activities on the case identified by DHCS for recall and return the case and all related information and materials to DHCS within five (5) business day of the recall request.

The RAC shall receive no payment for recalled cases.

5. Case Record Maintenance

The RAC shall maintain a case file for every improper payment that is identified. This file shall include documentation of all processes followed by the contractor including a copy of all correspondence. The case file may be electronic, paper or a combination of both. For electronic files, the case file shall be easily accessible and made available within 48 hours of request. At DHCS' request or no later than thirty (30) days after contract termination, the RAC shall return to DHCS all case files stored in accordance with DHCS instructions. Once an improper payment is determined all documentation shall be kept in the case file. The RAC shall not

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destroy any supporting documentation relating to the identification or recovery process. All files shall be transferred to DHCS at the termination of the contract.

All case files shall meet the standards issued by the State Administrative Manual (SAM), which can be found online at <http://sam.dgs.ca.gov/TOC/1600/default.htm>.

6. Recovery Deposits

The demand letters issued by DHCS will instruct debtors to forward their refund checks to the appropriate address at the applicable Medi-Cal FI. All refund checks shall be payable to the Medi-Cal program. If the RAC receives a refund check, the RAC shall forward the check to the appropriate address. Before forwarding the check, the RAC shall make copies of and otherwise document these payments. A copy shall be included in the appropriate overpayment case file.

7. Support OIG or Other Audits

Should the OIG, CMS or a DHCS authorized contractor choose to conduct an audit of the RAC, the RAC shall provide workspace and produce all needed reports and case files within 10 business day of the request.

8. RAC Availability

The RAC shall provide a toll free number and be available during normal business hours to assist with provider inquiries. The toll free number must be included in any correspondence between the RAC and a provider. The RAC shall log phone calls in the RAC database and include:

- a. Caller name, title, and organization
- b. Date and time of call
- c. Nature of the request
- d. The RAC response to the question/grievance

9. Public Relations & Outreach

DHCS and the RAC will work jointly to create an education and outreach program for the provider community. The RAC will be required to assist DHCS in any outreach activities at the request of DHCS. The RAC may be asked to perform independent education and outreach in conjunction with the joint DHCS/RAC efforts.

10. Quality Assurance (QA)

The RAC shall have, in place, a quality assurance program.

- a. RAC shall have internal QA procedures.
- b. RAC shall have Quality Control activities to ensure the highest form of program integrity exists
- c. RAC shall have specific program controls designed for this project.

EXHIBIT B
Cost and Payment Provisions**1. Audited Case Submission**

- A. Audited cases submitted to DHCS for determination and potential collection are the basis for DHCS establishing a claim for the contractor. In an agreed upon format, the contractor shall supply case information, as needed, to support tracking and the transformation of a submitted case to a claim, thereafter referred to as a claim.

Information is to be electronically submitted, or in an agreed upon format between by the Contracting Officer and Contractor:

- B. The Audited Cases Submissions must include, at a minimum, the following:

1. Contracting Officer/A &I
California Department of Health Services
Audits and Investigations
P.O. Box XXXX, MS XXXX
Sacramento, CA 958XX-XXXX
2. Bear the Contractor's name as shown on the agreement.
3. Include the contract agreement number.
4. Identify the month the Audited Case was submitted.
5. Including the following itemized information:
 - a) Medi-Cal provider's business name;
 - b) Provider number;
 - c) Authorizing physician (if appropriate);
 - d) Patient name;
 - e) Medi-Cal ID Number;
 - f) All adjustments made including adjustment amounts, original billing date and original claim number.
 - g) Any supporting documentation, as may be required.

- C. A monthly summary report of Audited Case Submission with details of the contents to be agreed a upon.

- D. On a monthly basis a report expenses attributed to Disabled Veteran Business Enterprise (DVBE) subcontractors or DVBE suppliers at any tier (if any).

- E. Certify that applicable requirements for performance have been met.

2. Payment of Claims

- A. Upon receipt of an audited case, the State agrees to establish a potential claim for compensation account for the Contractor.

- B. The potential claim for the compensation accounts will include either:

1. Overpayments to be recovered on behalf of the State, or

EXHIBIT B
Cost and Payment Provisions

2. Underpayments to be refunded to providers under this contract agreement.
- C. Upon determination of a potential claim DHCS will provide the contractor a determination of the identified claim and line item as:
 1. recovered /paid;
 2. denied;
 3. modified and amount recovered /paid.
- A. Claims will be reconciled against the Department's deposit listings, authorized provider refunds for authorized or authorized Department offsets of the provider's payments (Payments for Underpayments) prior to authorizing payment.
- B. No payment for any claim shall be authorized for an overpayment until collection from the provider has been made by the Department or the Department has authorized a refund to the Provider for an identified underpayment.
- C. Contractor payments will be made monthly in arrears based on a percentage of the amount recovered or as a percentage of the amount refunded to a provider.
- D. Monthly claims will be paid after approval and evaluation of the Contractor's performance. Payments will be made to the Contractor on the basis of recovery or refund on the month follow recovery/payment.

3. Rates Payable

Contractor will be reimbursed for services satisfactorily performed based on the following:

- A. For the recovery of Medi-Cal overpayments, including but not limited to, billing or coding errors, the Contractor is to receive 12.5% (twelve and one half percent) of each provider identified dollar recovered.
- B. For each provider identified underpayment dollar returned to a provider the contractor shall be paid 10% (ten percent) of the underpayment amount.
- C. Overpayment is defined as the identification and recovery of payments to the provider to which they were not entitled. The overpayments may be defined as but not limited to:
 1. Incorrect payment amounts
 2. Non-covered services
 3. Incorrectly coded services
 4. Duplicate services
 5. Medically unnecessary services
- D. Underpayment is defined as those lines or payment groups on a claim that were billed at a low level of payment but should have been billed at a higher level of payment. The RAC will review each claim line or payment group and consider all possible occurrences of an underpayment in that one line or payment group.

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Cost and Payment Provisions

Service lines or payment groups that a Provider failed to include on a claim are **NOT** considered underpayments for the purposes of the program.

4. Budget Contingency Clause

- A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.
- B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Contractor to reflect the reduced amount.

5. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

6. Timely Submission of Final Claim

- A. A final claim for all completed reviews shall be submitted no more than ninety (90) calendar days following the expiration or termination date of this agreement unless a later or alternate deadline is agreed to in writing by the program contract manager. Said claim should be clearly marked "Final Claim", thus indicating that no additional claims are forth coming under this agreement.
- B. The contractor shall be required to support the State in processing any remaining open claims on which the State has not made a determination at the expiration of the contract. Such additional assistance shall be viewed as required assistance established by the contract prior to its expiration.
- C. The State may, at its discretion, choose not to honor any delinquent claims after the ninety (90) calendar day following the expiration or termination date of this agreement if the Contractor fails to obtain prior written State approval of an alternate final claim submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.
- D. The contractor shall maintain a right to payment for any properly established claim under the terms established by contract. Expiration of the contract shall not void the Contractor's claim or the terms under which the contractor is to be paid.

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, "agreement", "grant", "grant agreement", "Grantee" and "Subgrantee" respectively.

The terms "California Department of Health Care Services", "California Department of Health Services", "Department of Health Care Services", "Department of Health Services", "CDHCS", "DHCS", "CDHS", and "DHS" shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

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1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

- a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
- e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

- g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Personnel Administration (DPA), for nonrepresented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the DPA rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to DPA rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

- (1) **Major equipment/property:** A tangible or intangible item having a base unit cost of \$5,000 or more with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.
 - (2) **Minor equipment/property:** A tangible item having a base unit cost of less than \$5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.
- b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.
- c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

- (1) Equipment/property purchases shall not exceed \$50,000 annually.

To secure equipment/property above the annual maximum limit of \$50,000, the Contractor shall

make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

- (2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.
- (3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:
 - (a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
 - (b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.
 - (c) Procurements shall be conducted in a manner that provides for all of the following:
 - [1] Avoid purchasing unnecessary or duplicate items.
 - [2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.
 - [3] Take positive steps to utilize small and veteran owned businesses.
- d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of \$5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.
- e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.
- f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.
- g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.
- h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

- a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

- (1) **Reporting of Equipment/Property Receipt** - DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

- (2) **Annual Equipment/Property Inventory** - If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

- (a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).
 - (b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.
 - (c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.
- b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.
- c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.
- d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.
- (1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.
- e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.

- f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

- (1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.
- (2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.
- (3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.
- (4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

- (a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of \$1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.
- (b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.
- (c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.
- (d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.
- (e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

- [1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).
 - [2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.
 - [3] The insurance carrier shall notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to each agreement number for which the insurance was obtained.
- (f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.
- (g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

- a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing \$5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding \$5,000, the Contractor shall obtain at least three bids or justify a sole source award.
- (1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.
 - (2) DHCS may identify the information needed to fulfill this requirement.
 - (3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:
 - (a) A local governmental entity or the federal government,
 - (b) A State college or State university from any State,
 - (c) A Joint Powers Authority,
 - (d) An auxiliary organization of a California State University or a California community college,
 - (e) A foundation organized to support the Board of Governors of the California Community Colleges,
 - (f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,
 - (g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,
 - (h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.3. View this publication at the following Internet address: <http://www.ols.dgs.ca.gov/Contract Manual/default.htm>.
- b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

- (1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.
- c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of \$5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHCS.
- d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by DHCS, make copies available for approval, inspection, or audit.
- e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.
- f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.
- g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.
- h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."
- i. Unless otherwise stipulated in writing by DHCS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.
- j. Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement shall be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of \$10,000.)

- a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.
- b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction.
- c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this

Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, CCR Title 2, Section 1896).

- d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of three years from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.
 - (1) If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of three years from the date of any resulting final settlement.
 - (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.
- e. The Contractor and/or Subcontractor shall comply with the above requirements and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code § 10115.10, if applicable.
- f. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.
- g. The Contractor shall, if applicable, comply with the Single Audit Act and the audit reporting requirements set forth in OMB Circular A-133.

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

- a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.
- b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

- c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.
- d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Intellectual Property Rights

a. Ownership

- (1) Except where DHCS has agreed in a signed writing to accept a license, DHCS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.
- (2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.
 - (a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.
- (3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor shall not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. **Except as otherwise set forth herein, neither the Contractor nor DHCS shall give any ownership interest in or rights to its Intellectual Property to the other Party.** If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.
- (4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor shall require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.
- (5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. Retained Rights / License Rights

- (1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.
- (2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. Copyright

- (1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter into a written agreement with any such person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.
- (2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, shall include DHCS' notice of copyright, which shall read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

d. Patent Rights

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. Third-Party Intellectual Property

Except as provided herein, Contractor agrees that its performance of this Agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required

for Contractor's performance of this Agreement, Contractor shall obtain a license under terms acceptable to DHCS.

f. Warranties

(1) Contractor represents and warrants that:

- (a) It is free to enter into and fully perform this Agreement.
- (b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.
- (c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.
- (d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.
- (e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.
- (f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.
- (g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.
- (h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

g. Intellectual Property Indemnity

- (1) Contractor shall indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by

Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

- (2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS shall be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.
- (3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS shall be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. Federal Funding

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. Survival

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

11. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of \$100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5.

- a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).
- b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

Contractor shall obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

13. Confidentiality of Information

- a. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.
- b. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.
- c. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.
- d. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.
- e. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.
- f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

14. Documents, Publications and Written Reports

(Applicable to agreements over \$5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds \$5,000.

15. Dispute Resolution Process

- a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.
 - (1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.
 - (2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal shall be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's

decision. The Deputy Director of the division in which the branch is organized or his/her designee shall meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee shall be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

- b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Division 25.1 (commencing with Section 38050) of the Health and Safety Code and the regulations adopted thereunder. (Title 1, Subchapter 2.5, commencing with Section 251, California Code of Regulations.)
- c. Disputes arising out of an audit, examination of an agreement or other action not covered by subdivision (a) of Section 20204, of Chapter 2.1, Title 22, of the California Code of Regulations, and for which no procedures for appeal are provided in statute, regulation or the Agreement, shall be handled in accordance with the procedures identified in Sections 51016 through 51047, Title 22, California Code of Regulations.
- d. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence shall be directed to the DHCS Program Contract Manager.
- e. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor shall be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

16. Financial and Compliance Audit Requirements

- a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.
- b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts shall not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).
- c. The Contractor, as indicated below, agrees to obtain one of the following audits:
 - (1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040) and receives \$25,000 or more from any State agency under a direct service contract or agreement;*** the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**
 - (2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040) and receives less than \$25,000 per year from any State agency under a direct service contract or agreement,*** the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**
 - (3) ***If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by the Federal Office of Management and Budget [OMB] Circular A-133) and expends \$500,000 or more in Federal awards,*** the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133 entitled "Audits of States, Local Governments, and Non-Profit Organizations". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

- (a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or
 - (b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.
- (4) If the Contractor submits to DHCS a report of an audit other than an OMB A-133 audit, the Contractor must also submit a certification indicating the Contractor has not expended \$500,000 or more in federal funds for the year covered by the audit report.
- d. Two copies of the audit report shall be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager shall forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.
 - e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.
 - f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.
 - g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.
 - h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.
 - i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.
 - j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.
 - k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

17. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

18. Novation Requirements

If the Contractor proposes any novation agreement, DHCS shall act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

- a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR Part 3017, 45 CFR 76, 40 CFR 32 or 34 CFR 85.
- b. By signing this Agreement, the 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) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
 - (3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and
 - (4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.
 - (5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.
 - (6) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
- c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS Program Contract Manager.
- d. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.
- e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

- a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.
- b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.
- c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.
- d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

21. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or \$3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

23. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

26. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

- (1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.
- (2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.
- (3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.
- (4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.
- (5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

28. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

29. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

- a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.
- b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.
- c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.
- d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

30. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

- a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.
- b. As used herein, fringe benefits do not include:
 - (1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
 - (2) Director's and executive committee member's fees.
 - (3) Incentive awards and/or bonus incentive pay.
 - (4) Allowances for off-site pay.
 - (5) Location allowances.
 - (6) Hardship pay.
 - (7) Cost-of-living differentials
- c. Specific allowable fringe benefits include:
 - (1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.
- d. To be an allowable fringe benefit, the cost must meet the following criteria:
 - (1) Be necessary and reasonable for the performance of the Agreement.
 - (2) Be determined in accordance with generally accepted accounting principles.
 - (3) Be consistent with policies that apply uniformly to all activities of the Contractor.
- e. Contractor agrees that all fringe benefits shall be at actual cost.

f. Earned/Accrued Compensation

- (1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.
- (2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.
- (3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

31. Suspension or Stop Work Notification

- a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.
- b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification shall remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.
 - (1) Upon receipt of a suspension or stop work notification, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.
 - (2) Within 90 days of the issuance of a suspension or stop work notification, DHCS shall either:
 - (a) Cancel, extend, or modify the suspension or stop work notification; or
 - (b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

- c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.
- d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.
- e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS shall allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.
- f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

32. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of \$100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

- (1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds \$100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.
- (2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.
- (3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:
 - (a) A cumulative increase of \$25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;
 - (b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or
 - (c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.
- (4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding \$100,000 at any tier under a contract or agreement, or grant shall file a certification, and a disclosure form, if required, to the next tier above.
- (5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an

officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
State of California
Department of Health Care Services

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of \$100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

_____ Name of Contractor	_____ Printed Name of Person Signing for Contractor
_____ Contract / Grant Number	_____ Signature of Person Signing for Contractor
_____ Date	_____ Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notify the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB
0348-0046

1. Type of Federal Action: ☐ a. contract ☐ b. grant ☐ c. cooperative agreement ☐ d. loan ☐ e. loan guarantee ☐ f. loan insurance		2. Status of Federal Action: ☐ a. bid/offer/application ☐ b. initial award ☐ c. post-award		3. Report Type: ☐ a. initial filing ☐ b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.	
4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, if known: Congressional District, If known:			5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:		
6. Federal Department/Agency			7. Federal Program Name/Description: CDFA Number, if applicable: _____		
8. Federal Action Number, if known:			9. Award Amount, if known: \$		
10.a. Name and Address of Lobbying Registrant (If individual, last name, first name, MI):			b. Individuals Performing Services (including address if different from 10a. (Last name, First name, MI):		
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. required disclosure shall be subject to a not more than \$100,000 for each such failure.			Signature: _____		
			Print Name: _____		
			Title: _____		
			Telephone No.: _____ Date: _____		
Federal Use Only				Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

EXHIBIT E
Additional Provisions

1. Additional Incorporated Exhibits

- A. The following additional exhibits are attached, incorporated herein, and made a part hereof by this reference:

Narrative Proposal	Submitted by Contractor	X page(s)
Cost Proposal	Submitted by Contractor	X page(s)
Exhibit F	HIPAA Business Associate Addendum Conflict of Interest Certification	9 page(s)
Exhibit G	HIPAA Business Associate Addendum Security Controls	3 page(s)

2. Contract Amendments

- A. Should either party, during the term of this agreement, desire a change or amendment to the terms of this Agreement, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by the State.
- B. The other party will acknowledge receipt of the proposal for contract amendment within ten days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party.
- C. Any proposal shall set forth a detailed explanation of the reason and basis for the proposed change, a complete statement of cost and benefits of the proposed change, and the text of the desired amendment to this contract that would provide for the change.
- D. If the proposal is accepted, this contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHS, DHHS, Department of Finance, and DGS, if necessary. Avoidance of Conflicts of Interest by Contractor
- E. DHCS intends to avoid any real or apparent conflict of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional information or a plan for resolving the conflict, subject to DHCS review and prior approval.

3. Avoidance of Conflicts of Interest by Contractor

- A. DHCS intends to avoid any real or apparent conflict of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional

EXHIBIT E
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information or a plan for resolving the conflict, subject to DHCS review and prior approval.

B. Conflicts of interest include, but are not limited to:

1. An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the Contract.
2. An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.
3. If DHCS is or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) working days from the date of notification of the conflict by DHCS to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by DHCS and cannot be resolved to the satisfaction of DHCS, the conflict will be grounds for terminating the contract. DHCS may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.

4. Cancellation / Termination

- A. This agreement may be cancelled by DHS without cause upon 30 calendar days advance written notice to the Contractor. Notice shall state the effective date of, and the reason for, the termination.
- B. DHS reserves the right to cancel or terminate this agreement immediately for cause. The Contractor may submit a written request to terminate this agreement only if DHS substantially fails to perform its responsibilities as provided herein.
- C. The term "for cause" shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this agreement.
- D. Agreement termination or cancellation shall be effective as of the date indicated in DHS' notification to the Contractor. The notice shall stipulate any final performance, invoicing or payment requirements.
- E. Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel or reduce subsequent agreement costs.
- F. In the event of early termination or cancellation, the Contractor shall be entitled to compensation for services performed satisfactorily under this agreement and expenses incurred up to the date of cancellation and any non-cancelable obligations incurred in support of this agreement.

EXHIBIT E
Additional Provisions

- G. All obligations to perform services under this contract shall automatically terminate on the effective date of any termination of this contract.
- H. Prior to termination of the contract and upon request by the State, the Contractor shall assist the State in the orderly transfer of any Complex Review cases under review as pursuant to Turnover Requirements in Exhibit E, Additional Provisions, Section 4.K. In doing so, the contractor shall make available to the State copies of case files, detail reports, and any other pertinent information, including information maintained by any subcontractors or sub-subcontractors (if applicable), necessary for efficient case management and recovery, as determined by the State. Costs of reproduction shall be borne by the State.

Upon termination of this contract, for any provider under a Complex Review, the State shall notify the provider and/or their representative of the change and appropriate contacts moving forward.

I. Contract Extension

The State shall retain the exclusive right to exercise the option to extend the term of the contract during the last twelve months of the contract, as determined by the original end date or by a new end date if an extension has been exercised. The State may invoke up to 3 (three) separate extensions of one year each. The Contractor shall be given at least 90 days prior written notice should the State choose to exercise this option and extend the contract. Term extensions are subject to funding availability, acceptable Contractor performance, and the Contractor's willingness to maintain existing recovery rates.

J. Turnover Requirements

The objective of the Turnover period is to ensure that the orderly transfer of necessary data is made from the previous Contractor to the State and then to the successor Contractor. This orderly transfer of required data ensures the continuity of *Complex Review* and the proper accounting of Medi-Cal expenditures.

The Contractor shall be flexible to changing requirements. If the State exercises its extension options, all Turnover activities shall be delayed a commensurate period of time. Upon expiration of the contract, the Contractor shall:

- 1) Transfer control of all *Complex Review* started but not completed by the contractor. For purposes of turnover the start of a *Complex Review* shall be defined as any contact with a provider in which the contractor has indicated an intent to review the Medi-Cal records of a provider.
- 2) Discontinue all other recovery actions and begin the physical transfer of all case related material as required. This physical transfer will be in an orderly, timely, and efficient manner, and in full compliance with the security and confidentiality provisions of the contract. The State shall retain the authority to designate the manner and method by which the data, equipment, and cases shall be transferred. Should the State determine that other data is required for Turnover, the State shall notify the Contractor in writing within the time constraints enumerated below. Costs of reproduction shall be borne by the State. Any delay in turning over to the State the data and/or equipment requested shall result in an assessment of a liquidated damage of \$500 per day against the Contractor beyond the 30 days in which any portion of the data and/or equipment is not received.

EXHIBIT E
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- 3) The Contractor shall develop a report describing, at the lowest level of detail understandable to the layperson, the data to be transferred to the State. This report shall be submitted to the Contracting Officer within ten workdays of expiration or termination of the contract.
- 4) All data and information provided by the Contractor shall be accompanied by letter, signed by the responsible authority, certifying to the accuracy and completeness of the materials supplied.

5. Conformance with State and Federal Statutes and Regulations

The Contractor shall comply with the requirements of State of California and federal law, to include related regulations and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the contract. These authorities include, without limitation, the California W&I Code, the California Government Code, the California Public Contract Code, the Code of Federal Regulations, Title 2 and Title 22 of the California Code of Regulations, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191, dated August 21, 1996). (See Exhibit H, HIPAA Business Associate Addendum.)

6. Consultant Conduct and Filing Requirements

- A. When a Consultant or representative of a DHCS Contractor performs work on DHCS premises, the Consultant or representative of a DHCS Contractor shall follow and adhere to all DHCS policies and procedures including, but not limited to, those governing health and safety, nondiscrimination, appropriate vehicle use, travel reimbursement, security and confidentiality of information, incompatible activities, acceptable employee conduct, information technology protocols and requirements, workplace violence prevention, and conflict of interest filing instructions (if applicable). Consultants may not access DHCS confidential, personal, or sensitive information until they have been trained on the DHCS policies and procedures for information privacy and security and sign a Confidentiality Statement. This training may be accomplished through the on-line Privacy/Security Training on the DHCS Intranet.
- B. Certain consultants designated by the DHCS' Conflict of Interest Code are required to complete and file a Statement of Economic Interest, Form 700. The Contractor agrees that if the Director of DHCS or his/her designee (i.e., Program Contract Manager, etc.) determines that a Statement of Economic Interests, Form 700, is required based upon the nature of the services that are to be performed, the Consultant shall be so notified by DHCS and the Consultant shall obtain a Form 700 and filing instructions from DHCS' Personnel Office or the Fair Political Practices Commission and fully complete the Form 700. The Consultant shall file the completed Form 700 in a timely manner with the DHCS Personnel Office and submit a copy to the DHCS Program Contract Manager. Failure to obtain, complete, or file a Form 700 in a timely manner as instructed by DHCS, may result in immediate contract termination or Consultant substitution/replacement.

7. Contractor Certifications

With respect to any report, invoice, record, papers, documents, books of account, or other contract-required data submitted to the Contracting Officer in support of an invoice or document submitted to meet contract requirements, the Contractor Representative or his/her designee shall certify that such submission is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such

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certification is expressly waived by DHCS in writing.

Contractor certifications may also required, but not limited to, proof of insurance, Lobbying Certifications and Disclosures, Conflict of Interest Disclosure Statements and/or Conflict of Interest Avoidance Plans, pursuant to the requirements of the contract.

Where in this contract there is a requirement that the Contractor "certify" or submit a "certification," such certification shall be in the form of an affidavit or declaration under penalty of perjury, dated and signed by the Contractor Representative or his/her designee.

8. Contractor's Duties to Maintain Confidentiality

In addition to the requirements of Exhibit D(F), any identifiable information concerning current or former Medi-Cal (managed care and/or fee-for-service) beneficiaries that is obtained by the Contractor or its subcontractor(s) under the Scope of Work of this Contract shall, at the termination of this Contract, (1) be returned to DHCS or maintained according to written procedures sent to the Contractor by DHCS for this purpose; and (2) protected from all other employees of the Contractor not assigned to the Scope of Work under the terms of this Contract.

9. Dispute Resolution Process

A. This provision replaces and supersedes provision 15 of Exhibit D(F).

B. Disputes and appeals shall be used by the Contractor as the means of resolving contractual disputes.

Filing a dispute shall not preclude the State from recouping the amount in dispute from the Contractor or from offsetting this amount from subsequent monthly payment(s). If the amount to be recouped exceeds 25 percent of the monthly payment, an amount up to 25 percent shall be withheld from each monthly payment until the amount in dispute is fully recouped. If a recoupment or offset is later found to be inappropriate, the State shall repay the Contractor the full amount of recoupment or offset, plus interest at the Pooled Money Investment Rate pursuant to Government Code, Section 16480 et seq.

C. The State and Contractor agree to attempt to resolve all contractual disputes through negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that implementation of this policy depends on open-mindedness and the need for both parties to provide adequate supporting information.

Before issuance of a Contracting Officer's decision, informal discussions with the parties by individuals who have not participated substantially in the matter in dispute shall be considered by the parties in efforts to reach a mutual agreement.

D. The Contractor shall notify the Contracting Officer in writing within 15 days of the date the dispute concerning performance of this contract arises or otherwise becomes known to the Contractor, describing the conduct (including actions, inactions and written or oral communications) which it is disputing.

The Contractor's notification shall state, on the basis of the most accurate information then available to the Contractor, the following:

EXHIBIT E
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- 1) That it is a dispute pursuant to this Section.
- 2) The date, nature and circumstances of the conduct that is the subject of the dispute.
- 3) The names, phone numbers, function and activity of each Contractor, subcontractor, CDHS/State official or employee involved in or knowledgeable about said conduct.
- 4) The identification of any documents and the substance of any oral communications involved in such conduct. Copies of all identified documents shall be attached.
- 5) The reason why the Contractor is disputing the conduct.
- 6) The cost impact to the Contractor directly attributable to the alleged conduct, if any:
 - a. What contract line item(s) have been or may be affected by the alleged conduct;
 - b. What labor or materials or both have been or may be added/deleted by the alleged conduct;
 - c. To the extent practicable, what delay and disruption in the manner and sequence of performance and effect on continued performance have been or may be caused by the alleged conduct;
 - d. What adjustments to contract price, delivery schedule and other provisions are required or have been or may be affected by the alleged conduct.
 - e. If no cost impact is involved, the Contractor's desired remedy.

The required documentation, including cost impact data, shall be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation shall serve as the basis for any subsequent appeal.

Following submission of the required documentation, with supporting documentation, the Contractor shall diligently continue performance of this contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

- E. Any disputes concerning performance of this contract shall be decided by the Contracting Officer in a written decision stating the factual basis for this decision. The Contracting Officer shall serve a copy of the decision on the Contractor. The decision of the Contracting Officer shall be rendered within 30 days of a receipt of a Notification of Dispute or any additional substantiating documentation requested by the Contracting Officer, unless the Contracting Officer provides a written explanation to the Contractor why a longer period is necessary. The decision shall be final and conclusive unless within 30 days from the date of service of such decision the Contractor files with the Contracting Officer a written appeal addressed to the Branch Chief.

The Contracting Officer's decision will:

- 1) Find in favor of the Contractor, deny the Contractor's dispute or request additional substantiating documentation, in which case the Contracting Officer may;

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- a. Countermand the earlier conduct which caused the Contractor to file a dispute; or reaffirm the conduct and issue a Change Order in accordance with Exhibit E, section 12, or
- b. Deny the Contractor's dispute and, where necessary, direct the manner of future performance; or
- c. Request additional substantiating documentation in the event the information in the Contractor's notification is inadequate to permit a decision to be made under paragraphs a. or b. above and shall advise the Contractor as to what additional information is required and establish how that information shall be furnished.

The Contractor shall have 30 days to respond to the Contracting Officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer shall have 30 days to respond with a decision. Failure to supply additional information required by the Contracting Officer within the time period specified above shall constitute waiver by the Contractor of all claims in accordance with Exhibit E, section 9.

- F. Pending final determination of any dispute hereunder, the Contractor shall proceed diligently with the performance of this contract and in accordance with the Contracting Officer's direction.
- G. In any appeal by the Contractor of a Contracting Officer's decision under Exhibit E, Section 6.E. where the amount in controversy is fifty thousand dollars (\$50,000) or less, the Contracting Officer and the Contractor may agree on the appointment of a single Dispute Examiner to consider and to decide the dispute.
- H. The Dispute Examiner shall render a written decision on the dispute within 30 days of its submission, which period may be extended for an additional 30 days by the Dispute Examiner in extraordinary circumstances. The Dispute Examiner may decide the matter on the basis of documentary evidence alone, without a hearing and may require either party to produce additional evidence necessary to the decision.
- I. The Dispute Examiner's decision is final and not subject to appeal to the Director by either party, except in cases of demonstrated bad faith, fraud or if unsupported by a reasonable determination of the evidence presented.
- J. If the Contracting Officer and Contractor cannot agree on a Dispute Examiner, the matter shall be processed as an appeal under Exhibit E, section 6.H.
- K. If no cost impact can be shown to be directly attributable to the conduct under the dispute or if there is no amount in controversy, the Contractor and the Contracting Officer shall mutually agree which type of appeal will be most appropriate to the circumstances, the appeal process described in Exhibit E, section 6.G. or the appeal process described in section 6.H. Failure to reach such an agreement shall be resolved by handling the appeal resolved by handling the appeal in the manner described in section 6.G.

10. Access Requirements and State's Right to Monitor

This provision is in addition to provision 8 in Exhibit D(F).

EXHIBIT E
Additional Provisions

- A. The State shall have the right to monitor all aspects of the Contractor's performance of the contract as well as the Contractor's compliance with applicable federal and State laws and regulations. Such monitoring activities shall include, but not be limited to, inspection and auditing of Contractor, subcontractor, and facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during the Contractor's or other facility's normal business hours. These monitoring activities will be either announced or unannounced.
- B. To assure compliance with the contract, and for any other reasonable purpose, the State and its authorized representatives and designees shall have the right to premises access, with or without notice to the Contractor. This shall include any such place where duties under the contract are being performed.
- C. Staff designated by the State shall have access to all security areas and the Contractor shall provide, and shall require any and all its subcontractors to provide, reasonable facilities, cooperation, and assistance to State representative(s) in the performance of their duties. Access shall be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the subcontractor(s). The right of access herein shall include on-site visits by authorized designees of the State, and by Potential Proposers involved in the procurement process for a successor Contractor.
- D. Any security device or system (e.g., badges, etc.) which the Contractor implements to identify and monitor persons seeking access to secured areas shall be supplied, by the Contractor, to the State and its authorized representatives and designees.

11. Confidentiality of Data

For purposes of this contract, all information, records, data, and data elements collected and maintained for the operation of the contract and pertaining to beneficiaries will be protected by the Contractor from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., W&I Code Section 14100.2, and state regulations.

The Contractor shall perform the duties and responsibilities with respect to confidentiality of information and data.

- A. Each staff member/new staff member assigned to the Scope of Work of this contract must sign an oath of confidentiality. The Contractor's Representative is responsible for maintaining and updating the oaths of confidentiality.
- B. The Contractor shall protect all identifiable information concerning a beneficiary and/or applicant from all other employees of the Contractor not assigned to the Scope of Work under the terms of this contract.
- C. Each staff member authorized direct computer access to confidential information that have a functional need for the data shall be individually assigned log-on identification codes and passwords.
- D. The Contractor shall present a security plan that provides for the protection of, and limits unauthorized access to, confidential records, information, data, and data elements.
- E. The Contractor shall not disclose, except as otherwise specifically permitted by the contract, any

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identifiable information concerning a beneficiary or applicant to any party other than the State without the State's prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et seq., W&I Code Section 14100.2, and state regulations. The Contractor shall promptly transmit to the State all requests for disclosure of any identifiable information concerning a beneficiary or applicant.

- F. The Contractor shall not use such identifiable information for any purpose other than carrying out the express terms of this contract.
- G. The Contractor shall be responsible for storing confidential information under lock.
- H. The Contractor shall, at the expiration or termination of the contract, return all information to the State or maintain such identifiable information according to written procedures sent to the Contractor by the State for this purpose.
- I. The Contractor shall destroy such confidential information when it is no longer required. Destruction shall be by shredding for paper and microfilm documents, and by the appropriate processes to destroy data on magnetic media.

12. Conflict of Interest, Incompatible Activity of Contractor and Employees

A. Contractor Responsibilities--General

The Contractor shall submit, for State review and approval, if acceptable, a "Conflict of Interest Disclosure Statement" (Disclosure Statement) for each employee:

- 1) Two weeks after the effective date of the contract;
- 2) An update seven months after the contract effective date;
- 3) A yearly update thereafter; and
- 4) Any time a change occurs which affects the previously submitted and approved statement. If such change occurs, a new statement, together with a Conflict of Interest Avoidance Plan, shall be sent to the Contracting Officer for prior review and approval within 14 days of the change.

B. Disclosure Statement

The Disclosure Statement shall fully describe any direct or indirect interest the Contractor, any parent corporation, or any subcontractor has in any Provider of Medi-Cal services (as defined in Title 22, CCR, Section 51051) or in any billing agent(s) for Medi-Cal services, together with the name and position description of the Contractor, any parent, or subcontractor employee, director, consultant, or officer about whom the disclosure is being made.

At a minimum, the Contractor's Disclosure Statement shall disclose the name and address of any and all Providers or billing agent(s) for Medi-Cal services in which:

- 1) The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's or any parent corporation's or any subcontractor's employees, directors, consultants, or officers had a direct or indirect interest of more than \$1000;
- 2) The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's or any subcontractor's employees, directors, consultants, or

EXHIBIT E
Additional Provisions

officers assigned to this contract is a director, officer, partner, trustee, employee, or holder of a management position, or is self-employed;

- 3) The Contractor, or any parent corporation, or any subcontractor, or any of the Contractor's, or any parent corporation's, or any subcontractor's employees, directors, consultants, or officer assigned to this contract, has derived more than \$250 in direct or indirect income within twelve months immediately prior to the submittal of a proposal.

The Contractor shall disclose the name of any subcontractor, consultant, officer, director, or employee who was employed by the State of California in the Department, the Governor's Office, Health and Welfare Agency, State Controller's Office, Office of the Attorney General, and/or the Legislature from 1994 to the present, in accordance with W&I Code, Section 14104.6.

If a real or apparent conflict exists, the Contractor shall, together with the disclosure and at the time of that document's submittal, submit a Conflict of Interest Avoidance Plan and procedures to hold separate such relationships and/or to safeguard against conflict. If the Contractor has nothing to disclose under this Contract Section, it shall so certify in the Disclosure Statement. The Contractor's Representative, or his/her designee, shall certify under penalty of perjury that such reports and updates to such reports are accurate, complete and current to the best of that individual's knowledge and belief, unless the requirement is expressly waived by the Contracting Officer in writing.

C. Avoidance Plan

When a real or apparent conflict of interest exists, the Contractor shall submit a Conflict of Interest Avoidance Plan, with the required Disclosure Statement, to safeguard against conflict of interests. This plan shall include procedures to:

- 1) Guard against conflict or interest;
- 2) Hold separate any disclosed relationships or any potential conflict of interest relationships that could arise during the life of the contract, including, but not limited to, such problematic matters as financial interactions, reporting, sharing of office space, staff interactions, or Contractor fulfillment of contract responsibilities;
- 3) Ensure that the contractor shall discharge its responsibilities and duties with disinterest skill, zeal, and diligence, and that no Contractors, parent corporations, or subcontractor's employee, officer, director, or consultant will be in a position to exploit that position for private benefit or for other Contractor, or parent corporation or subcontractor interests which are or may be in conflict with Departmental or State interests.

The State intends to avoid any real or apparent conflicts of interest on the part of the Contractor. Hence, the State reserves the right to, in its sole discretion, determine whether any information received from any source indicates the existence of a real or apparent conflict of interest and to require the Contractor to submit a Conflict of Interest Avoidance Plan for solving the conflict problem subject to prior State review and approval. While it is desirable that the Contractor not have any contractual or financial relationships with Providers, such relationships may be permissible so long as prompt, full disclosure is made and adequate protective Conflict of Interest Avoidance Plans and procedures are developed, reviewed, and accepted by the State.

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Additional Provisions

For purposes of this contract, indirect interest and indirect income shall be defined as any interest owned or income received by the spouse, parent(s), or dependents of the persons covered by the disclosure provisions of this contract, Exhibit E, Section 8.B.

13. Priority Hiring Considerations

- A. Contractor agrees that it shall give priority consideration in filling vacancies in positions funded by this agreement to qualified recipients of aid under Chapter 2 (commencing with Section 11200) of Part 3 of Division 9 of the Welfare and Institutions (W&I) Code, in accordance with Article 3.9 (commencing with Section 11349) of Chapter 2 of Part 3 of Division 9 of the W&I Code.
- B. This provision shall not be construed to do any of the following:
 - 1) Interfere with or create a violation of the terms of valid collective bargaining agreements
 - 2) Require the Contractor to hire an unqualified recipient of aid
 - 3) Interfere with, or create a violation of, any federal affirmative action obligation of a contractor for hiring disabled veterans or veterans of the Vietnam era
 - 4) Interfere with, or create a violation of, the requirements of Section 12990 of the Government Code implementing the State of California's nondiscrimination laws.

14. Insurance and Bonding Requirements

This Contract Section sets the requirements for insurance and fidelity bonding under the contract.

As used in this Section, a third party carrier means an insurance and/or bonding company licensed to provide the required lines of insurance in the State of California and in the amounts required by this contract.

No policy of insurance or bond provided or maintained under this Section shall provide for an exclusion for the acts of the Contractor's officers.

A. Insurance

- 1) Evidence of the insurance coverage required by Exhibit E, Section 10.A. must be submitted to the State within five days after execution of the contract and signed by the Contracting Officer and the Contractor's Representative.
- 2) The Contractor agrees that the insurance required herein will remain in effect at all times during the term of the agreement. In the event said insurance coverage expires at any time or times during the term of this agreement, the Contractor agrees to provide, at least 30 calendar days before said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of the term of the agreement or for a period of not less than one year. New certificates of insurance are subject to the approval of DGS, and the Contractor agrees that no work or services shall be performed prior to such approval. DHS may, in addition to any other remedies it may have, terminate this agreement on the occurrence of such event.

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- 3) If the required insurance is not to be provided by a third party carrier, the State must approve, in writing, any proposed alternative coverage prior to its use under this contract. Any request to use coverage other than standard insurance from a third party carrier must be submitted to the State in writing within ten days after the Notice of Intent to Award the contract. The request shall clearly and fully set out the arrangement proposed and how such arrangements will fully comply with the contract requirements. If the request is denied by the State, required insurance from a third party carrier must be obtained and evidence of coverage submitted to the State as prescribed above within five days of the denial.
- 4) The Contractor shall provide and maintain and shall require its subcontractors to provide and maintain the following insurance during the performance of this contract:
 - a. Workers' Compensation insurance in accordance with the statutory requirements of California where work will be performed.
 - b. Comprehensive general and automobile liability insurance with minimum aggregate limits of \$1 million per occurrence for bodily injury and property damage. Such coverage must apply to all locations where any work pertaining to this contract is performed.
 - c. The State of California must be named as an additional party on the policy of insurance, with the exception of the Workers' Compensation insurance.
- 5) The State will not be responsible for any premiums or assessments on the policy or policies. The State may, as its sole discretion, pay one or more premiums, if it decides that to do so would be in the best interest of the State. Should the State exercise this option to pay any premiums, it shall be fully reimbursed by the Contractor by an offset against future payments owed to the Contractor.
- 6) The Certificate of Insurance must include the following provisions stating that:
 - a. The insurer will not cancel the insured's coverage without 30 days' prior written notice to the State;
 - b. The State of California, its officers, agents, and employees are included as additional insureds, but only insofar as the operations under this contract are concerned;
 - c. The State will be notified of any failure by the Contractor to pay premiums, or any other change in the status of the scope of the required coverage within five days of such failure.

B. Bonding

- 1) The fidelity bond or other security required by Exhibit E, Section 10.B. shall be in place by the contract effective date. Evidence of the bonding coverage shall also be submitted to the State before the contract effective date.

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- 2) If required bonding is not provided to the Contractor by a third party carrier, the State must approve, in writing, any other equivalent arrangements made by the Contractor prior to their use under this contract. The initial request to secure required bonding from other than an authorized third party carrier should be submitted to the State in writing by the contract effective date. The request shall clearly and fully set out the arrangements proposes and how such arrangements will fully comply with contract requirements. If this request is denied by the State, required bonding from a third party carrier shall be obtained within 15 days from the denial.
- 3) A fidelity bond or other security shall be maintained by the Contractor and subcontractors for at least an amount equal to the minimum fidelity bond required per loss covering every employee except those classifications of employees as the State may allow to be exempted. The fidelity bond or other security must be maintained by the Contractor and subcontractors for the life of this contract and in a form satisfactory to the State, and must include the following conditions:
 - a. The State of California shall be named as joint obligee/beneficiary of the Contractor's bond. The Contractor's bond shall provide that the insurer or bonding company shall pay losses suffered by the State directly to the State.
 - b. The State will receive 30 days prior written notice of any intent to cancel or to make any other material change in the status, coverage, or scope of the required bond or of the Contractor's failure to pay premiums.
 - c. The State will not be responsible for any premiums or assessments on the bond, unless, at its sole option, it decides to pay one or more premiums, should the State exercise this option, it shall be fully reimbursed by the Contractor by an offset against future payments owed to the Contractor.

C. Contractor's Certification

With respect to any report, invoice, record, papers, documents, books of account, or other contract required data submitted to the State in support of an invoice or documents submitted to meet contract requirements, including, but not limited to, proofs of insurance and bonding, Lobbying Certifications and Disclosures, Conflict of Interest Disclosure Statements, and/or Conflict of Interest Avoidance Plans, pursuant to the requirements of this contract, the Contractor's Representative or his/her designee shall certify that the report, invoice, record, papers, documents, books of account, or other contract required data is current, accurate, complete and in compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by the State in writing.

15. Waivers

All conditions, covenants, duties, and obligations contained in the contract can be waived only by written agreement subject to written approval by the State. Forbearance or indulgence in any form or manner by a party shall not be construed as a waiver, nor in any way limit the legal or equitable remedies available to that party.

EXHIBIT E
Additional Provisions**16. Change Requirements****A. General Provisions**

During the life of this contract, the RAC will be a dynamic program that may require numerous changes to its operations. The development of a system that has the capability to implement such changes in an orderly and timely manner is of considerable importance.

The State recognizes that the scope and complexity of changes will vary widely over the life of the contract. The State requires adequate assurance that a given change will be correctly implemented and Departmental approval of change documents and related monitoring efforts will reflect this policy.

B. Contractor's Obligation to Implement

The Contractor shall be required to make changes mandated by the State. In the case of mandated changes in policy, regulations, statutes, or judicial interpretation, the State may direct the Contractor to immediately begin implementation of any change by issuing a Change Order. If the State issues a Change Order, the Contractor shall be obligated to implement the required changes while discussions relevant to any Cost Proposal adjustment, if applicable, are taking place.

The State may, at any time, within the general scope of the contract, by written notice make changes to the RAC requirements. The State will utilize a formal process to notify the Contractor, in an ongoing and timely manner, of changes to be made to the RAC.

C. Change in Counties

The State shall have the option of deleting counties that have been previously included in one Contractor's Region or transferring counties from one contract to another. These events will be implemented via a Change Order and may result either in a no-cost impact on a Contractor's rates or in the need for re-negotiation of those rates.

17. Equal Opportunity Employer

This provision is in addition to provision 1 in Exhibit D(F).

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and shall send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the State, advising the labor union or workers' representative of the Contractor's commitment to equal opportunity employment. The Contractor shall post copies of this notice in conspicuous places available to employees and applicants for employment.

EXHIBIT E
Additional Provisions**18. Governing Authorities**

This contract shall be governed and construed in accordance with:

- A. Welfare and Institutions Code [W&I Code], Section 14304(a), Sections 14124.70 through 14124.88;
- B. Title 22, Division 3, California Code of Regulations [CCR];
- C. California Labor Code, Section 3700;
- D. All other applicable laws and regulations.

Any Provision of this contract that is in conflict with the above laws, regulations, and federal Medicaid statutes is hereby amended to conform to the Provisions of those laws and regulations. Amendments to the contract shall be effective on the effective date of the statutes or regulations, and shall be binding on the parties even though such amendments may not have been reduced to writing and formally agreed upon and executed by the parties.

19. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this contract shall be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed, or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party shall have the right to invoke any remedy available under this Contract, contract, or under law, notwithstanding such forbearance or indulgence.

20. Liquidated Damages**A. General Damages**

It is agreed by the State and the Contractor that:

- 1) If the Contractor does not provide or perform the requirements referred to or listed in this provision, damage to the State will result;
- 2) Proving such damages will be costly, difficult, and time-consuming;
- 3) Should the State choose to impose liquidated damages, the Contractor will pay the State those damages for not providing or performing the specified requirements;
- 4) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

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- 5) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the contract;
- 6) The State and the Contractor recognize that it is the policy of the California Legislature to encourage the use of liquidated damages provision in State contracts, as shown by Civil Code section 1671(b), Public Contract Code section 10226, and 13 California Law Revision Commission Reports 1740 and 1741;
- 7) The State may, at its discretion, offset liquidated damages from payments owed the Contractor;
- 8) The maximum amount of liquidated damages payable by the Contractor over any twelve month period is five hundred thousand dollars (\$500,000);
- 9) In the event the Contractor's failures result from a single failure, which is subject to liquidated damages, the State will be entitled to assess the highest single liquidated damage penalty only. There will be no concurrent assessments of liquidated damages for cascading failures that result from a single failure.

Nothing in this provision shall be construed as relieving the Contractor from performing any other contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other contract duty hereby diminished.

21. Recovery Audit Contractor , Terms, and Conditions

Except as provided in Exhibit E, Section 20.A., for each and every Contractor requirement not provided or performed as scheduled, or if a requirements is provided or performed inaccurately or incompletely, the State, if it intends to impose liquidated damages, shall notify the Contractor in writing that the requirement was not provided or performed as specified and that liquidated damages will be assessed accordingly. The Contractor shall have 15 days from the date of such written notice from the State, or longer if the State allows upon written request, to provide or perform the requirement as specified.

If the Contractor does not provide or perform the requirement within 15 days of the written notice, or longer if allowed by the State, the State may impose liquidated damages of \$500 per requirement per day for each day the requirement continues not to be provided or performed. If after 15 additional days from the date of the State imposed liquidated damages, the requirements still have not been provided or performed, the State, after written notice to the Contractor, may increase the liquidated damages assessment to \$1,000 per State work day per requirement until the requirement is provided or performed.

22. Record Keeping/Retention

This provision is in addition to provision 7 of Exhibit D(F).

- A. The Contractor shall maintain such books and records as are necessary to disclose how the Contractor discharged its obligations under this contract. These books and records shall disclose the quantity of cases established and recovered upon, the quality of those services provided to effect recovery (i.e., number of cases negotiated, litigated), the manner and amount of payment made for those recoveries, a listing of Medi-Cal beneficiaries receiving settlements, and the manner in which the Contractor administered its daily business, and the cost thereof.

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- B. Such books and records shall include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including working papers; reports submitted to the State; financial records; all claim detail and managed care reports; and other documentation pertaining to the medical and non-medical services rendered to Medi-Cal beneficiaries.
- C. These books and records shall be maintained by the Contractor for six years after the termination date of this contract; or, in the event the Contractor has been duly notified that DHS and DHHS of the Controller General of the United State, the State Auditor, or their duly authorized representatives, have commenced an audit or investigation of the contract, the books and records shall be maintained six years or until such time as the matter under audit or investigation has been resolved, whichever is later.

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EXHIBIT F
HIPAA Business Associate Addendum

Conflict of Interest Compliance Certificate

- A. The Department of Health Care Services (DHCS) intends to avoid conflicts of interest or the appearance of conflicts of interest on the part of the Contractor, subcontractors, or employees, officers and directors of the Contractor or subcontractors. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information received from any source indicates the existence of a conflict of interest.
- B. Either of the following instances would be considered a "conflict of interest", including, but not limited to:
1. An instance where the Contractor or any of its subcontractors, or any employee, officer, or director of the Contractor or any subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the contract.
 2. An instance where the Contractor's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.
 3. Any other conflict of interest identified in federal or State statute or regulation.
- C. If the Proposer or any proposed subcontractor has a suspected or potential conflict of interest, the Proposer or proposed subcontractor shall attach to this form a description of the activity, a plan for ensuring that the activity will not adversely affect DHCS, and procedures to guard against the existence of an actual conflict of interest. Based on that information, and any other information DHCS may require, DHCS will determine whether a conflict of interest exists and whether it can be resolved to the satisfaction of DHCS.
- D. The Proposer shall place this Certificate in the Appendix Section of its proposal response. This Certificate shall bear the original signature of an official or employee of the Proposer who is authorized to bind the Proposer.
- E. This Certificate will be incorporated into the contract, if any, awarded from this RFP. It is understood that the requirements set forth in this Certificate shall be in effect for the entire term of the contract.
- F. The Contractor shall obtain a completed Certificate from any proposed subcontractor and submit it to DHCS prior to approval of the subcontractor by DHCS.

The Proposer or Contractor and each subcontractor shall notify DHCS, Administrative Services Unit, MS 4612, P.O. Box 997413, Sacramento, CA 95899-7413, within ten (10) working days of any change to the information provided on or attached to this Certificate.

- G. If DHCS becomes aware of a suspected or potential conflict of interest, the Proposer or Contractor or subcontractor will be given an opportunity to submit additional information as described in Paragraph C above or to resolve the conflict. The Proposer or Contractor or subcontractor will have five (5) working days from the date of notification of the conflict by DHCS to provide complete information regarding the conflict. If DHCS determines that a conflict of interest exists and it cannot be resolved to the satisfaction of DHCS, before or after the award of the contract, the conflict will be grounds for the proposal to be deemed non-responsive and/or termination of the contract or subcontract.

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HIPAA Business Associate Addendum**The undersigned hereby affirms that: (check one)**

- ☐ The statements above have been read and that no conflict of interest exists that would jeopardize the ability of the Proposer/Contractor to perform independently from DHCS influence.
- ☐ A suspected or potential conflict of interest does exist, and additional information (as described B.3. above) is attached along with a plan to address the possible conflict of interest.

Signed:**Title:****Date:**

Typed or Printed Name of Authorized Representative: _____

- A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations:").
- B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI").
- C. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental condition of an individual, the provision of health and dental care to an individual, or the past, present, or future payment for the provision of health and dental care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI shall have the meaning given to such term under HIPAA and HIPAA regulations, as the same may be amended from time to time.
- D. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.
- E. As set forth in this Agreement Contractor, here and after, is the Business Associate of DHCS that provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI.
- F. DHCS and Business Associate desire to protect the privacy and provide for the security of PHI created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, in compliance with HIPAA and HIPAA regulations and other applicable laws.
- G. The purpose of the Addendum is to satisfy certain standards and requirements of HIPAA and the HIPAA regulations.
- H. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms in the HIPAA regulations.

EXHIBIT F
HIPAA Business Associate Addendum

In exchanging information pursuant to this Agreement, the parties agree as follows:

1. Permitted Uses and Disclosures of PHI by Business Associate

- A. ***Permitted Uses and Disclosures.*** Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS.
- B. ***Specific Use and Disclosure Provisions.*** Except as otherwise indicated in this Addendum, Business Associate may:
- 1) ***Use and disclose for management and administration.*** Use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.
 - 2) ***Provision of Data Aggregation Services.*** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

2. Responsibilities of Business Associate

Business Associate agrees:

- A. ***Nondisclosure.*** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.
- B. ***Safeguards.*** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS; and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section C, Security, below. Business Associate will provide DHCS with its current and updated policies.
- C. ***Security.*** To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI, and provide data security procedures for the use of DHCS at the end of the contract period. These steps shall include, at a minimum:

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- 1) Complying with all of the data system security precautions listed in the Attachment A portion of this Addendum;
- 2) Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;
- 3) Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III- Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and
- 4) In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

- D. **Mitigation of Harmful Effects.** To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.
- E. **Business Associate's Agents.** To ensure that any agents, including subcontractors, to whom Business Associate provides PHI received from or created or received by Business Associate on behalf of DHCS, agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI, including implementation of reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI; and to incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents or subcontractors.
- F. **Availability of Information to DHCS and Individuals.** To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR Section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.
- G. **Amendment of PHI.** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR Section 164.526, in the time and manner designated by DHCS.

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- H. **Internal Practices.** To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations.
- I. **Documentation of Disclosures.** To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with 45 CFR 164.528.
- J. **Notification of Breach.** During the term of this Agreement:
- 1) **Discovery of Breach.** To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notification shall be provided by calling the DHCS ITSD Help Desk. Business Associate shall take:
 - i. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment and
 - ii. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.
 - 2) **Investigation of Breach.** To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer of:
 - i. What data elements were involved and the extent of the data involved in the breach,
 - ii. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data,
 - iii. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,
 - iv. A description of the probable causes of the improper use or disclosure; and
 - v. Whether Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual notifications of breaches are triggered.
 - 3) **Written Report.** To provide a written report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall include, but not be limited to, the information specified

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above, as well as a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure.

- 4) **Notification of Individuals.** To notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and to pay any costs of such notifications, as well as any costs associated with the breach. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications.
- 5) **DHCS Contact Information.** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Program Contract Manager	DHCS Privacy Officer	DHCS Information Security Officer
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of Legal Services Department of Health Care Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Help Desk (916) 440-7000 or (800) 579-0874

- K. **Employee Training and Discipline.** To train and use reasonable measures to ensure compliance with the requirements of this Addendum by employees and volunteers who assist in the performance of functions or activities on behalf of DHCS under this Agreement and use or disclose PHI; and discipline such employees and volunteers who intentionally violate any provisions of this Addendum, including by termination of employment. In complying with the provisions of this Section K, Business Associate shall observe the following requirements:

- 1) Business Associate shall provide information privacy and security training, at least annually, at its own expense, to all its employees and volunteers who assist in the performance of functions or activities on behalf of DHCS under this Agreement and use or disclose PHI.
- 2) Business Associate shall require each employee and volunteer who receives information privacy and security training to sign a certification, indicating the employee's/volunteer's name and the date on which the training was completed.
- 3) Business Associate shall retain each employee's/volunteer's written certifications for DHCS inspection for a period of three years following contract termination.

3. Obligations of DHCS

DHCS agrees to:

Recovery Audit Contractor
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SAMPLE

EXHIBIT F
HIPAA Business Associate Addendum

- A. **Notice of Privacy Practices.** Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR 164.520, as well as any changes to such notice. Visit this Internet address to view the most current Notice of Privacy Practices: <http://www.dhs.ca.gov/privacyoffice>.
- B. **Permission by Individuals for Use and Disclosure of PHI.** Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.
- C. **Notification of Restrictions.** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.
- D. **Requests Conflicting with HIPAA Rules.** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

4. Audits, Inspection and Enforcement

From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

- A. Failure to detect or
- B. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

5. Termination

- A. **Termination for Cause.** Upon DHCS' knowledge of a material breach of this Addendum by Business Associate, DHCS shall:
 - 1) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS;
 - 2) Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or
 - 3) If neither cure nor termination is feasible, report the violation to the Secretary of the U.S. Department of Health and Human Services.
- B. **Judicial or Administrative Proceedings.** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may

EXHIBIT F**HIPAA Business Associate Addendum**

terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

- C. **Effect of Termination.** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI or, if return or destruction is not feasible, shall continue to extend the protections of this Addendum to such information, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

6. Miscellaneous Provisions

- A. **Disclaimer.** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- B. **Amendment.** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:
- 1) Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section or
 - 2) Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.
- C. **Assistance in Litigation or Administrative Proceedings.** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy,

EXHIBIT F**HIPAA Business Associate Addendum**

which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

- D. **No Third-Party Beneficiaries.** Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.
- E. **Interpretation.** The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA regulations.
- F. **Regulatory References.** A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.
- G. **Survival.** The respective rights and obligations of Business Associate under Section 6.C of this Addendum shall survive the termination or expiration of this Agreement.
- H. **No Waiver of Obligations.** No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

EXHIBIT GHIPAA Business Associate Addendum
Security Controls**1. General Security Controls**

- A. **Confidentiality Statement.** All persons that will be working with DHCS PHI must sign a confidentiality statement. The statement must include at a minimum, General Use, Security and Privacy safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of three (3) years following contract termination.
- B. **Background check.** Before a member of the Contractor's workforce may access DHCS PHI, Contractor must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.
- C. **Workstation/Laptop encryption.** All workstations and laptops that process and/or store DHCS PHI must be encrypted with a DHCS approved solution, such as a solution using a vendor product specified on the California Strategic Sourcing Initiative (CSSI) located at the following link: www.pd.dgs.ca.gov/masters/EncryptionSoftware.html. The encryption solution must be full disk.
- D. Only the minimum necessary amount of DHCS PHI may be downloaded to a laptop or hard drive when absolutely necessary for current business purposes.
- E. **Removable media devices.** All electronic files that contain PHI data must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.) with a DHCS approved solution, such as a solution using a vendor product specified on the CSSI.
- F. **Email security.** All emails that include DHCS PHI must be sent in an encrypted method using a DHCS approved solution, such as a solution using a vendor product specified on the CSSI.
- G. **Antivirus software.** All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.
- H. **Patch Management.** All workstations, laptops and other systems that process and/or store DHCS PHI must have security patches applied and up-to-date.
- I. **User IDs and Password Controls.** All users must be issued a unique user name for accessing DHCS PHI. Passwords are not to be shared. Must be at least eight characters. Must be a non-dictionary word. Must not be stored in readable format on the computer. Must be changed every 60 days. Must be changed if revealed or compromised. Must be composed of characters from at least three of the following four groups from the standard keyboard:

EXHIBIT GHIPAA Business Associate Addendum
Security Controls

- J. **Data Destruction.** All DHCS PHI must be wiped from systems when the data is no longer necessary. The wipe method must conform to Department of Defense standards for data destruction. All DHCS PHI on removable media must be returned to DHCS when the data is no longer necessary. Once data has been destroyed, the DHCS Program Contract Manager must be notified.
- K. **Remote Access.** Any remote access to DHCS PHI must be executed over an encrypted method approved by DHCS using a vendor product specified on the CSSI. All remote access must be limited to minimum necessary and least privilege principles.

2. System Security Controls

- A. **System Timeout.** The system must provide an automatic timeout after no more than 20 minutes of inactivity.
- B. **Warning Banners.** All systems containing DHCS PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. User must be directed to log off the system if they do not agree with these requirements.
- C. **System Logging.** The system must log successes and failures of user authentication at all layers. The system must log all system administrator/developer access and changes if the system is processing and/or storing PHI. The system must log all user transactions at the database layer if processing and/or storing DHCS PHI.
- D. **Access Controls.** The system must use role based access controls for all user authentications, enforcing the principle of least privilege.
- E. **Transmission encryption.** All data transmissions must be encrypted end-to-end using a DHCS approved solution, such as a solution using a vendor product specified on the CSSI, when transmitting DHCS PHI.
- F. **Host Based Intrusion Detection.** All systems that are accessible via the Internet or store DHCS PHI must actively use a comprehensive third-party real-time host based intrusion detection and prevention solution.

3. Audit Controls

- A. **System Security Review.** All systems processing and/or storing DHCS PHI must have at least an annual system security review. Reviews must include administrative and technical vulnerability scanning tools.
- B. **Log Reviews.** All systems processing and/or storing DHCS PHI must have a routine procedure in place to review system logs for unauthorized access.
- C. **Change Control.** All systems processing and/or storing DHCS PHI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

EXHIBIT GHIPAA Business Associate Addendum
Security Controls**4. Business Continuity / Disaster Recovery Controls**

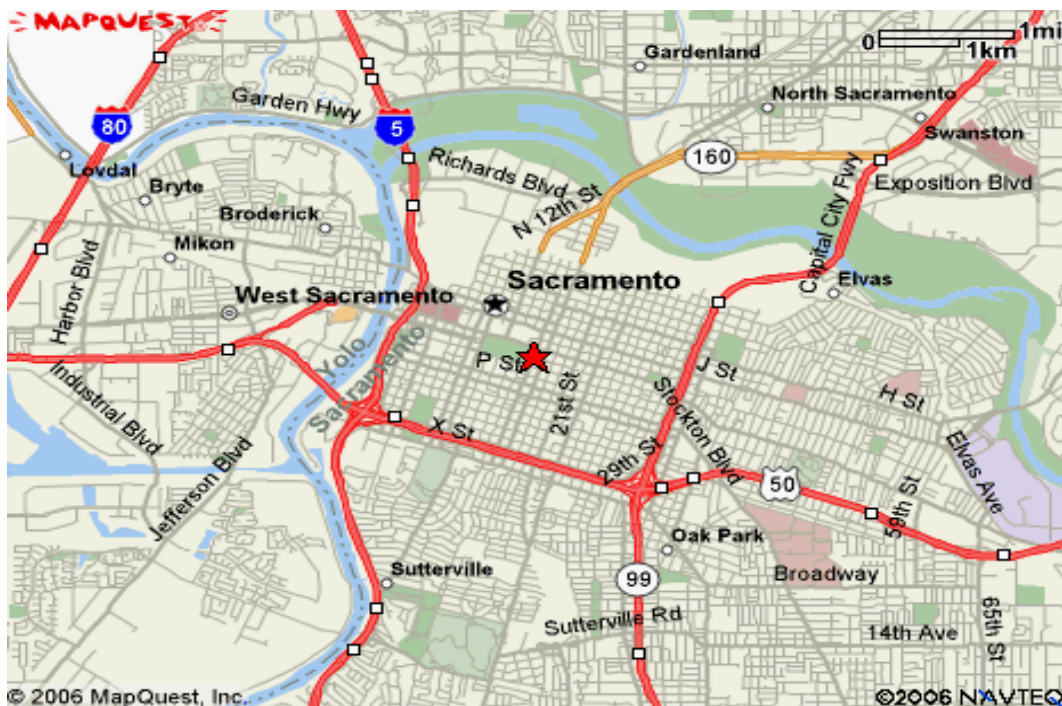
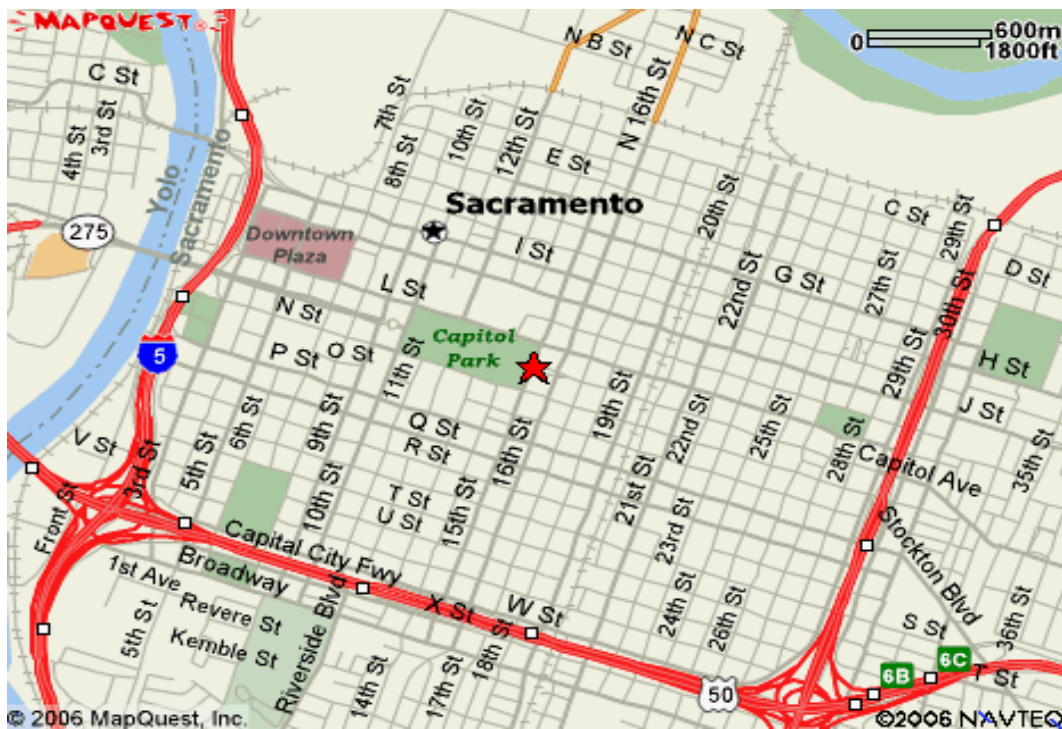
- A. **Emergency Mode Operation Plan.** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.
- B. **Data Backup Plan.** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and the amount of time to restore DHCS PHI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

5. Paper Document Controls

- A. **Supervision of Data.** DHCS PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.
- B. **Escorting Visitors.** Visitors to areas where DHCS PHI is contained shall be escorted and DHCS PHI shall be kept out of sight while visitors are in the area.
- C. **Confidential Destruction.** DHCS PHI must be disposed of through confidential means, such as cross cut shredding and pulverizing.
- D. **Removal of Data.** DHCS PHI must not be removed from the premises of the Contractor except with express written permission of DHCS.
- E. **Faxing.** Faxes containing DHCS PHI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.
- F. **Mailing.** DHCS PHI shall only be mailed using secure methods. Large volume mailings of DHCS PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted with a DHCS approved solution, such as a solution using a vendor product specified on the CSSI.

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Appendix 1

Maps/Directions



Data Library Links**State Administrative Manual**

<http://sam.dgs.ca.gov/TOC/1600/default.htm>

Health Information Portability and Accountability Act

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html>

Medi-Cal Policies and Articles

<http://www.medi-cal.ca.gov/>

Federal Register

<http://www.federalregister.gov/articles/2010/11/10/2010-28390/medicaid-program-recovery-audit-contractors>

Centers for Medicare and Medicaid Services

<http://www.cms.gov/>

Department of Health Care Services, Audits and Investigations

<http://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx>

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 455

[CMS–6034–F]

RIN 0938–AQ19

Medicaid Program; Recovery Audit Contractors

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule implements section 6411 of the Patient Protection and Affordable Care Act (the Affordable Care Act), and provides guidance to States related to Federal/State funding of State start-up, operation and maintenance costs of Medicaid Recovery Audit Contractors (Medicaid RACs) and the payment methodology for State payments to Medicaid RACs. This rule also directs States to assure that adequate appeal processes are in place for providers to dispute adverse determinations made by Medicaid RACs. Lastly, the rule directs States to coordinate with other contractors and entities auditing Medicaid providers and with State and Federal law enforcement agencies.

DATES: *Effective Date:* These regulations are effective on January 1, 2012.

FOR FURTHER INFORMATION CONTACT: Joanne Davis, (410) 786–5127.

SUPPLEMENTARY INFORMATION:

I. Background

A. Current Law

The Medicaid program is a cooperative Federal/State program designed to allow States to receive matching funds from the Federal Government to finance medical assistance to eligible low income beneficiaries. Medicaid was enacted in 1965 by the passage of the Social Security Act Amendments of 1965 creating title XIX of the Social Security Act (the Act).

States may choose to participate in the Medicaid program by submitting a State Plan for medical assistance that is approved by the Secretary of the U.S. Department of Health and Human Services. While States are not required to participate in the Medicaid program, all States, the District of Columbia, and the territories do participate. Once a State elects to participate in the program, it is required to comply with its State Plan, as well as the

requirements imposed by the Act and applicable Federal regulations.

CMS is the primary Federal agency providing oversight of State Medicaid activities and facilitating program integrity efforts. Our administration of the Medicaid program requires that we expend billions of dollars in Federal matching payments to States for Medicaid expenditures. We also have an obligation to prevent, identify, and recover improper payments to individuals, contractors, and organizations.

In November 2009, the President signed Executive Order (E.O.) 13520 in an effort to reduce improper payments by increasing transparency in government and holding agencies accountable for reducing improper payments. On March 22, 2010, the Office of Management and Budget (OMB) issued guidance for agencies regarding the implementation of E.O. 13520 entitled Part III to OMB Circular A–123, Appendix C (Appendix C). Appendix C outlines the responsibilities of agencies, determines the programs subject to E.O. 13520, defines supplemental measures and targets for high priority programs, and establishes reporting requirements under E.O. 13520 and procedures to identify entities with outstanding payments.

Section 6411 of the Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010) (the Affordable Care Act) directs States to establish programs by December 31, 2010 in which they will contract with 1 or more Recovery Audit Contractors (Medicaid RACs). The Medicaid RACs will review Medicaid claims submitted by providers of services for which payment may be made under the State Plan or a waiver of the State Plan to identify overpayments and underpayments.

Section 6411(a)(1) of the Affordable Care Act amended section 1902(a)(42) of the Act to provide that “the State shall establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h) * * *) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments * * *”. To offer context for our approach to the Medicaid RAC program, we provide background discussion on the Medicare RAC program under section 1893(h) of the Act.

B. Medicare RACs

Medicare RACs are private entities with which CMS contracts to identify underpayments and overpayments as well as recoup overpayments, until recently, limited to Medicare’s fee-for-service program. Initially authorized by the Congress as a 3-year demonstration program by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173, enacted on December 8, 2003) (MMA), Medicare RACs were permanently authorized in the Tax Relief and Health Care Act of 2006 (Pub. L. 109–432, enacted on December 20, 2006) (TRHCA).

During the Medicare RAC demonstration period, CMS contracted with RACs to review claims from Medicare participating providers and suppliers in New York, Florida, California, Arizona, Massachusetts, and South Carolina. From 2005 through 2008, the Medicare RACs identified and corrected over \$1 billion in improper payments. The majority, or 96 percent, of the improper payments were overpayments, while the remaining 4 percent were underpayments. As a result of the demonstrated cost effectiveness of the Medicare RACs, the TRHCA required CMS to implement a nationwide Medicare RAC program. The TRHCA directed CMS to expand the Medicare RAC program nationwide by January 1, 2010.

In our evaluation of the Medicare RAC demonstration, providers were surveyed and they identified to CMS a number of concerns and processes that needed to be improved. For example, Medicare RACs were reportedly inconsistent in documenting their “good cause” for reviewing a claim. In addition, providers complained that a lack of physician presence on Medicare RAC staffs contributed to Medicare claims incorrectly being denied. As a result, we met with stakeholders, including the provider community, and made a number of changes to improve the Medicare RAC program. In the permanent Medicare RAC program, CMS directed Medicare RACs to consistently document their “good cause” for reviewing a claim. In addition, CMS now requires each Medicare RAC to hire a minimum of 1.0 Full Time Equivalent (FTE) physician Medical Director to oversee the medical record review process; assist nurses, therapists, and certified coders upon request; manage quality assurance procedures; and maintain relationships with provider associations.

Both the MMA and the TRHCA required CMS to pay Medicare RACs on a contingency fee basis. Currently, CMS

pays Medicare RACs a contingency fee rate ranging between 9 and 12.50 percent. These contingency fees were not fixed by CMS, but were established by the contractors through a bidding process with CMS. Providers may appeal Medicare RAC determinations through the established Medicare appeals process. During the demonstration period, Medicare RACs were required to return contingency fees if the claim determination was overturned on the first level appeal. However, Medicare RACs were entitled to retain contingency fees if the determination was overturned on subsequent levels of appeal. In the permanent Medicare RAC program, CMS requires Medicare RACs to return the contingency fee payment if the determination is overturned at any stage of the appeals process.

C. Existing State Contingency Fee Contracts

There is precedent for State Medicaid contingency fee contracts for purposes of recovering Medicaid overpayments subject to third party liability (TPL) requirements. Section 1902(a)(25) of the Act requires States to take all reasonable measures to determine the legal liability of third parties to pay for medical assistance furnished to a Medicaid recipient under the State Plan. Several States have elected to do so through the use of contingency fee arrangements with TPL contractors. In addition, several States currently contract with contingency fee contractors to recover Medicaid overpayments unrelated to TPL. In a memorandum to CMS Regional Administrators dated November 7, 2002, we revised our policy prohibiting Federal financial participation (FFP) for States to pay costs to contingency fee contractors, unrelated to TPL. The revised policy allowed contingency fee payments if the following conditions were met: (1) The intent of the contingency fee contract must be to produce savings or recoveries in the Medicaid program and (2) the savings upon which the contingency fee payment is based must be adequately defined and the determination of fee payments documented to CMS's satisfaction.

II. Provisions of the Proposed Medicaid RAC Rule

In the November 10, 2010 **Federal Register** (75 FR 69037), we published a proposed rule that set forth guidance to States related to Federal/State funding of Medicaid RACs and the payment methodology for State payments to Medicaid RACs in accordance with the Affordable Care Act. We proposed

adding new regulatory provisions in 42 CFR part 455 subpart F governing Program Integrity—Medicaid.

Section 6411(a) of the Affordable Care Act amended and expanded section 1902(a)(42) of the Act to require States to establish Medicaid RAC programs by December 31, 2010, to contract with 1 or more contractors to audit Medicaid claims and to identify underpayments and overpayments and collect overpayments. While States were required to establish their Medicaid RAC programs by December 31, 2010, via the State Plan amendment (SPA) process, the Medicaid RAC programs were not required to be implemented by this date. In the November 10, 2010 proposed rule, we stated that, absent an exception, States were required to fully implement their Medicaid RAC programs by April 1, 2011.

The difference between establishing and implementing Medicaid RAC programs was clarified for States prior to the publication of the proposed rule. On October 1, 2010, we issued a State Medicaid Director (SMD) letter providing preliminary guidance to States on the implementation of their RAC programs. In the SMD letter, States were advised that they should attest that they would establish a Medicaid RAC program by submitting a SPA to CMS no later than December 31, 2010, or indicate that they would be seeking to be excepted from one or more of the proposed provisions, or indicate that they would be seeking a complete exception from establishing a Medicaid RAC program. Subsequently, on February 1, 2011, we issued an *Informational Bulletin* stating that the proposed April 1, 2011 implementation date would be delayed, in part, to ensure that States would be able to comply with the provisions of the final rule.

Section 1902(a)(42)(B) of the Act directs all States to establish Medicaid RAC programs, subject to the exceptions and requirements as the Secretary may require. This provision enables CMS to vary the Medicaid RAC program requirements, or except a State from establishing a Medicaid RAC program in certain circumstances, including where it would be inconsistent with State law. For example, the Secretary may exempt a State from the requirement to pay Medicaid RACs on a contingent basis for collecting overpayments when State law expressly prohibits contingency fee contracting. However, some other fee structure could be required under any exception.

Similarly, during the Medicaid RAC SPA process, some States advised CMS that they were required to enact

legislation before amending their State plans. Because the establishment of a Medicaid RAC program is accomplished by a SPA, some State legislatures did not have the opportunity to convene and enact the amendment to their State plans prior to December 31, 2010. In this case, those States submitted requests to delay establishing Medicaid RAC programs until after those State legislatures met. CMS granted these requests.

Also, there were circumstances, unrelated to the examples above, where States sought exceptions from some or all of the requirements of the Medicaid RAC program. Accordingly, § 455.516 proposed that States seeking exceptions from contracting with Medicaid RACs must submit a written justification for the request to CMS. We anticipate granting complete Medicaid RAC program exceptions rarely, and only under the most compelling of circumstances.

Section 6411(a) of the Affordable Care Act amended section 1902(a)(42) of the Act, regarding States Medicaid RAC programs:

- Under section 1902(a)(42)(B)(ii)(I) of the Act, payments must be made to a Medicaid RAC under contract with a State only from amounts recovered. As discussed in the proposed rule, we interpret this to mean that payments to Medicaid RACs may not exceed the total amounts recovered. For example, if a Medicaid RAC's efforts result in the recovery of a total of \$1 million, the fees paid to the RAC for its work regarding both overpayments and underpayments must not exceed \$1 million. The intent of the statute is for States and the Federal government to reduce improper payments in the Medicaid program in order to realize savings. Additionally, we interpret this to mean that payments to contractors were not made based upon amounts merely identified but not recovered, or amounts that may initially be recovered but that subsequently must be repaid due to determinations made in appeals proceedings.

In the proposed rule, we stated that the payment methodology determinations for States, as well as the timing of payments to Medicaid RACs for their work, were separate but closely related issues. We stated that the distinction between amounts recovered and amounts identified had implications for how States structured and administered payment agreements with Medicaid RACs, as well as the timing of Medicaid RACs' receipt of payments. We offered two options illustrating ways that States could structure payments.

In option one, for example, State A paid RAC A its fee when RAC A identified and recovered an overpayment. If provider A appealed and prevailed at any stage, RAC A would be required to return any portion of the contingency fee that corresponded to the amount of an overpayment that was overturned at any level of appeal.

In the second option, State B determined it would pay RAC B its contingency fee at the point at which the recovery amount is fully adjudicated; that is, at the conclusion of any and all appeals available to provider B. At that point, State B would pay RAC B a contingency fee based on the amount recovered.

- Under section 1902(a)(42)(B)(ii)(II)(aa) of the Act, payments to a Medicaid RAC contractor must be made on a contingent basis for collecting overpayments from the amounts recovered. In the proposed rule, we noted that we were aware that the Medicaid RAC program, by virtue of the differences between the Medicare and Medicaid programs, would not operate identically to the Medicare RAC program. We recognized that each State must tailor its Medicaid RAC activities to the uniqueness of its own State, and indicated that we would not prescribe a set contingency fee rate for States. Instead, we would implement certain guidelines based upon section 1902(a)(42)(B) of the Act and our experience with the Medicare RAC program, but allow States the discretion to set their fees within those guidelines.

Medicaid RACs will contract with States and territories to identify and collect overpayments, and will be paid on a contingency fee basis by the States. In the Medicare RAC program, CMS contracts with Medicare RACs to identify and recover overpayments from Medicare providers, and are paid on a contingency fee basis by CMS. In the proposed rule, we recognized the differences among States and territories when coordinating the collection of overpayments with RACs. The statute requires Medicaid RACs to collect overpayments. However, some States may not be able to delegate the collection of overpayments to contractors, while other States may have other restrictions.

Currently, there are 4 Medicare regional RACs operating. Those RACs are paid an average contingency fee rate of 10.86 percent by CMS, with the highest rate being 12.50 percent. We interpret the statutory language that States must establish a Medicaid RAC program “in the same manner as the Secretary enters into contracts with”

Medicare RACs to mean that some of the provisions of the Medicare RAC program, generally, should serve as a model for the proposed Medicaid RAC program, not that Medicaid RACs should be structured identically to Medicare RACs. Accordingly, in § 455.510(b)(3) and (b)(4), we stated that CMS would not provide FFP for any amount of a State’s contingency fee in excess of the then highest Medicare RAC contingency fee rate unless a State requests an exception from CMS and provides an acceptable justification.

We proposed that, in the absence of an approved exception, a State may only pay a RAC from the overpayments collected, and may only receive FFP on a contingency fee up to the highest Medicare RAC contingency rate. Any additional payment from the State to the RAC must be made using State-only funds. FFP is not available for administrative expenditure claims for the marginal difference between the highest Medicare fee and the State’s contingency fee. For example, unless an exception applies, if the highest Medicare RAC contingency fee is 12.50 percent and the State pays a Medicaid RAC 14 percent, we will not pay the Federal match on the 1.50 percent difference. In other words, the State must use State-only funds to make up the difference between the State’s 14 percent contingency fee and the 12.50 percent contingency fee ceiling. Currently, the Medicare RAC contracts have an established period of performance of up to 5 years, beginning in calendar year 2009. Initially, the maximum contingency fee rate for which FFP will be available for States to pay Medicaid RACs will be the highest Medicare RAC contingency fee, which is 12.50 percent. We anticipate that fee will be the maximum rate when States implement their RAC programs. Subsequently, we will make States aware of any modifications to the payment methodology for contingency fees and Medicaid RAC maximum contingency rates for which FFP will be available by publishing in a **Federal Register** notice, by December 31, 2013, the maximum Medicare contingency fee rate, which will apply to FFP availability for any Medicaid RAC contracts covering the period of performance beginning on July 1, 2014. The established rate will be in place for 5 years, or until we publish a new maximum rate in the **Federal Register**.

The Medicare RAC program is still a relatively new program. In our early outreach campaign to provide technical support and assistance to States in the procurement of their RAC contracts, we studied many of the lessons learned

from the Medicare RAC Demonstration, as well as the current provisions of the permanent Medicare RAC program and sought to incorporate many lessons learned in this final rule. For example, we proposed that States require their Medicaid RACs to employ trained medical professionals to review Medicaid claims, as we now require the Medicare RACs to do. We indicated that States should also be cognizant of potential organizational conflicts of interest and should take affirmative steps to identify and prevent any conflicts of interest.

In the proposed rule, we reported that the Office of Inspector General of the U.S. Department of Health and Human Services (HHS–OIG) had found that the Medicare RACs identified over \$1 billion in improper payments, but referred only two cases of potential fraud to CMS. HHS–OIG opined that Medicare RACs had no incentive to make fraud referrals because the RACs did not receive contingency fees for those referrals. In the proposed rule, we cautioned States, in their design of Medicaid RAC programs, to ensure that the Medicaid RACs report instances of fraud and/or abuse in addition to the pursuit of overpayments. At § 455.508(b), we proposed that whenever RACs had reasonable grounds to believe that fraud and/or abuse had occurred, they must report it to the appropriate law enforcement officials. We solicited comments on these proposals, as well as other issues that States should consider in the design of their RAC programs. At § 455.508(c), we proposed that Medicaid RACs must meet the additional requirements that States may establish.

- Under section 1902(a)(42)(B)(ii)(II)(bb) of the Act, payment to a Medicaid RAC for identifying underpayments may be made in any amount as the State may specify. Currently, Medicare RACs are paid a contingency fee to identify underpayments, similar to the way in which they are paid to identify and recover overpayments. In the proposed rule, we stated that a State may elect to use a similar approach, or elect to establish a set fee or some other fee structure for the identification of underpayments. Consistent with a State’s obligation to ensure that it pays the correct amount to the right provider for the appropriate service at the right time for the right beneficiary, whatever methodology a State chooses must adequately incentivize the detection of underpayments. At § 455.510(c), we proposed granting States the flexibility to specify the underpayment fee for Medicaid RACs. Additionally, we stated

that CMS would monitor the methodologies and amounts paid by States to Medicaid RACs to identify underpayments, and may consider future additional regulation depending on what data reveal over time.

Section 1902(a)(42)(B)(ii)(I) of the Act requires that payments to a Medicaid RAC only come from amounts recovered. We proposed that Federal matching payments were not available for RAC contingency fees paid in excess of the overpayment amounts collected. The proposed rule stated that the total fees paid to a Medicaid RAC included both the amounts associated with: (1) Identifying and recovering overpayments; and (2) identifying underpayments. Due to the requirement in section 1902(a)(42)(B)(ii)(I) of the Act that contingency fees only come from amounts recovered, total fees must not exceed the amount of overpayments collected.

In the proposed rule, we cited data from the Medicare RAC Demonstration that overpayment recoveries by Medicare RACs exceeded underpayment identification by more than a 9:1 ratio. Therefore, we concluded that States would not need to maintain a reserve of recovered overpayments to fund Medicaid RAC costs associated with identifying underpayments. However, we proposed that States maintain an accounting of amounts recovered and paid.

We also proposed that States report overpayments to CMS based on the net amount remaining after all fees are paid to the Medicaid RAC. In the proposed rule, we linked the treatment of the fees and expenditures to the specific statutory language implementing the Medicaid RAC requirements and did not extend it to Medicaid overpayment recoveries in other contexts.

We stated, for example, RAC X's fee for overpayment identification is 10 percent of the recovery amount. The fee for identification of underpayments is 10 percent of the amount identified. If an overpayment recovery amount was \$100, and the total amount of underpayment was \$20, the total fees paid to the Medicaid RAC would be \$12 (\$10 for the identification and recovery of the overpayment and \$2 for the identification of the underpayment). The State would report the recovery (collection) amount of \$100 and the \$10 RAC fee at the original match rate for the overpayment and the \$2 RAC fee at the match rate for payment of the underpayment. If the State paid a provider based on the Medicaid RAC-identified underpayment, and that expenditure was claimed in accordance with timely filing requirements, we

proposed, the \$20 expenditure would be matched at the regular Federal Medical Assistance Percentage (FMAP), or the appropriate FFP rate.

Currently, § 433.312 directs States to refund the Federal share of overpayments, regardless of whether the State actually recovers the overpayments from the provider. In the proposed rule, we noted that this requirement, and all other requirements relating to overpayments, would apply to Medicaid RAC-identified overpayments. Therefore, if a Medicaid RAC identified an overpayment to a provider, the State would refund the Federal share of the overpayment amount to the Federal Government, regardless of whether the State collected the overpayment.

- Under section 1902(a)(42)(B)(ii)(III) of the Act, States must have an adequate appeals process for entities to challenge adverse Medicaid RAC determinations. We proposed at § 455.512 that States must provide appeal rights available under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination. We proposed two alternatives the State could use to achieve this. In alternative one, a State may utilize an existing appeals infrastructure to adjudicate Medicaid RAC appeals. The State would submit to CMS a proposal describing the appeals process, which would need to be approved prior to implementing its RAC program.

In alternative two, a State may elect to establish a separate appeals process for RAC determinations, which must also ensure providers adequate due process in pursuing an appeal. Accordingly, in § 455.512 we proposed to give States the flexibility to determine the appeals process that will be available to providers seeking review of adverse RAC determinations. However, through the State Plan amendment (SPA) process, each State has indicated that it already has in place an administrative appeals infrastructure they will use for a provider to appeal an adverse Medicaid RAC determination.

Finally, we also noted in the proposed rule that the potential length of a State's administrative appeals process may have an impact on the methodology or structure of the payment agreement between a State and a Medicaid RAC. For example, in a contract between State X and RAC X, where State X's administrative appeal process can extend for 2 years, RAC X may not receive payment for an extended period of time. Accordingly, RAC X's contingency fee rate will most likely reflect operating, maintenance and legal

costs over that period. Alternatively, in State Y, completion of the administrative appeals process takes 9 months. A contract between State Y and RAC Y may reflect a different contingency fee rate.

- Under section 1902(a)(42)(B)(ii)(IV)(aa) of the Act, for purposes of section 1903(a)(7) of the Act, expenditures made by the State to carry out the Medicaid RAC program are necessary for the proper and efficient administration of the State Plan or waiver of the plan. We interpret this reference to section 1903(a)(7) of the Act to mean that amounts expended by a State to establish and operate the Medicaid RAC program (aside from fee payments, the treatment of which is discussed elsewhere in this preamble) are to be shared by the Federal Government at the 50 percent administrative rate. Therefore, we proposed at § 455.514(b), that FFP is available to States for administrative costs subject to reporting requirements.

We also proposed that States would report to CMS certain elements describing the effectiveness of their Medicaid RAC programs. These proposed elements included general program descriptors (for example, contract periods of performance, contractors' names) and program metrics (for example, number of audits conducted, recovery amounts, number of cases referred for potential fraud). These elements will be provided in sub-regulatory guidance specified by CMS.

- Sections 1902(a)(42)(B)(ii)(IV)(bb) and 1903(d) of the Act apply to amounts recovered (not merely identified) under the Medicaid RAC program. In the proposed rule, we indicated that a State would be required to refund the Federal share of the net amount of overpayment recoveries *after* deducting the contingency fees paid to a RAC (in conformance with the restrictions discussed above, including the maximum allowed RAC contingency fee and the exception process). In other words, a State would be required to take a RAC's contingency fee "off the top" *before* calculating the Federal share of the overpayment recovery to be returned to CMS. The amounts recovered would be subject to a State's quarterly expenditure estimates and the funding of the State's share.

Additionally, we noted in the proposed rule that the U.S. territories operate under a separate funding authority that is statutorily-capped. As a result of the limitations placed on FFP by section 1108(g) of the Act, territories would need to assess the feasibility of implementing and funding Medicaid RAC contractors in their jurisdictions.

As of the date of this final rule, all of the territories requested and were granted exceptions from establishing RAC programs. These exceptions will not be reassessed. Should RAC programs become feasible due to a change in circumstances, the territories can amend their State Plans to establish RAC programs.

- Under section 1902(a)(42)(B)(ii)(IV)(cc) of the Act, States and their Medicaid RACs must coordinate their efforts with other contractors or entities performing audits of entities receiving payments under the State Plan or waiver in the State, including State and Federal law enforcement agencies. In the proposed rule, we emphasized that Medicaid RACs were not intended to, and would not, replace any State program integrity or audit initiatives or programs. We proposed under § 455.508(b) that an entity that wanted to enter into a contract with a State to perform the functions of a Medicaid RAC must agree to coordinate its audit recovery efforts with other entities.

In the proposed rule, we stated that although overlapping or multiple provider audits may be necessary, we hoped to minimize the likelihood of overlapping audits. Section 1902(a)(42)(B)(ii)(IV)(cc) of the Act directs States to assure CMS that they will coordinate Medicaid RAC audit activity with an array of other entities that also conduct audits of Medicaid providers. Providers are currently subject to audits by the States' routine program integrity audits, CMS' Medicaid Integrity Contractors' (MICs) audits, as well as audits conducted by other State and Federal entities. For example, the MICs perform audits of providers, on behalf of CMS, in order to identify overpayments. Payment Error Rate Measurement (PERM) audits are ongoing CMS audits that measure improper payments in the Medicaid and Children's Health Insurance Program and error rates for each program. As we stated in the proposed rule, we anticipate working both internally and with the States to minimize this administrative burden on Medicaid providers.

In addition to the obligation to coordinate auditing efforts to reduce the overburdening of Medicaid providers, we also wanted to ensure coordination between Medicaid RACs and law enforcement organizations so that suspected cases of fraud and abuse were processed through the appropriate channels. Law enforcement organizations may conduct audits or investigations of Medicaid providers in addition to Federal and State agencies.

Those organizations include, but are not limited to, the HHS-OIG, the U.S. Department of Justice, including the Federal Bureau of Investigation, State Medicaid Fraud Control Units (MFCUs), other Federal and State law enforcement agencies, as appropriate, and CMS. We concluded that States are in the best position to coordinate audit activities.

We also proposed at § 455.508(b) that a Medicaid RAC must report fraud or criminal activity to the appropriate law enforcement officials whenever it has reasonable grounds to believe that such activity has occurred.

III. Analysis of and Responses to Public Comments

We received 76 timely comments on the November 10, 2010 proposed rule (75 FR 69037) from State associations, hospitals, medical associations, providers, managed care organizations, and contingency fee contractors. We reviewed each commenter's comments and grouped related comments. After associating like comments, we placed them in categories based on subject matter. Summaries of the public comments received and our responses to those comments are set forth below.

A. General

Comment: One commenter requested clarification and asked CMS to consider addressing the fundamental differences between Medicaid RACs and Medicare RACs.

Response: Medicaid RACs are State funded, designed, procured, operated and administered programs authorized by section 6411 of the Affordable Care Act to identify underpayments and overpayments and to recover overpayments to Medicaid providers, on a contingency fee basis. Medicare RACs are regionally operated contractors that are federally funded, procured, operated and administered programs authorized permanently by section 302 of the TRHCA to identify underpayments and overpayments and to recoup overpayments under parts A and B of the Medicare program. The Congress provided for payments to the Medicare RACs on a contingency fee basis for correcting overpayments and identifying underpayments. In constructing this final rule, we took into consideration these fundamental differences between the Medicaid and Medicare programs along with feedback from commenters on how these differences can be addressed as well as how best practices from the Medicare RAC program can be incorporated.

Comment: One commenter asserted that CMS should seek input from States concerning reporting metrics and that a

cooperative approach to this requirement should provide CMS with the data needed for oversight of the program but not be overly burdensome to the States.

Response: We agree with the comment regarding reporting metrics. We anticipate working with States to develop performance metrics and will issue sub-regulatory guidance regarding specific reporting criteria when appropriate.

Comment: One commenter indicated that the Medicaid RAC program would be further enhanced by developing consistent objective criteria for States to follow and this information should be publicly available to establish a baseline for the community.

Response: We agree that the Medicaid RAC program should have consistent and objective criteria. As a result of comments from stakeholders, we considered and are finalizing the following provisions:

- State coordination of recovery audit efforts with other auditing entities (§ 455.506(c)).
- State reporting of fraud and/or abuse, as defined by § 455.2, to its MFCU or other appropriate law enforcement agency (§ 455.506(d)).
- State established limit on the number and frequency of medical records requested by a RAC (§ 455.506(e)).
- The entity must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval (§ 455.508(b)).
- A requirement that RACs hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims (§ 455.508(c)).
- The RAC must work with the State to develop an education and outreach program component, including notification of audit policies and audit protocols (§ 455.508(d)).
- Mandatory RAC customer service measures, including: Providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact

(§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request (§ 455.508(e)(3)); and notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4)).

- A three-year maximum claims look-back period (§ 455.508(f)).
- Timely referral of suspected cases of fraud and/or abuse by the Medicaid RAC to the State (§ 455.508(h)).
- Return of contingency fees within a reasonable timeframe as prescribed by the State if a Medicaid RAC determination is reversed at any level of appeal (§ 455.510(b)(3)).

Comment: One commenter indicated that parallel Medicare and Medicaid RAC standards are consistent with CMS' aim of harmonization of the anti-fraud activities of the Medicare and Medicaid programs under the Center for Program Integrity (CPI).

Response: We agree with the commenter. Medicaid RAC programs are, by statute, administered differently than Medicare RAC programs. However, we have concluded that many aspects of the Medicaid RAC program can operate in alignment with the Medicare RAC program including the following: Staffing requirements (§ 455.508(a), (b), and (c)); State and RAC development of an education and outreach program, including notification of audit policies and protocols (§ 455.508(d)); minimum customer service measures including: Providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request (§ 455.508(e)(3)); notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4)); a 3 year maximum claims look-back period (§ 455.508(f)); and a State established limit on the number and frequency of medical records requested by a RAC (§ 455.506(e)).

Comment: Several commenters indicated that processes should be developed to minimize provider burden to the greatest extent possible in connection with the identification of improper payments. Additionally, the commenters stated that the final rule should incorporate increased accountability and transparency provisions which ultimately became

part of the permanent Medicare RAC program.

Response: Again, we have concluded that many aspects of the Medicaid RAC program can operate in alignment with the Medicare RAC program, consistent with State law, thereby minimizing provider burden including the following: Staffing requirements (§ 455.508(a), (b), and (c)); State and RAC development of an education and outreach program, including notification of audit policies and protocols (§ 455.508(d)); minimum customer service measures including: Providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request (§ 455.508(e)(3)); notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4)); a 3 year maximum claims look-back period (§ 455.508(f)); and a State established limit on the number and frequency of medical records requested by a Medicaid RAC (§ 455.506(e)). States are obligated to coordinate auditing efforts to reduce the overburdening of Medicaid providers.

Comment: One commenter expressed concern with the implementation of a "Medicare based audit program" due to budget deficits in the States and pressure to look for opportunities to find savings in the already underfunded Medicaid program.

Response: We understand the commenter's concerns. However, the Affordable Care Act requires the implementation of a Medicaid RAC program, with certain exceptions as permitted by the Secretary. Because the Affordable Care Act requires States to contract with RACs on a contingency fee basis, out-of-pocket expenses should be minimized. Therefore, the majority of the program costs will be offset by overpayment recoveries. Further, Medicaid RACs are part of a significant initiative to reduce waste and improper payments and recoup the improper payments. Accordingly, we believe that the Medicaid RAC program will lead to significant savings for States, as indicated in Section VI. of this final rule, titled "Regulatory Impact Analysis."

Comment: One commenter urged CMS to balance the goal of recovery of funds improperly paid with the

"respectful treatment of the overwhelming number of Medicaid providers who continue to provide healthcare services at substantially less than market rates and who diligently attempt to abide by all applicable regulations and payment policies." Another commenter suggested that providers would no longer participate in Medicaid and its clients would no longer have access to care.

Response: We agree that Medicaid providers deserve to receive respectful treatment from CMS and we understand the commenters' concerns regarding the burden of additional audits on providers. In the proposed rule, we specifically emphasized that States and their RACs must undertake coordination efforts to reduce the potential overburdening of Medicaid providers, as well as ensuring that suspected cases of fraud and abuse are processed through the appropriate channels. We emphasized that it is the State's obligation to ensure that RACs do not duplicate or compromise the efforts of other entities performing audits. In the final rule, we require at § 455.506(c) that States must coordinate the recovery audit efforts of their RACs with other auditing entities.

Comment: One commenter stated that the Department of Health and Human Services (HHS) should better target program integrity dollars to efforts that have the most opportunity for success.

Response: We believe that the Medicare and Medicaid RAC programs are an investment in successful program integrity efforts. In FY 2010, Medicare RACs identified and corrected \$92.3 million in combined overpayments and underpayments. Eighty-two percent of all RAC corrections were collected overpayments, and 18 percent were identified underpayments that were refunded to providers. We expect that States will realize a similar ratio of overpayments to underpayments in connection with the implementation of the Medicaid RAC program, and will examine the trends among the States over several years.

Comment: One commenter indicated that HHS should clarify whether it is considering or recommending to the Congress that it eliminate the Audit Medicaid Integrity Contractor (MIC) and Review of Provider MIC effort since it appears to be duplicative of the Medicaid RAC program.

Response: We disagree that the work of MICs, both Audit and Review of Provider, is duplicative of Medicaid RACs. As stated previously, Federal MICs are better positioned to address certain Medicaid program

vulnerabilities than State-administered RACs.

Comment: One commenter recommended that CMS require States to provide transparency in coding/billing rules and guidelines, share screening guidelines for medical necessity determinations, and provider education. According to the commenter, this can ensure provider success as well as develop a framework for auditing bodies to follow. This commenter believes that existing State rules and guidelines are often vague or unwritten. Therefore, audits should not be allowed except where the State has promulgated clear criteria.

Response: We agree that States should be as transparent as possible with regard to their Medicaid RAC programs. While we are not requiring States to provide coding/billing guidelines, we are requiring RACs to work with the State to develop a provider education and outreach program, including notification of audit policies and protocols for auditing bodies and providers to have clearly defined roles and expectations (§ 455.508(d)).

Comment: One commenter indicated that allowing contingency fees to be based on actual recoveries puts a “tremendous strain on a company’s cash flow.” The commenter indicated that a company has to prepare for a long lead time between providing the service of identifying a recovery and being paid after a governmental agency has made the effort to collect the recovery and then process the payment. This commenter further stated that the company providing the service has no input or control over the collection process and must rely on the good faith of the agency to process payments in a timely and efficient manner.

Response: We disagree with this comment because we do not believe that there is credible evidence to suggest that any State agency would intentionally withhold compensation from one of its contractors. As envisioned, a State and a RAC would voluntarily enter into a contractual agreement with provisions protecting both parties’ interests. Thus, the agency would agree to pay the RAC according to the contractual agreement. As a general rule, contingency fee contractors should be aware of the financial risk of working on a contingency fee basis. In addition, States have an incentive to collect overpayments as soon as possible. Moreover, the RAC can recoup overpayments directly from providers if its contract with the State is structured to permit RAC collection of overpayments.

Comment: One commenter expressed concern that the proposed rule does not reflect the potential savings associated with the correction of repeated provider billing errors. Thus, the current rule does not incentivize a RAC to help a State stop systemic overpayments as that would eliminate the RAC’s contingency fee. This commenter suggested that HHS consider some method to reward a RAC for identifying and reporting solutions to a State which would end overpayments that occur from system error or other administrative problems on an ongoing basis.

Response: While we encourage States to work with their RACs to identify potential State vulnerabilities or other similar problem areas, a RAC reward for the activities is outside the scope of the proposed and final rules. Generally, a Medicaid RAC is required to review post-payment claims for the purpose of identifying and collecting overpayments as well as identifying underpayments. Sections 1902(a)(42)(B)(i) and (ii)(I)(aa) of the Act require RACs to be compensated on a contingency fee basis for the identification and recovery of overpayments, to the extent it is consistent with State law. The statute does not require Medicaid RACs to identify State administrative issues. We encourage States to evaluate identified overpayments to determine if trends are apparent and whether solutions can be developed to address noted vulnerabilities.

Comment: Several commenters indicated that the final rule should require CMS, State Medicaid agencies (SMAs), and RACs to use program “fixes” to educate providers as well as implement payment system changes to avoid billing mistakes before they are made.

Response: We agree and have included, in this final rule, a requirement for States and their RACs to develop an education and outreach program at § 455.508(d), including notification to providers of audit policies and protocols. We believe that States should implement additional process improvements to their payment systems to the extent possible. Those improvements should not substitute for program integrity initiatives or programs to ensure that proper payments are made to providers.

Comment: One commenter suggested that CMS place oversight of the State Medicaid RAC programs and Medicare RAC contractors within the CMS CPI. Based on its core function and experience base, CPI is uniquely positioned to oversee the Medicare and Medicaid RACs because its duties are to

perform Medicare and Medicaid program integrity activities.

Response: While we appreciate the commenter’s suggestion, the Medicaid RACs will be procured, administered and operated by the States according to State laws and regulations. Additionally, there will be no privity of contract between CMS and the Medicaid RACs. We recently provided support and technical assistance to the States in the form of sub-regulatory guidance, all-State call forums, webinars, and a video entitled “Medicaid RACs: Are You Ready?” We will continue to provide technical support and assistance to States after publication of this final rule. The appropriate CMS component to oversee the Medicare RAC program is outside the scope of this final rule.

Comment: One commenter indicated that it was fundamentally opposed to contingency fees in Medicare and Medicaid auditing. According to the commenter, this type of behavior has the overwhelming tendency to push auditors “to take a chance” and inappropriately deny claims.

Response: We understand the concerns of the commenter. However, the statute requires Medicaid RACs to be paid on a contingency fee basis for the identification and recovery of overpayments. Contingency fee contracting is a type of payment methodology that has been a standard practice accepted among private healthcare payers for more than 20 years. In the final rule, we clarified that Medicaid RACs will only review post-payment claims for overpayments and underpayments. Accordingly, the Medicaid RACs will not deny claims.

Comment: One commenter expressed concern that the proposed rule does not indicate that CMS is aware of abuses to providers. As support, the commenter cited anecdotes experienced by providers during the Medicare RAC Demonstration period. According to the commenter, CMS was advised of the “horrific costs incurred by providers in fighting denials, particularly in California, and the extremely high percentage of denials overturned * * * but tremendous cost had been incurred and the damage was done in terms of reputation, reallocation of resources, etc.”

Response: We disagree with the comment. While we are aware of issues in California, we are not aware of explicit “abuses to providers.” We have attempted to address the concerns of providers and incorporate the lessons learned from the Medicare RAC Demonstration period into the permanent Medicare RAC program, including, but not limited to, requiring

the Medicare RAC to document their “good cause” for reviewing a claim and requiring each Medicare RAC to hire a minimum of 1.0 Full Time Equivalent (FTE) physician Medical Director to oversee the program. In addition, we have attempted to incorporate those lessons learned in the Medicare RAC program to the development of the Medicaid RAC program.

Comment: One commenter expressed disappointment that the proposed rule does not contain best practices from the Medicare RAC Demonstration and recommends that CMS reconsider its proposed Medicaid RAC program policies in the final rule.

Response: We agree with the spirit of the comment. As a result of numerous comments from stakeholders, we are making modifications to the proposed Medicaid RAC program in this final rule. For example, we are requiring in this final rule that each Medicaid RAC hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy. A State may request an exception, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting written justification and receiving approval from CMS. We finalize this provision at § 455.508(b). We are also requiring Medicaid RACs to hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims. We finalize this provision at § 455.508(c). Additionally, we are requiring State and RAC development of an education and outreach program for providers, including notification of audit policies and protocols (§ 455.508(d)); minimum customer service measures, including those measures found in the Medicare RAC program such as: Providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers’ request (§ 455.508(e)(3)); notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4)); a 3 year maximum claims look-back period (§ 455.508(f)); and a State-established limit on the number and frequency of medical records requested by a RAC (§ 455.506(e)). States may request exceptions to § 455.508(f) through the

SPA process, and RACs may request from States, exceptions to § 455.506(e).

Comment: One commenter recommended that States should implement the RAC program, through the use of “regional RACs” to minimize provider burden and to maximize consistency and efficiency.

Response: We agree that regional Medicaid RACs can be an innovative strategy for States to share resources. There is nothing in the statute that would preclude a group of States from joining together to contract with a Medicaid RAC. There has been some State interest in forming/procuring a regional RAC. We encourage their efforts. However, we will not mandate that States adopt this strategy.

Comment: One commenter asserted that requiring close oversight of the RAC program will be challenging due to budget constraints.

Response: We understand the commenter’s concerns. However, the Medicaid RACs are part of a significant initiative to reduce improper payments and recoup the overpayments that have occurred.

Comment: One commenter requested that CMS provide “extremely tight monitoring” of Medicaid RAC review, auditing behavior and denial patterns if CMS interprets section 6411 of the Affordable Care Act to mandate contingency fees regarding the identification and recoupment of overpayments.

Response: Section 1902(a)(42)(B)(ii)(II)(aa) of the Act mandates that RACs be paid on a contingency fee basis for the identification and recoupment of overpayments. We will oversee State implementation of Medicaid RAC programs to ensure compliance with the Act and these regulations, but do not anticipate the need to, as the commenter suggests, engage in “extremely tight monitoring” at this point. States have attested through their SPAs that they will implement a Medicaid RAC program consistent with this final rule (unless a State has been granted an exception).

Comment: Several commenters suggested that “[t]he audit should include all of Medicaid, and not be restricted to narrow areas. This will ensure the maximum benefit of program recoveries and preventive actions on the broadest scope possible.”

Response: We believe that States should have the ability to direct the audit targets, but that, so long as consistent with State direction, the RACs should have the ability to audit the entire Medicaid program.

Comment: Several commenters questioned CMS’ authority to require States to continue existing program integrity efforts. Most of these commenters recommended that CMS exempt States that have Medicaid Integrity Programs or similar audit programs from the requirement to establish RAC programs. These commenters argued that there is no statutory authority for CMS to compel States to maintain levels of funding and activity for a duplicate program, and questioned the assertion that States have no option to choose to either be audited by a Federal MIC or establish a Medicaid RAC program. Several commenters also expressed concern that the continuation of existing program integrity efforts greatly reduces flexibility and creates duplicative audits and review processes which may ultimately impact provider participation and access to care. Finally, one commenter recommended that CMS remove the requirement to continue existing program integrity activities completely.

Response: Continuation of existing program integrity activities is important to ensure a comprehensive State program integrity program that includes more than a claims auditing program, such as the Medicaid RAC program. Other critical components of a Medicaid integrity program include Surveillance and Utilization Review (SUR) unit activities, MMIS system monitoring, and fraud prevention and detection activities, including coordination with law enforcement.

We disagree that the Medicaid RAC program is duplicative of the Federal national audit program, in which Federal MICs conduct audits of Medicaid providers. In particular, while RACs are an efficient way to identify payment errors, they are not the most effective approach to identify or prevent fraudulent practices. Federal MICs can focus on audit issues that may be less advantageous for a contingency-fee based contractor. In addition, fraudulent schemes may not lead to overpayment recoveries, which provide the source of RAC fees. Moreover, Medicaid RAC programs are poised to address State-specific issues stemming from the individual characteristics of each State’s Medicaid program (for example, special payment structures under a Medicaid demonstration) and will focus on the needs and vulnerabilities associated with a particular State. In contrast, Federal MICs are poised to address vulnerabilities on a regional and national basis. These regional and national trends would likely go undetected by an individual Medicaid

RAC. Accordingly, the national audit program is complementary to a State Medicaid RAC program.

We are not exempting States that have Medicaid integrity programs from establishing a Medicaid RAC program. Although there is no specific requirement in the Affordable Care Act regarding the continuation of program integrity efforts, the Congress directed CMS to promulgate regulations to carry out section 6411 of the Affordable Care Act with full awareness of the various program integrity initiatives for which it had given previous authority and that are currently in place in States. Congress did not relax any of those previously authorized program integrity activities in the Affordable Care Act. We take this to mean that Congress intended this policy to supplement previously authorized program integrity activities at both the State and Federal levels. We also believe that States should play a significant role in coordinating the audit activities of their respective integrity programs, RACs, and any other auditing entities under contract with the State. We are very concerned about provider participation and beneficiary access to care as well as minimizing the potential for multiple audits of the same provider. However, States should not supplant existing State program integrity initiatives with a Medicaid RAC program because of the fundamentally different and complementary approaches of the two audit programs.

B. Implementation Date

Comment: Several commenters expressed concern that "States must fully implement their Medicaid RAC programs by April 1, 2011." While some commenters recommended specific alternative implementation dates ranging between July 1, 2011 and January 1, 2012, the majority of the commenters asserted that April 1, 2011, did not allow States enough time to complete the procurement process, or allow States that require legislative authority to obtain approval for contracting with RACs. One commenter requested clarification as to the meaning of "fully implement" by April 1, 2011. Another commenter suggested voluntary implementation, on the part of States, from the present date until January 1, 2012.

Response: Although we proposed an implementation date of April 1, 2011, the date was contingent upon the rule being finalized. We recognize the need to provide a reasonable period of time between publication of the final rule and the date for required implementation of the Medicaid RAC program to ensure States' compliance

with the final rule. Accordingly, absent an exception, States will be required to implement their RAC programs by January 1, 2012.

Comment: One commenter asked if there will be a penalty if a State does not implement a RAC program.

Response: When a State elects to participate in the Medicaid program, it is required to comply with its State Plan, as well as the requirements imposed by the Act and applicable Federal regulations. Section 1902(a)(42)(B)(i) of the Act requires States to implement RAC programs, which is consistent with States' commitment to promote program integrity. Additionally, States are required by section 1903(a)(7) of the Act to administer funding necessary for the proper and efficient administration of the State Plan or waiver of the plan. If the Secretary deems that a Medicaid RAC program is necessary to ensure the integrity and the efficiency of a State's Medicaid program, a State's failure to implement the program may violate section 1903(a)(7) of the Act. A potential consequence of a State's failure to implement a RAC program is the loss of FFP. If a State is unable to implement a RAC program, then that State should request from CMS an exception either from a specific Medicaid RAC program requirement(s) or a complete exception from implementing the RAC program. However, as stated in the proposed rule, we will grant complete exceptions from the Medicaid RAC program or exceptions to RAC requirements only rarely and only under the most compelling of circumstances.

Comment: One commenter recommended that CMS adopt a phase-in strategy similar to the Medicare program to ensure that the provider community can actively participate in outreach programs.

Response: We provided early guidance for States with regard to the creation and implementation of a Medicaid RAC program. States already have the ability to request delayed implementation of RAC programs through the Medicaid SPA process. Additionally, we provided support and technical assistance to the States in the form of sub-regulatory guidance, all-State call forums, webinars and an informative video entitled "Medicaid RACs: Are You Ready?" We fully anticipate continuing to provide technical assistance after the publication of the final rule. Therefore, we are not adopting a global phase-in strategy.

C. Program Requirements

Comment: Numerous commenters inquired about the overall program approach of the Medicaid RAC program. One commenter indicated that it interpreted the Affordable Care Act to read that Medicaid RACs should be established in the same manner as CMS currently contracts with Medicare RACs, and with the same program requirements. Several commenters suggested that CMS should standardize program elements of the Medicare RACs into Medicaid RAC programs. Several commenters expressed their concerns that a variation in Medicaid RAC program requirements between bordering States would cause an undue burden on providers that operate nationally or in multiple States.

Response: Consistent with the flexibility afforded States in the design and operation of their Medicaid programs, we did not prescribe every element of the Medicaid RAC program in the proposed rule. We received many comments encouraging CMS to adopt measures in the Medicaid RAC program that could operate in alignment with Medicare RAC requirements. We considered the effect of aligning Medicare provisions upon individually State-run programs and existing State laws and regulations and balanced that with the spirit of the statute. Accordingly, in the final rule, we are requiring certain specific program elements that are consistent with the program elements established by the Medicare RAC program. These program elements include the following:

- Requiring the entity to hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval (§ 455.508(b));
- Requiring the entity to hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims (§ 455.508(c));
- Requiring the development of an education and outreach program component, including notification to providers of audit policies and protocols (§ 455.508(d));
- Requiring RAC customer service measures including: Providing a toll-free customer service telephone number in all correspondence sent to providers

and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request (§ 455.508(e)(3)); notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4));

- 3-year maximum claims look-back period (§ 455.508(f));
- State established limit on the number and frequency of medical records requested by a RAC (§ 455.506(e));

- State coordination of recovery audit efforts with other auditing entities (§ 455.506(c)); and

- Return of contingency fees within a reasonable timeframe as prescribed by the State, if a Medicaid RAC determination is overturned at any level of appeal (§ 455.510(b)(3)). As noted below, States will have flexibility as to timing of payment.

In addition, we strongly encourage States to adopt specific program elements that are part of the permanent Medicare RAC program within the flexibility States have to design and implement their RAC programs in the following areas:

- Medical necessity reviews;
- Extrapolation of audit findings;
- External validation of accuracy of RAC findings; and
- Types of claims audited.

For contingency fees, States maintain the flexibility of paying contingency fees either from amounts identified and recovered, but not fully adjudicated, or after the overpayment was fully adjudicated and all appeals available to the provider were exhausted. As noted above, the RAC will be required to return the contingency fee, within a reasonable timeframe as prescribed by the State that corresponds to the amount of the overpayment if an adverse determination is overturned at any level of appeal.

Program elements where we will grant States complete flexibility regarding the design, procurement, administration and operation of their RAC programs, largely because of the requirements of State laws, are as follows:

- Underpayment methodology;
- State appeals process;
- Contingency fee rates (States have complete flexibility in the contingency fee rates they pay, exclusive of FFP. However, we will provide FFP only for amounts that do not exceed the then-

highest contingency fee rate paid to Medicare RACs);

- State exclusion of claims;
- Bundling of procurements; and
- Coordination of the collection of RAC overpayments.

With regard to the providers serving beneficiaries in multiple States that expressed concern about the variation among Medicaid RAC program elements, we believe that a strong education and outreach campaign developed by the States and RACs and required as a part of every Medicaid RAC program will help alleviate the concerns that were expressed.

As we described in more detail, in sections II. and III.G. of this final rule, we are granting States the flexibility to design their appeals processes, but States are required by section 1902(a)(42)(B)(ii)(III) of the Act to have an adequate process for entities to appeal adverse RAC determinations.

Comment: One commenter suggested that Medicaid RAC program goals be created based on the error rate established by the Payment Error Rate Measurement (PERM) program.

Response: PERM addresses specific error measures in the Medicaid program. Under section 1902(a)(42)(B)(i) of the Act, the Medicaid RACs shall identify underpayments and overpayments and shall recoup overpayments. Thus, there is no authority under Federal law for Medicaid RAC programs to apply any measure except to ensure that States make no improper payments to providers.

Comment: One commenter inquired whether existing patient identifiers can be used so that files can be readily retrieved by the provider.

Response: We do not intend for States to deviate from processes that are already in place to readily identify claims. We encourage States to work with their contractors to include the necessary fields to effectively identify overpayments and/or underpayments.

Comment: Several commenters stated that during the Medicare RAC Demonstration, many providers experienced inappropriate and arbitrary RAC denials. These commenters indicated that the RAC neither informed providers of the types of issues they were auditing, nor did they provide a rationale for adverse determinations. Additionally, commenters reported RACs audited claims using the wrong payment codes and audited claims from several years ago. According to commenters, this led to provider appeals, 64 percent of which were decided in the favor of the provider.

Response: As stated previously, we are applying numerous lessons learned from the Medicare RAC demonstration. We are requiring in this final rule that each Medicaid RAC must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval. We finalize this provision at § 455.508(b). We are also requiring Medicaid RACs in this final rule to hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims. We finalize this provision at § 455.508(c). Finally, we are requiring that there be a 3 year maximum claims look-back period. We finalize this provision at § 455.508(f).

Comment: One commenter inquired whether Medicaid RACs are required to comply with the reopening regulation located at § 405.980 similar to Medicare RACs, which requires a RAC to have good cause before it reopens a claim.

Response: Section 405.980 applies to administrative appeals under the Medicare program. States have different administrative appeal processes from the Medicare program. Accordingly, we did not require States to comply with the reopening regulation as set forth in the Medicare RAC program. As stated previously, States will retain the flexibility to design, procure, operate, and administer their RAC programs in accordance with State laws, regulations, and policies.

Comment: One commenter suggested that patients not receive a letter regarding a Medicaid RAC audit until the appeal process has ended and a determination is final, similar to the Medicare program.

Response: The Medicaid RAC program is designed to review claims submitted by providers of items and services or other individuals furnishing items and services for which payment has been made under section 1902(a) of the Act. Accordingly, States have the flexibility to decide the issue of patient notification of final claims resolution.

Comment: Several commenters stated that the best way to reduce common billing and coding mistakes is through targeted education and outreach, rather than onerous audits performed by outside contractors with incentives to deny claims. These commenters asserted that education and outreach

efforts are insufficient across the Medicare and Medicaid programs.

Response: We agree that targeted education and outreach is one way of reducing common billing and coding mistakes. Accordingly, we have finalized at § 455.508(d), that States and their RACs are required to develop a education and outreach program as part of their Medicaid RAC programs. This includes, at a minimum, notification of audit policies and protocols.

Comment: Several commenters recommended the exclusion of medical necessity reviews from the Medicaid RAC program.

Response: We disagree with the commenters. Providers are required to furnish medically necessary services in State Medicaid plans and medical necessity reviews by Medicaid RACs are permitted to the extent they are consistent with State laws and regulations.

Comment: Several commenters suggested that if medical necessity reviews are permitted in Medicaid RAC programs, then CMS should issue key oversight provisions in the final rule to mitigate incentives for aggressive and/or inaccurate medical necessity review denials.

Response: We disagree that we should issue oversight provisions regarding medical necessity reviews in the Medicaid RAC program. Providers are required to furnish medically necessary services in accordance with State Medicaid plans, and thus medical necessity reviews by Medicaid RACs are permitted to the extent the reviews are consistent with State laws and regulations. In those cases, we encourage States to adopt measures reflected in the Medicare RAC program sub-regulatory guidance. We intend to continue providing technical assistance to States that will inform them of best practices from the Medicare RAC program. Accordingly, we decline to issue oversight provisions in the final rule regarding medical necessity reviews.

Comment: Several commenters recommended that if medical necessity reviews are permitted in the Medicaid RAC program and an improper payment is identified, providers should be allowed to re-bill for the lower appropriate claim amount.

Response: If a Medicaid RAC identifies an improper payment as a result of a medical necessity review, or any RAC review, the issue of whether a provider is permitted to re-bill a corrected claim is governed by State law, regulation, and policy which set time limits on the submission of providers' claims.

Comment: One commenter recommended increased physician involvement in medical necessity reviews.

Response: In the Medicare RAC program, no physician involvement is required in medical necessity reviews. We require that registered nurses (RNs) must be utilized, and that the Medicare RAC generally, employ a Medical Director. Similarly, we have finalized at § 455.508(b), that each RAC must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval. In addition, States that elect to permit medical necessity reviews in their Medicaid RAC programs should develop criteria consistent with their own State laws and regulations.

Comment: One commenter recommended that CMS establish reporting mechanisms to monitor contractor accuracy when reviewing claims for medical necessity in the Medicaid RAC program.

Response: If States elect to include medical necessity reviews in their Medicaid RAC program, we encourage the States to monitor the reviews for accuracy. We have finalized § 455.502(c) and § 455.514(b) which require State reporting. Additionally, we will issue sub-regulatory guidance, generally, on reporting and performance metrics for Medicaid RACs.

Comment: One commenter recommended that CMS should establish appropriate guidelines for Medicaid RAC medical necessity reviews, and require the RACs to have qualified personnel with both the clinical and regulatory experience to review medical necessity review claims.

Response: We disagree that CMS should establish guidelines for medical necessity reviews conducted by Medicaid RACs. States must follow the guidance that is provided in State Medicaid plans, State law, regulation, and policy. In the final rule at § 455.508(b), however, we are requiring that each RAC must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a

minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval.

Comment: Several commenters suggested that Medicaid RACs should conduct sample medical necessity audits to support the data identifying the pattern of errors that will be targeted through the audits.

Response: As previously stated, if States elect to include medical necessity reviews in their Medicaid RAC programs, we encourage the States to monitor the reviews for accuracy.

Comment: Several commenters recommended that final validation of medical necessity review denials should be signed off by a physician.

Response: In the Medicare RAC program, a physician's approval is not required in the validation of a medical necessity review denial. States have the flexibility to determine the parameters for medical necessity reviews. Therefore, we are not requiring final validation of medical necessity review by a physician.

Comment: Several commenters recommended that the RACs be required to submit a rationale for each medical necessity review to the SMA for review and approval.

Response: Similar to the Medicare RAC program in which the agency formed a "New Issue Review Board" which approves audit issues prior to widespread review, we encourage the formation of State review teams for Medicaid RACs that can approve new audit issues prior to review. We will provide technical assistance to States who decide to include medical necessity reviews in their Medicaid RAC programs.

Comment: One commenter recommended that the SMA be required to share training materials with providers that are used by Medicaid RACs to conduct a medical necessity review.

Response: Although we will not require States to share Medicaid RAC training materials with providers, we encourage States and SMAs, consistent with their laws, regulations, and policies, to make every effort to ensure transparency in the Medicaid RAC program. Additionally, we have finalized § 455.508(d), which requires an education and outreach component in every Medicaid RAC program including, at a minimum, notification to providers of audit policies and protocols.

Comment: One commenter recommended that CMS exclude medical necessity reviews in States where prior authorization programs

require medical necessity reviews prior to payment approval.

Response: To the extent that medical necessity reviews are consistent with Medicaid State Plans, State laws or regulations, medical necessity reviews are permitted. Accordingly, we did not adopt the commenter's recommendation.

Comment: One commenter suggested that CMS and SMAs use RAC audit findings to educate providers and implement payment system fixes to avoid billing mistakes before they are made.

Response: We agree with the comment. If Medicaid RACs identify program vulnerabilities as a result of their findings, we encourage RACs to share this information with States so that they can implement corrective action, such as pre-payment edits or other similar system fixes. States can also use RAC findings to develop provider education in an attempt to prevent billing errors.

Comment: Several commenters expressed concern that all staff conducting automated or complex reviews must demonstrate knowledge of the State's published Medicaid guidelines and coding criteria for the dates and types of services.

Response: We believe that States should make the relevant Medicaid coverage guidelines and coding criteria available as part of the procurement process. This can be done in detail within the request for proposal or by providing the necessary links where guidelines and criteria are located for the various program types.

Comment: A commenter requested that the Medicaid RAC Statement of Work (SOW) exclude Evaluation and Management (E & M) Services from RAC review.

Response: States that contract with a RAC engage the RAC for the purpose of reviewing claims submitted by providers for items or services for which payment has been made under the Medicaid program. We expect that E & M Services, that is, those services provided by physicians and non-physician practitioners to evaluate patients and manage their care, will be included within the scope of Medicaid RAC review.

Comment: A commenter suggested having an internal State agency staff member review claims before auditing by the Medicaid RAC.

Response: We do not oppose States setting up processes to ensure the validity of claims before a determination is made as to whether a claim is an overpayment or underpayment. Because of the uniqueness of each State

Medicaid program, the States should have the flexibility to design their Medicaid RAC programs specific to their individual program needs.

Comment: One commenter strongly recommended hiring professionally trained and certified coders, who have the appropriate skill sets that would facilitate improved reviews and reduce duplicative work in reviewing records correctly.

Response: We agree with the commenter. Accordingly, we have included § 455.508(c) in this final rule which requires Medicaid RACs to hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims.

Comment: Several commenters suggested that the final rule require each Medicaid RAC to have a minimum of 1.0 FTE physician Medical Director who is currently licensed; has relevant work experience in the health insurance industry; has extensive knowledge of Medicaid coverage and payment rules; and has appropriate clinical experience practicing medicine. Other commenters suggested that CMS not require Medicaid RACs to hire physician Medical Directors, but require that the appropriate level of medical expertise be staffed by the RAC to review medical records. The commenters also suggested that the medical personnel not have a record of adverse disciplinary actions.

Response: We agree with those commenters who suggested that the Medicaid RACs should each hire a Medical Director who is a Doctor of Medicine or a Doctor of Osteopathy and has relevant work and educational experience. Accordingly, we have finalized at § 455.508(b) that each Medicaid RAC must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval. We also require Medicaid RACs at § 455.508(a) to employ personnel who are trained medical professionals, as defined by the State, in good standing with the relevant State licensing authorities, where applicable, to review Medicaid claims.

Comment: One commenter requested that CMS consider clarifying the language in the final rule to include State policies and provider handbooks, where Medicaid RACs would review

post-payment claims for overpayments and underpayments consistent with State laws and regulations.

Response: States have a certain amount of flexibility to design their Medicaid RAC program according to their needs. We believe that States' current practices regarding the processing of claims, including the use of policies and provider handbooks, should not differ in the Medicaid RAC program. Accordingly, each State should provide its RAC with all available resources to help facilitate claim review.

Comment: One commenter requested that CMS clarify the types of technical abilities that an entity wishing to perform as a Medicaid RAC must demonstrate, as referenced in proposed § 455.508 of the regulation, and incorporate other examples of technical abilities in addition to, trained medical professionals in the final rule.

Response: We expect that RACs will have the ability to review claims submitted by providers of items and services for which payment has been made under section 1902(a) of the Act as required by § 455.506(a). We have finalized § 455.508(a), which requires RACs to employ trained medical professionals, as defined by the State, to review Medicaid claims. These trained medical professionals could include, for example, nurses or physical therapists. States have the discretion to determine the types of medical professionals they require based upon their individual Medicaid RAC program needs.

Comment: One commenter requested that CMS recognize that not all recovery efforts require trained medical professionals; their experience with claims review includes the significant input of non-medical trained professionals, including CPAs, coding professionals, investigators, and accountants who are able to identify inappropriate payments that arise out of non-clinical issues.

Response: We appreciate the comment and recognize that the review of claims could involve a variety of disciplines to ensure the identification of inappropriate payments. However, we have finalized at § 455.508(a), (b), and (c) that Medicaid RACs must hire trained medical professionals, as defined by the State, to review Medicaid claims, each RAC must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a

minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval. In addition, the Medicaid RAC must hire certified coders (unless the State determines that certified coders are not required for the effective review of Medicaid claims).

Comment: A commenter suggested that CMS use the Medicare definition of “good cause” found in our regulation at § 405.986 as a floor in its final regulation for the Medicaid RAC program. This commenter also suggested that providers should have the right to challenge a lack of good cause to review a claim by the Medicaid RACs. Another commenter requested that CMS require Medicaid RACs to document good cause for claim review.

Response: RACs are required to review Medicaid claims. States will have the flexibility to establish requirements regarding the documentation of good cause to review a claim. Additionally, States may consider establishing requirements regarding the documentation of good cause to review a claim if they do not already have this requirement. In addition to those program elements specifically required, we encourage States to replicate the Medicare practices that would be beneficial to their Medicaid RAC programs, including, without limitation, documentation of good cause. However, we will not require States to document good cause because that requirement applies to the Medicare administrative appeals process. Each State has already assured CMS via the State Plan amendment process that it has in place an administrative appeals infrastructure whereby a provider may avail itself of its due process rights to appeal an adverse Medicaid RAC determination. States, therefore, must follow their own administrative appeals processes, which may or may not require documentation of good cause.

Comment: One commenter requested that CMS institute an issue approval process similar to the process now provided in the Medicare RAC program.

Response: In general, issues reviewed by the Medicare RACs are approved by CMS prior to widespread review. CMS uses a New Issue Review Board to provide oversight in conjunction with issues that are reviewed by the Medicare RACs. States may opt to establish an issue review board similar to the Medicare RAC program in which they consider topics for audit review. States will have the flexibility to determine the issues that are relevant to their respective Medicaid programs which will be subject to Medicaid RAC review.

Comment: One commenter suggested that CMS require Medicaid RACs to hold “meet and greet” forums.

Response: We recognize that each State has different considerations and must tailor its Medicaid RAC activities to the uniqueness of its own State. Accordingly, we will not require Medicaid RACs to hold “meet and greet” forums. However, we believe that States should promote transparency in their respective RAC programs. A “meet and greet” forum is an example of one way a State can promote transparency in its RAC program by allowing providers to interact with the contractor’s personnel.

Comment: Several commenters asked that CMS require the following customer service measures that will assist providers in ensuring the timely submission of sufficient documentation to support the services billed and generally increase the efficiency of the process:

1. Implement timeframes for RAC determinations and notification of the same.
2. Require RACs to obtain correct provider addresses and points of contact.
3. Require RACs to give extensions to providers if RAC provider notices are sent to a wrong address or other extenuating circumstances.
4. Require RACs to maintain websites and post audit issues.
5. Require RACs to maintain provider portals of customer service information.
6. Require RACs to provide a toll-free phone number in case of questions.
7. Require RACs to respond to providers in a timely manner.
8. Require RACs to give providers a rationale for denials.
9. Require RACs to send correspondence to providers in clearly marked envelopes.
10. Implement deadlines for submission of medical records and clearly indicate those deadlines in an Additional Documentation Request (ADR) letter and indicate in that letter the suggested documentation that will assist RACs in adjudicating the claim.
11. Initiate contact with the provider who is the focus of the audit before issuing an overpayment determination for failure to submit documentation.
12. Accept provider submission of medical records on CD/DVD or via facsimile.

Response: After consideration of these numerous comments, we are requiring at § 455.508(e), that Medicaid RACs provide minimum customer service measures including: Providing a toll-free customer service telephone number in all correspondence sent to providers

and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers’ request (§ 455.508(e)(3)); notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4)). States should also rely upon internal processes and procedures for notification requirements and identify specific timeframes for required responses between the Medicaid RAC and providers, if possible.

Comment: Several commenters asked that the proposed rule require each Medicaid RAC to include a toll-free customer service telephone number in all correspondence sent to providers.

Response: We agree and have finalized at § 455.508(e) the requirement that Medicaid RACs must provide minimum customer service measures including: Providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)).

Comment: One commenter asked if the notification of findings of overpayments or underpayments would include information on how overpayments may be repaid/offset, time limits for repayment without interest, and information on timeliness of additional payments and methods of additional payments.

Response: We have finalized at § 455.508(e)(4), that RACs must notify providers of overpayment findings within 60 calendar days. Also, at § 455.510(c)(3), we require States to notify providers of underpayments that are identified by the RACs. Each State will have the discretion to determine any additional information that it wants to include in provider notifications.

Comment: One commenter asked CMS to require States and their RACs to give advance notice to providers of audit focus areas in preparation for reviews, as occurs in the Medicare RAC program.

Response: States have a certain degree of flexibility to design their Medicaid RAC programs to fit their individual needs. We believe that States should promote transparency in their RAC programs. States requiring RACs to give advanced notice to providers of audit areas in preparation of a review is an

example of how States can facilitate transparency.

Comment: One commenter asked CMS to require States to be transparent with regard to their coding/billing rules and guidelines as well as the screening guidelines that are used for making medical necessity determinations.

Response: We encourage States to make coding/billing rules and guidelines available to the extent possible to promote transparency.

Comment: Some commenters recommended that CMS develop a Medicaid RAC national SOW, similar to the Medicare RAC program.

Response: We disagree with the comment. The proposed Medicaid RAC program will not be one national program, like Medicare; rather it will be more than 50 State-specific programs. In this context, it would be nearly impossible to standardize the SOW for the Medicaid RAC program, as Medicare does. We have previously stated that as a result of comments, we have reconsidered the proposal to allow States complete flexibility regarding most aspects of their RAC programs, and have finalized at § 455.506 and § 455.508 certain requirements for States and their RACs to better align with Medicare RACs. With regard to Medicaid RAC program elements where we encourage States to adopt those measures that were incorporated into the permanent Medicare RAC program, we will continue to provide technical assistance after the publication of the final rule.

Comment: Several commenters expressed concern about allowing the RAC to develop or apply its own coverage, payment, or billing policies.

Response: States establish Medicaid coverage, payment and billing policies. The contract established with the RAC should address how the RAC will audit claims based on those established policies. Whether or not RACs develop or apply their own coverage, payment or billing policies is a contract issue resolved between States and their RACs.

Comment: Commenters expressed concern that small and solo practice physicians are already overwhelmed as a result of requests for records by other audit programs. Other commenters suggested that CMS require the RACs to assume the cost of copying and mailing, as well as allow for the electronic submission of records.

Response: We agree with the commenters with regard to limiting the number of medical records that may be requested by a Medicaid RAC. Accordingly, we have finalized at § 455.506(e) that States must set limits on the number and frequency of medical

records to be reviewed by the RACs, subject to requests for exceptions from RACs. With regard to the costs of copying and mailing, as well as the electronic submission of records, we require at § 455.508(e)(3) mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the provider's request.

Comment: One commenter requested guidance regarding the parameters associated with potential conflicts of interests that may develop as a result of the same contractor performing services on behalf of providers, for example, coding and billing as well as seeking to perform RAC audits of these same providers in which they acted as consultants.

Response: We indicated in the proposed rule that States should be cognizant of the potential for conflicts of interest, and should take steps to identify and prevent conflicts of interest. These conflicts of interest may arise among contractors or their subcontractors that perform audit related services for providers and then seek to perform audit recovery services on behalf of the State.

Comment: One commenter requested that the Medicaid RAC obtain approval from CMS to audit new issues and to post CMS-approved issues on the Medicaid RAC's website prior to the claims review similar to the current Medicare RAC process.

Response: The Medicaid RAC program differs from the Medicare RAC program in that it is a State-run program. Accordingly, specific areas of RAC review should be determined by the State in conjunction with its RAC. We recognize that there could be issues that are unique to a particular State in terms of areas that should be the focus of an audit. Therefore, we believe States are in the best position to make this determination.

Comment: One commenter requested that CMS clarify whether RAC contracts must be for a period of 5 years, similar to the term for Medicare RAC contracts.

Response: As stated earlier, States will have the flexibility to set periods of performance in their respective Medicaid RAC contracts that fit their program needs and are consistent with State law.

Comment: One commenter requested that CMS require States to use a validation contractor to independently examine Medicaid RAC vulnerability and claim determinations, and to issue annual accuracy scores.

Response: While we will not require States to engage a validation contractor, we believe that States should set targets

for validation of the accuracy of RAC determinations and measure those targets accordingly. In addition, we plan on developing performance metrics in conjunction with the States to assist with determining the accuracy of RAC reviews.

Comment: One commenter requested that CMS require Medicaid RACs to accept electronic documentation submission in response to RAC audits.

Response: As part of the customer service measures, we are requiring Medicaid RACs at § 455.508(e)(3) to accept electronic submissions of medical record documentation to facilitate provider response in connection with RAC audit requests, without compromising the security and privacy of that data, unless the State requests and receives an exception from CMS.

Comment: One commenter suggested that CMS include additional provisions in the final rule that will serve to protect independent community pharmacies against abusive auditors and audit practices by requiring RACs to accept the records of a hospital, physician, or other authorized practitioner that are made available by the pharmacy to validate pharmacy records and prescriptions for confirming the accuracy of Medicaid claims filed by the pharmacy.

Response: We disagree that it is necessary to include additional provisions to protect independent pharmacies against abusive audit practices. States will have the flexibility to design their Medicaid RAC programs consistent with their laws, regulations, and policies.

Comment: One commenter requested that CMS include licensed pharmacists or a company representative in the RAC auditing process.

Response: We decline to require Medicaid RACs to hire licensed pharmacists or company representatives. However, States have the flexibility to require Medicaid RACs to hire licensed pharmacists or company representatives if they so choose. We are finalizing staffing requirements at § 455.508 (a), (b) and (c).

Comment: One commenter suggested that CMS require Medicaid RACs to form panels comprised of practicing physicians representing various specialties, which can advise RACs on medical issues.

Response: We do not oppose States requiring Medicaid RACs to form panels of practicing physicians who represent various specialties that can advise them on medical issues. We encourage States to adopt measures that will promote transparency and improved

communication among States, Medicaid agencies, Medicaid RACs, and providers.

Comment: One commenter suggested that CMS require each Medicaid RAC auditor to be trained on Medicaid payment and coverage policy relating to all target areas approved by the State, billing and re-billing protocols, and the Medicaid appeals process. Each RAC auditor should also be required to demonstrate proficiency in these areas prior to conducting audits.

Response: We understand the concerns of the commenter regarding the need to have highly trained personnel. At § 455.508(a), we require that Medicaid RACs hire trained medical professionals, as defined by the State, to review Medicaid claims.

Comment: One commenter urged CMS to designate a percentage of recovered program dollars to improve education, increase pre-payment claim edits to eliminate payment of duplicate claims and those obviously submitted in error (for example, age-specific services provided to a patient outside the designated age range), and to provide continuous outreach with information on newly discovered and commonly occurring billing errors in both the Medicare and Medicaid programs.

Response: We agree with the commenter that education and outreach is a necessary element to Medicaid RAC programs. Accordingly, we include in this final rule at § 455.508(d), the requirement that States and RACs develop an education and outreach program, including notification to providers of audit policies and protocols. We will not require States to designate a percentage of recovered program dollars to improve education and increase pre-payment claim edits.

Comment: A commenter recommended that CMS consider relief in the presence of a disaster, whether widespread or in an individual location, in the way of an extension of the deadline for receipt of records or refund, acceptance of reconstructed records or exemption from review for records that were completely destroyed, and/or delay of reviews for up to 6 months.

Response: States should already have policies and procedures in place for handling unanticipated events when they occur, including provisions for requests of records.

Comment: Several commenters requested CMS to exclude payments made to disproportionate share hospitals (DSH) or special hospital payments from the scope of Medicaid RAC review in the final rule.

Response: We do not believe that DSH payments or special hospital payments

should be excluded in the final rule. States have the flexibility to determine whether those payments should be the focus of RAC review.

Comment: One commenter suggested that CMS require States to publish Medicaid and Medicare RAC audit reports for public viewing.

Response: We believe that States should be as transparent as possible with regard to their Medicaid RAC programs. While we will not require States to publish Medicaid audit reports, we encourage States to consider making those reports available for public viewing.

D. Definitions

Comment: One commenter requested that CMS offer a definition of “overpayment.”

Response: For purposes of the Medicaid RAC program, we believe that States should define “overpayment” consistent with 42 CFR 433.304 which defines “overpayment” as “the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.”

Comment: One commenter indicated that the proposed rule does not include a definition of “underpayment.” In addition, this commenter suggested that the definition of underpayment could range from: (a) Broad and include a service that was never billed by a provider, to (b) narrow and reflect an error that was made in the reimbursement calculation.

Response: For purposes of the Medicaid RAC program, we believe that States should define “underpayment” consistent with their State law and/or plans. In the Medicare RAC program, an “underpayment” is generally defined as an amount paid to a provider or supplier for items or services furnished to a Medicare beneficiary at a lesser amount due and payable under the Act, implementing regulations, and policies.

E. Contingency Fees

Comment: One commenter inquired whether RAC determinations include cost-based adjustments or cost-based settlements. This commenter also wanted to know whether contingency fees would be paid to a Medicaid RAC for those determinations.

Response: We understand that certain States use cost reports for reimbursement of Medicaid claims. Accordingly, States need the flexibility to structure their RAC programs to permit review of cost-based services to identify and recover potential

overpayments as well as identify underpayments. Therefore, contingency fees are payable to a Medicaid RAC for the identification and recovery of overpayments from cost-based service providers. With regard to whether a RAC determination can include cost-based settlements, we believe the State has the authority to make adjustments to a provider's cost report and/or cost-based settlements based upon a RAC determination.

Comment: One commenter indicated that the proposed rule fails to require RACs to return their contingency fee if a denial is overturned at any stage of the appeals process. Another commenter suggested that allowing States to determine at what stage in the Medicaid RAC process, post-recovery, that the RACs will receive contingency fees preserves an unacceptable risk of improper incentives which might otherwise encourage a Medicaid RAC to prematurely or even improperly identify and recover funds from a provider. Another commenter suggested that RACs should be paid upon recovery rather than after adjudication.

Response: With regard to the timing of RAC payments, we are finalizing the requirement at § 455.510(b)(2) that States must have the flexibility to determine at what stage of the audit process their RACs may receive contingency fees for the collection of overpayments from Medicaid providers. In addition, if the provider appeals the overpayment determination and the determination is reversed at any level of the appeals process, we are also requiring Medicaid RACs to return their contingency fees within a reasonable timeframe as prescribed by the State, as reflected in this final rule at § 455.510(b)(3). For example, a State should specify in its contract with the Medicaid RAC the timeframe in which the State expects the RAC to return the contingency fee, that is, repayment will occur on the next applicable invoice. As we indicated in the proposed rule, payments to RACs may not be made based upon amounts merely identified but not recovered or amounts initially recovered from providers but that are subsequently repaid due to determinations made in appeals proceedings. Accordingly, if a State pays a contingency fee to a RAC based upon amounts recovered prior to the conclusion of the appeals process that is available to a provider, then the RAC must return the portion of the contingency fee that corresponds to the amount of the overpayment that is reversed at any level of appeal. We do not believe that this improperly

incentivizes a RAC to identify and recover funds from a provider.

Comment: One commenter suggested that CMS' illustration regarding the timing of payment to the RAC that would permit payment to the RAC when it recovers an overpayment but would subsequently require reimbursement by the RAC if the recovery is overturned on appeal, is directly contrary to CMS' interpretation of "payments to contractors may not be made based upon amounts merely identified but not recovered, or amounts that may initially be recovered but that subsequently must be repaid due to determinations made in appeals proceedings."

Response: We disagree with the comment. The illustration mentioned by the commenter is consistent with the Act which requires the amount paid to a RAC to be from the overpayment amount recovered. If a State pays a RAC prior to the adjudication of the appeals process, then the RAC must refund the amount paid by the State within a reasonable timeframe as prescribed by the State, in connection with the overpayment in the event the overpayment is reversed at any level of appeal. For example, a State should specify in its contract with the Medicaid RAC the timeframe in which the State expects the RAC to return the contingency fee, that is, repayment will occur on the next applicable invoice.

Comment: One commenter indicated that the cap on contingency fees creates an unnecessary administrative burden on States with smaller Medicaid programs which may not be able to attract qualified contractors at the rate provided for in the proposed rule. Specifically, the commenter stated that it is administratively burdensome to pay for the excess with State only funds or request and receive an exception to the cap. Commenters further indicated that the market should determine an equitable contingency fee rate on a State by State basis. Another commenter indicated that limiting contingency rates will create the unintended consequence of limiting recoveries. This commenter was concerned that artificial rate caps would preclude an auditing firm from uncovering complex improper payments because it will not be able to do so profitably. Alternatively, another commenter suggested raising the cap to 18 percent but CMS should continue to have an exception process. Finally, other commenters indicated that strict limits should be set on the amount of contingency fees.

Response: We believe that the contingency fee rates for identifying and collecting overpayments should be reasonable and determined by each

State, taking into account factors, for example, the level of effort to be performed by the RAC and the size of the State's Medicaid population. We recognize that each State has different considerations and must tailor its Medicaid RAC activities to the unique factors of its own State. Nevertheless, based upon our experience with the Medicare RACs, we believe that the contingency fee paid to a State Medicaid RAC should not be in excess of the highest fee paid to a Medicare RAC unless the State can provide sufficient justification. The Medicaid RAC contingency fee limit may be adjusted periodically to maintain parity with the Medicare RAC contingency fee cap.

Comment: One commenter requested that CMS use guidance as reflected in the Medicare RAC SOW to pay contingency fees to identify underpayments.

Response: We disagree with the commenter. Section 1902(a)(42)(B)(ii)(II) of the Act requires States to pay Medicaid RACs for the identification of underpayments from amounts recovered and "in such amounts as the State may specify." Therefore, States have discretion to pay RACs for the identification of underpayments so long as the payments are from amounts recovered. In FY 2010, the Medicare RACs identified and corrected \$92.3 million in combined overpayments and underpayments. Eighty-two percent of all RAC corrections were collected overpayments, and 18 percent were identified underpayments that were refunded to providers. We expect that States will realize a similar ratio of overpayments to underpayments in connection with the implementation of the Medicaid RAC program. That is, CMS requires at § 455.510(c)(2) that States must "adequately" incentivize the detection of underpayments identified by the RACs. We will evaluate individual States' indicators of adequacy, using the Medicare RAC benchmark, and will examine the trends among the States over several years.

Comment: One commenter requested clarification regarding whether the contingency fee percentage may vary according to a specific Medicaid RAC focus area of review.

Response: We do not object to a State using a tiered structure for contingency fee payments to its Medicaid RAC, so long as the maximum fee percentage does not exceed the highest fee we pay to the Medicare RACs. We will not pay FFP for amounts paid to RACs above the highest fee paid to Medicare RACs, unless the State requests and is granted an exception to that maximum rate. Any tiered structure must also ensure that

the Medicaid RACs are incentivized to identify underpayments as well as overpayments.

Comment: One commenter requested clarification of CMS' expectations with regard to fees paid for the identification of underpayments when a State lacks the legal authority to pay fees for the action. This commenter recommended that CMS consider including alternatives that achieve the goal to incentivize the identification of underpayments.

Response: If a State is legally prohibited from requiring a RAC to identify underpayments, then a State may submit to CMS a written request for an exception related to this requirement.

Comment: One commenter opposed any exception to an increase in the FFP limit as a result of an exception to pay a Medicaid RAC a contingency fee that is higher than the Medicare RAC contingency fee. The commenter maintains that the contingency fee structure is inappropriate for any RAC program because it "perversely incentivizes RACs to engage in bounty hunting, which leads to increased expenses and administrative burdens for providers." In addition, this commenter stated that allowing the State to obtain exceptions for the maximum FFP is needless and exacerbates the predatory nature of RAC audits.

Response: The statute requires Medicaid RACs to be paid on a contingency basis for the identification of overpayments. Thus, States do not have an option with regard to the method of payment for the identification of overpayments for their RACs unless State law prohibits the arrangement. We also recognize that certain States may need an exception to the contingency fee cap. For example, States with small Medicaid populations may need to pay a much larger contingency fee rate to attract RAC contractors to work in their State. Accordingly, under certain circumstances, a State may request authorization to pay a RAC a higher contingency fee than the maximum amount for which FFP is paid. Therefore, we disagree that exceptions to pay a RAC a higher contingency than the Medicare RAC contingency fee rate of 12.5 percent are never justified.

Comment: Several commenters suggested that the proposed contingency fee structure imposes no disincentive on RACs for pursuing situations where there is little or no solid evidence of an overpayment. The commenters recommended that payments to RACs should: (1) Be made only upon conclusion of all provider appeals; and (2) not compensate RACs for the time

required for appeals to be exhausted. A few commenters also suggested that RACs should be required to pay a penalty to compensate providers for claims ultimately determined to be unfounded or falsely identified.

Response: As previously stated, we have surveyed States that have RAC-like programs which utilize a contingency fee payment structure and have not learned of any circumstances in which RACs were improperly incentivized to recover overpayments from Medicaid providers. In addition, our evaluation of the Medicare RAC program provides a basis for contingency payments to RACs for the identification and recovery of overpayments. Therefore, we will not compel States to require RACs to pay a penalty to providers for claims ultimately determined to be unfounded. With regard to the timing of payments to RACs, States need the flexibility to determine the most appropriate payment methodology given the uniqueness of its own State. Accordingly, States should decide when it is most appropriate to pay Medicaid RACs for their work.

Comment: Several commenters suggested that because the law provides a strong financial incentive for RACs to focus on overpayments and not the identification of underpayments, CMS should require States to apply the same contingency fee schedule for overpayments to underpayments. One commenter stated that the “small, flat fee” for underpayments is unacceptable. This commenter also suggested that CMS should require States to increase their underpayment fee when RACs are not applying a balanced approach to identifying underpayments and overpayments.

Response: With regard to underpayments, we have proposed that a State may choose to pay its RAC a contingency fee for the identification of underpayments, similar to Medicare RACs, or a State may opt to establish a set fee or some other structure for the identification of underpayments. We believe that States should have the flexibility to determine the best payment structure consistent with their State Plans. We also included language in the final rule at § 455.10(c)(2) indicating that States must adequately incentivize their RACs to identify underpayments. In FY 2010, 82 percent of all Medicare RAC corrections were collected overpayments, and 18 percent were identified underpayments that were refunded to providers. We expect that States will realize a similar ratio of overpayments to underpayments in connection with the implementation of the Medicaid RAC program. We will

evaluate individual States’ indicators of adequacy, using the Medicare RAC benchmark, and will examine the trends among the States over several years.

Comment: One commenter suggested that CMS clarify that underpayments discovered through RAC audits are only payable if claims are filed by the provider within prescribed timeframes.

Response: Generally, RACs are required to review post-payment claims. If a Medicaid claim is not timely filed by a provider, then it would seem that the claim is not payable. Accordingly, these claims should not be subject to RAC review. If a RAC identifies an underpayment and the time for re-filing a claim has passed in accordance with State law, we believe the State has the discretion to determine whether the provider may re-file the claims with the correct information.

Comment: One State commenter indicated that the proposed rule does not state that underpayments must be reimbursed. This commenter stated that providers are responsible for reviewing their remittance advice to determine if they were paid correctly. Further, any adjustments must be made within specific timeframes. This commenter stated that requiring States to reimburse providers for underpayments outside of existing timeliness rules is not appropriate.

Response: The Act mandates that RACs be compensated for the identification of underpayments to providers. While the statute is silent regarding the remittance of underpayments to providers as a result of RAC identification of the underpayments, we are concerned about provider participation in the Medicaid program as well as States making proper payments to providers. Accordingly, we believe that States should compensate all providers for any identified underpayments to the extent possible and consistent with State law. States must notify providers of underpayments that are identified by their Medicaid RACs. We have included this requirement in this final rule at § 455.510(c)(3).

Comment: One commenter appreciated the flexibility extended to States regarding the fees paid to RACs for the identification of underpayments. The commenter, however, disagreed with CMS’ approach with regard to the possibility of additional rulemaking should CMS deem it necessary as a result of future CMS review of data, indicating that RACs are not appropriately incentivized to identify underpayments. This commenter believes any further Federal regulation of underpayment identification will

create an undue burden on the States and requested that it be removed from consideration.

Response: We appreciate the comment. However, the burden of potential future rulemaking is outside the scope of this final rule. Nevertheless, further rulemaking may be necessary to achieve the statutory mandate for Medicaid RACs to identify underpayments. Accordingly, we have maintained this language in this final rule.

Comment: Several commenters suggested that CMS should require SMAs to: (1) Monitor the volume of underpayment audits conducted by the RACs; (2) increase the underpayment fee if a RAC is not applying a balanced approach to identifying underpayments and overpayments; and (3) include information on the general methods used to identify Medicaid underpayments in the RAC annual report as well as the steps taken to ensure a balance between underpayment and overpayment review. Another commenter recommended that the Medicaid RAC be required to submit annual reports that include information on methods used to identify underpayments, the number of underpayments identified, and any steps taken to ensure that underpayments are addressed.

Response: As stated in the proposed rule, we expect to monitor the methodologies and amounts paid by States to Medicaid RACs to identify underpayments. We may consider future rulemaking depending on the data we review regarding RAC incentive to pursue underpayments. At this time, we are not requiring States to submit annual reports. However, we plan to issue sub-regulatory guidance on future reporting requirements. Accordingly, we will consider the commenters’ suggestions regarding the data elements for an annual report. At this time, we will not require States to increase the fee paid to RACs for the detection of underpayments.

Comment: One commenter requested clarification as to whether States can choose to issue payments only to certain providers based upon underpayments that are identified by the RAC versus identified underpayments of all providers. This commenter also mistakenly asserted that Medicaid RACs are only paid for dollars recovered on overpayments and suggested that RACs also be paid for the identification of underpayments.

Response: States are required to pay RACs for the identification of overpayments as well as the identification of underpayments.

Although the statute is silent regarding actual payments to providers as a result of RAC identification of underpayments, we believe that States should compensate all providers for any identified underpayments consistent with State law.

Comment: One commenter suggested that Medicaid RACs should be required to identify underpayment determinations and ensure that the underpayments are remitted to providers in a timely fashion. In addition, this commenter suggested that the States and/or CMS should ensure that Medicaid RACs have the system capability to identify underpayments before they begin auditing claims.

Response: The Act requires States to establish programs to contract with a Medicaid RAC for the purpose of, in relevant part, identifying underpayments. Accordingly, the task of identifying underpayments should be included in the SOW that is part of the contract between a State and its RAC. Therefore, we will assume that a State has verified that its RAC has the capability to identify underpayments even before a RAC has begun auditing claims. With regard to remittance of underpayments, it is the State that is responsible for the payment, not the RAC. The RAC is required to identify, not remit, an underpayment. Although we recognize that the State has discretion with regard to timing of the remittance of underpayments, we encourage States to remit identified underpayments to providers within a reasonable timeframe.

Comment: One commenter pointed out that the proposed rule indicates that "CMS contracts with Medicare RACs to identify and recover overpayments from Medicare providers, and to identify and pay underpayments to Medicare providers." (Emphasis added). This commenter requested that CMS clarify this statement given that he has not found any other reference to RACs making payments to Medicare providers for identified underpayments.

Response: We agree with the commenter. Medicare RACs do not pay underpayments to Medicare providers. The Medicare program pays underpayments to providers.

Comment: One commenter disagrees with CMS' proposed approach to publishing the maximum Medicaid RAC contingency fee consistent with the schedule of publishing the maximum Medicare RAC contingency fee every 5 years. The next update is scheduled for 2013. Specifically, the commenter stated that because fee structures can change over the life of a contract, CMS should publish any modifications to the

Medicare RAC payment methodology and contingency rates within 30 days of the modification as opposed to the existing 5-year schedule. In addition, another commenter suggested not requiring the States to conform to the Medicare timetable because Medicaid RACs will be tailored to each State's needs and States need the ability to set rates and increases that are not restricted by Medicare requirements.

Response: While we proposed to publish the maximum Medicaid RAC contingency fee consistent with the highest Medicare RAC fee, a State is not precluded from increasing the rate paid to its RAC outside of that schedule if necessary. To the extent that a State needs to increase the rate paid to its RAC before the expiration of the scheduled 5-year Medicare RAC contingency fee, the State can submit a SPA describing that an increase is required to reflect whether the State is paying the amount above the Medicare rate with State-only funds, or is requesting matching FFP.

Comment: One commenter suggested removing the contingency fee cap because it will allow States to pursue individualized RAC programs that align the fees with the complexity and scale of the workload and allow smaller States to garner a larger field of bidders from which to choose. Another commenter indicated that States need the flexibility to establish contingency fees separately from Medicare due to the difficulty States will have in reacting to the changes associated with the implementation of a RAC program in light of various State budgeting and contracting/procurement constraints. In addition, a commenter suggested that States need the ability to set rates and increases that are not restricted by Medicare requirements because the Medicaid RAC program needs to be tailored to each State's needs. Therefore, commenters suggested not requiring the States to conform to the higher Medicare contingency fee rate cap.

Response: Based upon our experience with the Medicare RACs, we believe that the contingency fee paid to a State Medicaid RAC should not be in excess of the highest fee paid to a Medicare RAC unless the State can provide sufficient justification. We recognize that States with small Medicaid populations may need to pay a much larger contingency fee rate to attract the RAC contractors to work in their State. For example, if a State receives a proposal from a prospective contractor for a contingency fee that is higher than the maximum contingency fee set by CMS for Medicare RACs but it accurately reflects the scope of work to

be performed in that particular State, then the State should submit a request for an exception to CMS for consideration.

Comment: One commenter believes that the Affordable Care Act does not specifically mandate that a State Medicaid RAC contingency fee be linked to the Medicare RAC maximum contingency fee. One commenter stated that the contingency fee cap is not in the best interests of the Federal Government, the State or the taxpayer, and is not consistent with the law. Commenters suggested letting the competitive procurement process define the contingency fee percentage limit for Medicaid, as was done for the Medicare RAC program at its inception. One commenter requested that State contingency-based recovery contracts competitively procured at a higher percentage rate be "grandfathered" in at those higher rates with a State commitment to transition to the lower percentage limit with the next procurement cycle.

Response: Section 1902(a)(42)(B)(i) of the Act requires States to "establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h) [of the Act], subject to such exceptions or requirements as the Secretary may require" Although the Act does not specifically set the State Medicaid RAC contingency fee, we believe that the contingency fee paid to a State Medicaid RAC should not be in excess of the highest fee paid to a Medicare RAC unless the State can provide sufficient justification that it is consistent with the statute. If a State cannot procure a contractor at the 12.5 percent rate, then a State can request an exception from CMS. For those States that may already have a RAC-like program in place in which the contingency fee is higher than the Medicare rate, we will work with these States to establish an acceptable resolution, which may or may not include "grandfathering" in the higher rate.

Comment: One commenter requested clarification with regard to the process associated with State requests for approval to pay a RAC a contingency fee that is higher than the 12.5 percent cap set by CMS. This commenter questioned how CMS will assure nationwide consistency on contingency rate approval decisions if States have to submit their requests for approval to the appropriate CMS Regional Office(s). Other commenters wanted clarification regarding the general exception process.

Response: Generally, State requests for approval for exceptions from the requirements of the RAC program, including higher contingency fees, are made using the SPA process and are determined by the Secretary, through delegated authority provided to CMS. CMS, through partnerships between CPI, the Center for Medicaid, CHIP and Survey & Certification (CMCS), and individual CMS Regional Offices, reviews and considers requests for exceptions. CMS strives to ensure consistency to the extent possible with regard to responses to State exception requests. We will review all relevant facts and circumstances surrounding requests for an exception. If a State's request for a higher contingency fee is denied, the decision is appealable to the Departmental Appeals Board. State commenters with additional questions regarding the process associated with exceptions to the RAC program, including questions about the SPA process, should contact their CMS Regional Office.

Comment: One commenter expressed concern that CMS will be injecting itself into a State's decision-making process on a Federal mandate by denying a State's request for using a higher contingency rate and the associated FFP.

Response: Generally, when a State completes a new State Plan preprint page or SPA because of changes in its Medicaid program, it must be approved by CMS in order for the State to receive Federal matching funds. This holds true for the majority of changes to a Medicaid program when FFP is at issue, not just with regard to the Medicaid RAC program. We have the authority to approve a SPA when FFP is at issue. If we deny a SPA or elements thereof, then the State has the right to appeal the decision.

Comment: One commenter recommended that States be given the flexibility to deploy the most appropriate procurement process for their individual State so long as they are within the legal confines of State and Federal procurements laws and regulations, including bundling Medicaid RAC procurements with other services or combining multiple States with one RAC vendor. Another commenter requested that the bundling of RAC services with other recovery services—such as a TPL contractor—should not be permitted because it will limit competition by excluding the most qualified Medicaid RAC firms. This commenter suggested that TPL contractors may not have the skill set to effectively handle complex reviews.

Response: We expect that all States will procure a RAC contractor. If a State feels that its unique situation may preclude it from meeting this expectation, a State must submit a request for an exception to CMS. However, if a State is interested in “bundling” its RAC procurement with other services performed by an existing contractor, then the State must execute a separate task order outlining the requirements of the RAC program with the existing contractor. If a number of States are interested in combining resources and utilize one contractor for their respective RAC programs, we do not object if there are no conflicts of interest and the arrangement comports with Federal and State law.

Comment: One commenter suggested that States should be permitted to apply for an exception from the RAC program to the extent that a State is unable to attract and acquire a RAC vendor.

Response: States are required to procure a RAC contractor. To the extent that a State is having difficulty procuring that contractor, then that State should contact CMS to discuss a potential resolution, which may include additional time to procure a qualified contractor. It is unlikely that we will grant an exception from the entire RAC program as a result of a State needing additional time to procure a RAC vendor.

Comment: One commenter requested public access to the payment rates furnished to Medicaid RACs, similar to the public availability of Medicare RAC payment rates.

Response: We decline to require States to publicly post their Medicaid RAC payment rates. However, we encourage States to make this information available to the extent possible to promote transparency.

Comment: One commenter requested that CMS allow States to engage in contractual agreements with RACs that limit RAC reimbursements to an amount less than the total amount recovered, but to grant States flexibility in meeting this requirement. This would include allowing States to recover from the provider both the amount of the overpayment and the contingency fee when overpayments have been identified.

Response: Section 1902(a)(42)(B)(i) of the Act mandates that payments made to RACs “shall be made to such contractor only from amounts recovered” and that the payments “shall be made on a contingent basis.” Allowing States to recover the contingency fee for the RAC from the provider is inconsistent with the language in the statute. To the extent

that State law prohibits it from complying with the statute, then the State should submit a request for an exception to CMS for consideration.

Comment: One commenter indicated that a large number of pharmacy claims being audited include those claims that are questionable due to administrative or clerical errors. This commenter suggested that providers should only be expected to pay the part of the claim that is determined to be an overpayment, not the “clean” portion of the claim or those resulting portions of the claim that are the result of technical or administrative errors.

Response: Medicaid RACs are statutorily mandated to audit Medicaid claims for the purpose of identifying and recouping overpayments as well as identifying underpayments. We would expect a provider to return any identified overpayment to the State Medicaid program. To the extent there are additional errors associated with the claim that do not relate to the RAC's required purpose, the issue is outside the scope of the proposed rule.

Comment: One commenter requested clarification about the following statement in the proposed rule: “States must ensure that they do not pay in total RAC fees more than the total amount of overpayments collected.” Specifically, the commenter inquired whether this is in the aggregate across all audits during a particular time period or if it applies to one particular audit.

Response: States must track the aggregate of claims that are identified as overpayments to appropriately calculate the contingency fees owed to the RAC. States must also account for the costs associated with the identification of underpayments. States must ensure that they do not pay in total RAC fees more than the total amount of overpayments collected.

F. Coordination

Comment: Several commenters expressed concern regarding the duplication of audits. These commenters suggested that CMS should prohibit Medicaid RACs from conducting audits on claims that are already under review by a Medicaid Integrity Contractor or other entity in the final regulation. Commenters also suggested that Medicaid RACs should be required to use a RAC data warehouse to identify any claims that are being reviewed by the RAC or other Medicaid audit program. In addition, the commenters suggested that the final regulation should exclude from RAC review, claims in which payment has been denied and/or withdrawn.

Response: We are concerned about minimizing the potential for multiple audits of the same provider. We recognize the need to minimize the burden on providers associated with responding to multiple audit requests, to the extent possible. States and their RACs are statutorily mandated to coordinate auditing efforts with those of other entities conducting audits of providers receiving payments for Medicaid claims. We have finalized this requirement at § 455.506(c). Under certain limited instances, overlapping audits may be necessary or otherwise unavoidable. For example, if a claim has been reviewed by a Medicaid RAC, and it suspects fraud, then that claim must be referred to law enforcement for review. However, in an effort to limit duplicate audit activity, we have included language in this final rule at § 455.508(g) indicating that Medicaid RACs should not audit a claim that has already been audited or is currently being audited by another entity, including the Medicare RACs. However, we decline to require States to create or use a data warehouse at this time. First, we are not aware of the existence of a data warehouse containing State Medicaid claims data. We are aware that States that have existing RAC-like programs have systems in place to achieve coordination. For example, one SMA reviews a list of claims to ensure that there are no open audits or referrals, whereas another SMA screens cases and meets monthly with its MFCU in an effort to achieve coordination. Second, we are aware that States have limited resources and cannot mandate the creation of a data warehouse. Ultimately, we believe that States need the flexibility to determine the best method of achieving coordination with the resources available to them. With regard to the review of denied claims, the Act requires Medicaid RACs to review Medicaid claims for overpayments. Accordingly, we do not see the need to change the regulation to incorporate denied claims in the final rule. With regard to claims that have been filed and subsequently withdrawn by the provider, we believe that the claims, to the extent that no payment has been made, should not be the subject of RAC review.

Comment: One commenter suggested that CMS should provide centralized access to claims data or State policies to limit the burden on States.

Response: There is no centralized repository of Medicaid claims data. We have and will continue to work with States to provide technical assistance to help States comply with

implementation requirements and lessen the burden on States.

Comment: One commenter recommended coordination between vendors when requesting records from hospitals.

Response: We are aware of the potential for overlapping audits of the same provider by multiple auditing entities and are concerned about minimizing the potential for multiple audits of the same provider. States have the flexibility to achieve coordination within a reasonable timeframe. Coordination among auditing entities in a State is achievable. We have learned that States that already have RAC-like programs have systems in place to coordinate the efforts of auditing entities to minimize provider burden. In addition, we are working to assist States with coordination of their auditing efforts with those of other entities.

Comment: In anticipation of the proposed implementation date of April 1, 2011, one commenter suggested that CMS should allow States additional time to accomplish certain tasks to ensure effective implementation of RAC contracts, including coordination of audit activity. Specifically, this commenter indicated that there must be time for careful consideration of how duplicate audit activity will be avoided.

Response: We are aware of the potential for overlapping audits of the same provider by multiple auditing entities and are concerned about minimizing the potential for multiple audits of the same provider. In response to several commenters, we have delayed implementation of this final rule until January 1, 2012. Therefore, States have an opportunity to achieve coordination within a reasonable timeframe. Coordination among auditing entities in a State is achievable. Indeed, we have learned that States that already have RAC-like programs have systems in place to coordinate the efforts of auditing entities to minimize provider burden.

Comment: One commenter inquired whether RACs are required to coordinate their auditing efforts with other entities that conduct cost-based audits for settlement.

Response: The statute requires a State and any contractors under contract with the State to coordinate their recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State Plan or waiver in the State. Accordingly, at the direction of the State, a RAC is required to coordinate its auditing efforts with those of other auditing entities, including those performing cost-based audits of Medicaid claims.

Comment: One commenter suggested that CMS should include a provision in the final rule requiring CMS and the State to monitor the coordination efforts of States and their RACs to ensure that the coordination is taking place.

Response: We have already surveyed the coordination efforts of States that have a RAC-like program in place. We are very interested in learning about the different methods of coordination that will be utilized by the States. Although we decline to put a monitoring requirement in the final rule, we plan to do this on an informal basis. In addition, as discussed in our responses to other comments, we expect the State to play a vital role with regard to coordination of entities seeking to audit providers who receive payments under the State Medicaid Plan or waiver in the State. We have included language in this final rule requiring States to coordinate the recovery audit efforts of their RACs with other auditing entities at § 455.506(c).

Comment: Several commenters suggested that proposed § 455.508 lack specificity with regard to oversight of RAC eligibility requirements. These commenters also expressed concern about the administrative burden associated with having to respond to multiple requests for the same documentation from different auditors in a given period of time.

Response: The State, not CMS, determines whether its RAC has the ability to perform the requirements outlined in § 455.508. CMS is not involved in the RAC selection process. With regard to the coordination of audits, we are concerned about minimizing the potential for multiple audits of the same provider. We recognize the need to minimize the burden on providers associated with responding to multiple audit requests, to the extent possible. States and their RACs are required to coordinate auditing efforts with other entities conducting audits of Medicaid claims. We finalize this requirement at § 455.506(c). However, we have also included language in this final rule at § 455.508(g) indicating that Medicaid RACs should not audit claims that have already been subject to audit or that are currently being audited by another entity. We recognize that subsequent reviews of claims by other auditing entities may be necessary or otherwise unavoidable. Finally, we hope to develop a system to facilitate State coordination among auditing entities.

Comment: One commenter suggested that once a claim has been reviewed by an auditing entity, that claim should not be subject to review by another auditing

entity. For example, if a claim is selected for review by a Medicaid RAC contractor and the claim has previously been reviewed by a State's internal audit department or fraud unit, then the claim should be exempt from any RAC review. Similarly, if a RAC reviews a claim, then a State internal audit department should not subsequently review that claim or include it in a universe of claims that are part of any audit extrapolation.

Response: Generally, if a claim is already subject to review and an overpayment is collected as a result of the audit process, then the claim should not be subsequently reviewed by another auditing entity for the same purpose. We have included language in the final rule at § 455.508(g). However, there are circumstances in which claims may be the subject of multiple reviews, including, but not limited to, potential fraud. Accordingly, the claims at issue may be subject to subsequent review.

Comment: One commenter agreed with CMS' approach to allow States the flexibility to coordinate the collection of overpayments identified by the RAC rather than the RAC itself collecting the overpayment. The commenter currently collects the overpayments from providers and requested CMS approval to continue to collect the overpayments.

Response: We appreciate the commenter's support and inquiry. Generally, States utilize the SPA process to seek our approval regarding any change to their Medicaid programs. States interested in the changes should contact CMS directly with regard to its SPA.

Comment: One commenter recommended that CMS allow States to contract with RACs to only identify overpayments and underpayments and not require the collection of any identified overpayments.

Response: RACs are not required to collect identified overpayments. We specified in the proposed rule at § 455.506(b) that States have the discretion to coordinate the recoupment of overpayments with their RACs. We recognized that States may not be able to delegate the collection of overpayments to contractors and, therefore, granted States the flexibility of coordinating the collection of overpayments. We are finalizing § 455.506(b) as proposed.

Comment: One commenter requested guidance from CMS with regard to the role of Medicare RACs and Medicaid RACs in reviewing claims for dually eligible beneficiaries, those enrolled in both the Medicare and Medicaid programs.

Response: Medicaid RACs are not prohibited from reviewing claims for dually eligible beneficiaries. However, to the extent possible we want to minimize provider burden and if the claims were already reviewed by a Medicare RAC, then the Medicaid RAC should not review the claims. We note that there is little financial incentive for Medicaid RACs to review claims involving dually eligible beneficiaries since Medicare is the primary payer on claims for dual eligibles. Additionally, many States already use TPL contractors to identify overpayments involving eligibility issues.

Comment: One commenter suggested that States should have the flexibility to coordinate with other State and Federal agencies performing audits of providers who receive payment in connection with services furnished to Medicaid beneficiaries. Other commenters suggested coordination between auditing companies when requesting records from hospitals.

Response: States and their RACs are required to coordinate their auditing efforts with other entities that perform audits of providers that receive payments under the State Medicaid Plan. We believe that States have a significant role in coordinating the auditing efforts of their respective integrity programs, RACs, and any other auditing entities under contract with the State as well as any Federal agency seeking to audit a State's Medicaid providers. To the extent a State plays an active role in coordinating the efforts of the various entities seeking to review Medicaid claims, we believe that this will help to minimize the potential for multiple requests for records from different auditing entities.

Comment: One commenter requested that CMS delay implementation of the final rule until coordination issues are resolved.

Response: We disagree with the comment. Implementation of the final rule is not contingent on coordination of auditing entities. As previously discussed, we are very concerned about minimizing provider burden associated with responding to multiple audits and are working to develop a system for States to help facilitate coordination. Additionally, we note that the new effective date for the rule will be January 1, 2012, due in part, to the additional time it will take for States to be prepared for implementation.

Comment: One commenter inquired whether States are required to exclude Payment Error Rate Measurement (PERM) claims from Medicaid RAC review.

Response: Section 1902(a)(42)(B)(i) of the Act mandates that States and their RACs coordinate their "recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State * * *." The Act requires the State and its RAC to coordinate with the PERM contractor. PERM uses a random sample of claims to develop the error rates. Accordingly, if certain claims have already been audited by the PERM contractor, then the State, to the extent possible, should not subject the same claims to a subsequent audit by its Medicaid RAC. However, we recognize that the PERM contractor may in fact include claims in its sample that were previously audited by the Medicaid RAC since the PERM is measuring the error rate of payments that do not meet statutory, regulatory or administrative requirements.

Comment: One commenter who participated in the CMS Webinar "Contract Template: Statements of Work," in which coordination with other entities such as CMS and OGC was discussed, inquired about the meaning of "OGC" and what the State is supposed to coordinate with those entities.

Response: "OGC" is an acronym for the Office of the General Counsel, which is the legal advisor to the Department of Health and Human Services. Coordination with OGC is not necessary, as OGC does not conduct audits of Medicaid claims. With regard to coordination, States and their RACs are required to coordinate their auditing efforts with other entities that perform audits of providers that receive payments under the State Medicaid plan. We believe that States have a significant role in coordinating the auditing efforts of their respective integrity programs, RACs, and any other auditing entities under contract with the State as well as any Federal agency that is conducting potential fraud reviews or seeking to review State Medicaid providers.

Comment: One commenter asked if an Audit Medicaid Integrity Contractor already requested records from a provider for certain claims but did not complete the review at CMS direction, whether the claims should be suppressed from review by a Medicaid RAC.

Response: Generally, if there were no audit findings associated with the review of certain claims, then the claims may be subject to additional review unless the State determines that there is no basis for the audit of the claims.

Comment: One commenter noted that allowing States to contract with more

than one RAC poses the risk of duplicate audits of the same provider. This commenter, therefore, suggested that the proposed rule should be modified to ensure that when a State contracts with more than one RAC, the State and its RACs should be required to coordinate their efforts to prevent duplication of audits.

Response: We agree with the comment and are making this change in this final rule at § 455.506(c).

Comment: Several commenters recommended that States be allowed to manage the reporting and referral of potential fraud to law enforcement. They proposed that RACs would report suspected fraud to States and the States would then refer it to the appropriate law enforcement entities such as the “MFCUs, SMA, Federal OIG and local law enforcement.” The States would be able to provide a more comprehensive referral to law enforcement by providing information on past interaction with or conduct by the provider in question. They indicated that State coordination of fraud and/or abuse is consistent with Federal and State laws and regulations.

Response: We agree that States are in the best position to know of potentially fraudulent activities by providers in their States. Accordingly, we have specified in this final rule at § 455.506(d) that States, not RACs, have the responsibility to make referrals of suspected fraud to the MFCU or other appropriate law enforcement agency.

Comment: Several commenters requested that CMS reconsider the scope of work and/or expertise of the Medicaid RAC to distinguish fraud or criminal activity from erroneous billing. These commenters believe that suspicion of fraud and criminal activity should be referred for further investigation by other MICs with expertise to determine whether or not a referral to law enforcement is appropriate.

Response: We understand the concerns of commenters. We believe that States should determine whether there is a sufficient basis for a fraud referral to their State MFCUs or other appropriate law enforcement agency. Accordingly, we are making this change in this final rule at § 455.506(d).

Comment: One commenter indicated that CMS’ proposed standard of “reasonable grounds” concerning law enforcement referrals in proposed § 455.508 of the regulation, is subject to variable interpretation and could result in inappropriate referrals. This commenter stated that CMS must clearly define the term “reasonable grounds” and include examples of same.

Response: Based upon the comments received, we have changed the responsibility of making fraud referrals to law enforcement from the Medicaid RACs to the States. We have reflected this change in this final rule at § 455.506(d). We believe that this is consistent with existing Federal regulations that govern State referrals of fraud and abuse, as defined by § 455.2, to the appropriate law enforcement agency as well as require the State to adhere to certain fraud referral standards. In addition, we have removed the language regarding “reasonable grounds” from this final rule. We have also included in this final rule at § 455.508(h) that Medicaid RACs must refer suspected cases of fraud and/or abuse to the State in a timely manner. We expect States to provide clear definitions of timely referrals in its contract with the RAC or other applicable guidance.

Comment: One commenter recommended that CMS adopt the recommendations in the OIG Medicare RAC Referral Report. That report outlined a number of recommendations including requiring Medicare RACs to receive mandatory training on the identification and referral of fraud.

Response: We disagree with the commenter. In the permanent Medicare RAC program, we provided RACs with a presentation about fraud in Medicare, the definition of fraud, and examples of potential Medicare fraud. The OIG stated in its report that because Medicare RACs do not receive their contingency fee for cases they refer and are determined to be fraud, there may be a disincentive for RACs to refer to cases of potential fraud. Medicaid RACs are a State operated program, whereas the Medicare RACs are a national program. Accordingly, the responsibility of making fraud referrals should belong to the State instead of the Medicaid RAC, as initially proposed. We have finalized this change at § 455.506(d).

Comment: One commenter requested the removal of the requirement of immediate referral for suspicion of fraud to law enforcement from the final rule. The commenter suggested the requirement exceeds the authority of the statute. The commenter continued that he/she did not believe that the determination of what may constitute reasonable grounds for referral is within the purview of Medicaid RACs, or that RACs should be required to make the referrals.

Response: We agree that the Medicaid RACs should not have the responsibility to make fraud referrals and that the responsibility belongs to the State. Accordingly, we have made the change

in this final rule by adding new subparagraph § 455.506(d). In addition, we have included in this final rule at § 455.508(h) that the Medicaid RAC must refer suspected cases of fraud and/or abuse to the State in a timely manner, as defined by the State. We expect States to provide clear definitions of timely referrals in the contract with its RAC or other applicable guidance.

Comment: One commenter requested clarification on how States and Medicaid RACs will be notified of efforts initiated by the OIG or criminal investigations to facilitate coordination of efforts. The commenter expressed concern that routine RAC activities such as record requests may alert providers and subsequently jeopardize investigations.

Response: We have finalized that States are required to make referrals of suspected fraud and/or abuse to the MFCU or other appropriate law enforcement agency at § 455.506(d). We believe the States play a significant role with regard to coordination generally, and should share information regarding investigative activities or other auditing efforts in the States with their RACs to the extent possible. However, nothing in this final rule requires the Office of Inspector General or other law enforcement authorities to disclose investigative information to Medicaid RACs.

G. Appeals Process

Comment: One commenter asked about the error rate associated with the RACs finding improper payments that ultimately are reversed on appeal. Another commenter asked about the frequency with which an organization believes a RAC has made an error but does not want to go through the appeal process.

Response: We presume that the commenter was inquiring about data from the Medicare RAC program. In the Medicare RAC program, we have contracted with a validation contractor that does an accuracy review for CMS. That contractor reviews a sample of claims each month (overpayments and no findings) to determine if the Medicare RAC was making accurate decisions. In the Medicare RAC Demonstration, only 8.2% of all claims with an improper payment were overturned on appeal. We do not have specific data with regard to providers that decline to appeal Medicare RAC determinations or that believe that a RAC determination was made in error.

Comment: One commenter asked who bears the cost of the appeal if an adverse Medicaid RAC determination is appealed. Specifically, the commenter

inquired as to whether the State would be able to claim FFP for the cost of the appeal if the appeal reversed the RAC determination. The commenter also wanted to know if the determination is upheld, whether the provider could include the costs in its cost report.

Response: The cost of a State's appeal would be an allowable administrative cost under the State's Cost Allocation Plan. If a State is establishing a new appeals process for RAC determinations, the State may have to amend its Cost Allocation Plan to cover the new appeals process. A provider's appeal costs are administrative costs that are not allowable under Medicaid.

Comment: One commenter asked how long the appeal process would take an organization to go through.

Response: We are not mandating a single appeals process that all States must use for RAC appeals, therefore the length of time for a provider's appeal in a given State will differ, based on the nature of the State's appeals process and the issues on appeal. However, under section 1902(a)(42)(B)(ii)(III) of the Act, all States must have an appeals process in place for providers to appeal adverse RAC determinations.

Comment: A few commenters asked whether they must seek CMS approval if they intend to use their existing appeals process, or if the requirement to submit to CMS a proposal describing the appeals process which must be approved prior to implementation of the RAC programs applied only when the State intended to establish a separate RAC appeals process or when the State did not currently have an appeals process in place.

Response: The proposed rule provided States with 2 options for their appeals process from which States may choose as they deem appropriate: (1) Either take advantage of an existing appeals process, or (2) establish a separate appeals process for RAC determinations. The proposed rule also required States to submit a proposal describing the appeals process, which we would approve prior to the State implementing its RAC program. In this final rule, we now clarify that we will only require a description and prior approval of any new RAC appeals process that a State will use, not any existing appeals process.

Comment: One commenter encouraged CMS to prohibit any ability for States to establish a new appeals process. The commenter believed a new appeals process would be problematic for those providers that have entities in more than one State, as each would have to comply with more than one

process to submit appeals on a timely basis.

Response: We are not mandating a single appeals process that all States must use for RAC appeals. Given that each State has provided us with assurances through the SPA process that it will comply with the statutory requirement to provide an adequate appeals process for entities to appeal adverse RAC determinations, it would be unreasonably burdensome on the States for us to impose a single appeals process for RAC appeals. We are not prohibiting States from establishing a new appeals process for RAC appeals. States will have the flexibility to determine what form of appeals process best suits their respective RAC programs. We are aware that responding to multiple States' processes could be a challenge for providers that are enrolled in multiple States' Medicaid programs. However, the providers would have been involved with the RACs' overpayment determination processes and should have received notice of appeals timeframes.

Comment: One commenter noted that the language of the preamble to the proposed rule refers to "ensuring providers adequate due process rights" while the proposed regulation at § 455.512 only provides for general appeal rights with no mention of due process. The commenter recommends strengthening the rule by changing § 455.512 to read "States shall provide appeal rights that ensure adequate due process under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination."

Response: We appreciate the commenter's concerns, however we note that section 1902(a)(42)(B)(ii)(III) of the Act only refers to "an adequate process for entities to appeal any adverse determination." To allow the States maximum flexibility and to accommodate differences in State laws regarding due process, we are not prescribing specific requirements for an appeals process for adverse RAC determinations. Instead, consistent with the statutory language, we are requiring States to provide an adequate appeals process. Therefore, we decline to revise § 455.512 in accordance with the commenter's request.

Comment: A commenter asked whether the RAC program contractor activities may include legal defense of an appealed overpayment determination, or, in other words, whether the State may contractually obligate the RAC to defend its findings in the administrative appeal. The commenter also asked whether the State

specific requirements must be articulated in the SPA.

Response: When designing their RAC programs, States have the discretion to require their RACs by contract to appear in the State's administrative or judicial appeals hearings to defend the RACs' overpayment findings. The Medicaid SPA does not require a detailed description of the State's RAC program. However, in this final rule, we are finalizing at § 455.502(c) the requirement that the State report to CMS elements describing the effectiveness of the State's RAC program, including, but not limited to, general program descriptors (for example, contract periods of performance, contractors' names) and metrics (for example, number of audits conducted, recovery amounts, number of cases referred for potential fraud). CMS will provide sub regulatory guidance to States related to performance metrics, State reporting requirements and other milestones contained in the RAC program.

Comment: A commenter asked CMS to add clarifying language in 42 CFR part 455 subpart F that the SMA and not the RAC is the final arbiter of whether an overpayment or underpayment has been discovered.

Response: When an overpayment is discovered it is governed by § 433.316 of the regulation. To the extent that an overpayment discovered in the course of a RAC audit is not the result of fraud, it would be subject to § 433.316(c). The issue is not which party is the final arbiter of the overpayment, but which party has taken the action that results in the overpayment being discovered. The party that discovered the overpayment would depend upon the process established in the State's RAC contract and which action occurs first in time: From whom communications with providers are initiated, that is SMA or the RAC, and whether the RAC initiates recoupment proceedings.

Comment: One commenter requested that CMS reconsider its position that States could share a part of recovery from a civil or criminal fraud proceeding with a RAC. The commenter was concerned that CMS might unintentionally create strong incentives (through the prospect for multiple damages) that RACs would presume potential fraud where unfounded. The commenter suggested that even without an incentive under the Medicare RAC demonstration, RACs often inaccurately determined the existence of overpayments, with 64 percent of contested cases overturned on appeal, and cited the June 2010, "CMS Update to the RAC Demonstration Report."

Response: We proposed that nothing would preclude a State from agreeing to pay a RAC a contingency fee from funds recovered and returned to the State as the State share of an overpayment (or restitution) at the close of the civil or criminal proceeding. It would be within the State's discretion to design a RAC program that paid a contingency fee to a RAC on this basis, that is, if the RAC contributed to the recovery and the recovery was fully adjudicated. We are sensitive to the potential for creating an incentive for contingency fees for fraud recoveries. However, given that a fully adjudicated fraud recovery could take several years, we believe the potential pay-off for the RAC would be outweighed by the delay in the payment. We recognize that the Medicare RAC Demonstration program experienced a moderate overturn rate and are hopeful that States will be able to design programs that take the Medicare RAC experience, including overturn rate, into consideration to reduce the burden on the providers and State Medicaid programs.

Comment: One commenter urges CMS to modify the proposed rule to permit only the second option that CMS proposed for structuring payments to RACs in which a State pays a RAC only when the recovery amount is fully adjudicated and all appeals available to the provider have been concluded. Adoption of the second option, the commenter argues, is not only consistent with the expressed interpretation of the statute by CMS, it is also sound policy, as it would incentivize Medicaid RACs to conduct their audits with greater care to avoid errors that would generate appeals. The commenter believes the first option in which a State pays a RAC when the RAC recovers an overpayment and the State requires reimbursement by the RAC if the recovery is overturned on appeal is inconsistent with the language of section 1902(a)(42)(B)(ii)(I) of the Act, which requires that payment must be made only from amounts recovered.

Response: As we stated in the proposed rule, we interpret the statute to mean that (a) payments may not exceed the total amounts recovered, and (b) payments may not be made based upon amounts merely identified but not recovered, or amounts that may initially be recovered but that subsequently must be repaid due to determinations made in appeals proceedings. Therefore, under (a), because the payment is a contingency fee it is relative to the amounts recovered; and under (b), the identified amounts must be recovered for the contingency fee to be paid to the RAC, or the contingency fee must be

recouped from the RAC if a recovered overpayment is found at any level of appeal to not have been overpaid by the provider. While some RACs may find the second contingency fee option to be a disincentive to committing errors when performing audits, we think that a delay of as long as two years to be paid the contingency fee would act as a disincentive to contracting with the States at all. We are permitting the States the most flexibility in designing their RAC programs, which includes the timing of payment to their RACs.

Comment: One commenter noted that the level of provider appeals related to RAC determinations could, according to the commenter, "drive substantial program costs." The commenter asked for clarification as to whether the expenses related to the additional appeals will be subtracted from the Federal share to be refunded.

Response: As stated above, a State's appeal costs would be an allowable administrative cost under the State's Cost Allocation Plan. A provider's appeal costs are administrative costs that are not allowable under Medicaid.

Comment: Several commenters recommended a discussion period between RACs and the providers prior to the commencement of the right to appeal to avoid inaccurate determinations of overpayments. During the discussion period, the providers could provide RACs with information necessary to make an accurate determination. The commenters noted that when the discussion period was implemented in the Medicare RAC program, providers and RACs avoided the time and expense of going through the appeals process. The commenters suggested that SMAs would participate when issues arose regarding RACs' interpretation of the State Plan and other Medicaid payment policies. One commenter recommended a discussion period of 25 days. Another commenter suggested that CMS and the States should monitor how Medicaid RACs observe the discussion period so that it is not treated as a mere formality but, rather, a meaningful opportunity for the parties to address any errors in the determination.

Response: We appreciate the commenters' suggestions and are cognizant of the lessons we might learn from the Medicare RAC program, as well as other audit programs. Providers that submit additional information to auditors during the discussion or comment period may avoid subsequent appeals or they may find that the auditor's findings will stand. Section 1902(a)(42)(B) of the Act establishes a State RAC program, which we are

interpreting to grant States the flexibility to design programs, consistent with their State laws and that meet the needs of their States. We will not mandate that States use discussion periods, either at all or of any specified duration. However, we encourage States to require a discussion or comment period prior to a RAC's audit becoming final, as is commonplace in audits. If a State chooses to implement a discussion or comment period in its RAC program, we recommend but do not require that the State monitor the RAC's compliance with that discussion or comment period requirement.

Comment: Several commenters suggested that we should require each State to prescribe a clear appeals process that is robust and provides for multiple levels of appeal. Some commenters urged us to prescribe specific requirements for Medicaid appeals.

Response: We are not mandating a single appeals process that all States must use for RAC appeals nor dictating the manner of the appeals processes that the States must implement for RAC appeals. In the event that, through the SPA process, a State proposed a process that did not provide entities with an adequate opportunity to appeal adverse RAC determinations, we would engage in discussions with the State about its appeals process until the State was able to provide assurances that its appeals process was compliant with section 1902(A)(42)(B)(ii)(III) of the Act. Given that each State has provided us with assurances that it will comply with the statutory requirement to provide an adequate appeals process for entities to appeal adverse RAC determinations, it would be unreasonably burdensome on the States for us to impose a single appeals process for RAC appeals.

Comment: Several commenters objected that our proposed rule failed to prevent RACs from recouping funds associated with denials under appeal. The commenters also objected that the proposal failed to require RACs to return their contingency fee if a denial is overturned at any stage of the appeals process. The commenters believe that CMS' silence on these important issues in the proposed rule will result in overzealous and inappropriate denials on the part of the Medicaid RACs, and urge that RACs must not be able to recoup funds until the appeals process is exhausted and must not receive their contingency fee in cases where the denial is overturned.

Response: We proposed 2 payment options to provide States with the most flexibility in designing their RAC programs: (1) States may pay RACs from

amounts identified and recovered, but not fully adjudicated, but the RAC would be required to return any contingency fee that corresponded to the amount of an overpayment overturned on appeal; or, (2) States could pay the RAC after the overpayment was fully adjudicated, that is after the exhaustion of all appeals available to the provider. We disagree that we failed to require RACs to return their contingency fee if a denial is overturned during the appeals process. In the first option as we described it in our proposal, the RAC would be required to return any portion of the contingency fee that corresponded to the amount of the overpayment overturned at any level of appeal.

The commenters are concerned that the opportunity for a contingency fee will act as an incentive to the RACs to find overpayments, even if those are later overturned on appeal and the RACs must return the contingency fee. We believe that the possibility of a contingency fee being overturned would be outweighed by the likelihood that the State would not be able to attract a RAC for its RAC program, were the State limited to payment of the contingency fee after exhaustion of appeals. The appeals process can take years and a RAC would go unpaid for all its cases in the initial years while providers exhausted their appeal rights.

Comment: Several commenters noted that the proposed rule does not require the Medicaid RAC to provide any data on the number of claims appealed and the number of denials overturned during the appeals process. The commenters recommend that these data be captured on a timely basis and urge that the data be used to hold RACs accountable for inappropriate denials. The commenters also urge that information on appeal turnover rates be shared with the public. Two of the commenters also suggested that RACs with a turnover rate of 25 percent or greater per year should be subject to a monetary penalty.

Response: Whether States should require RACs to provide any data on the number of claims appealed or the number of denials overturned during the appeals process, or any penalty to be assessed for high appeal turnover rates is within the discretion of the States when designing their RAC programs. Whether to release Medicaid RAC appeal turnover rates is subject to each State's laws and rules. We proposed that the States provide us with elements describing the effectiveness of the RAC programs, including general program descriptors (contract periods of performance, contractors' names, etc.)

and program metrics (number of audits conducted, recovery amounts, number of cases referred for potential fraud, etc.). We will issue sub-regulatory guidance to the States regarding the data to be provided.

Comment: One commenter suggested that CMS set minimum appeal rights that all States must incorporate into their appeals processes. The commenter suggested that a standardized Medicaid RAC appeals process include the following minimum elements:

1. A clearly defined appeals process describing the providers' rights and responsibilities, including the right to submit documentary evidence and to be heard in person.
2. A minimum discussion period, such as 120 days, to rebut the RAC response.
3. A multi-tiered appeals process which provides for an independent review.
4. A process by which recoupment is delayed until the appeals process is finished or has reached a certain stage.
5. A description of how interest will be applied to overpayment determinations.
6. Timeframes regarding appeal deadlines, providing supporting documentation, and issuing review decisions.
7. Detailed decisions describing the basis for upholding the overpayment determination and informing the provider of further appeal rights and deadlines.
8. Agreements between the State, the Medicaid RAC, and any other entities involved in the Medicaid RAC process to ensure the timely and accurate flow of information.
9. Penalties for noncompliance with time frames that should apply to both the provider and the entity adjudicating the RAC appeal.

Response: States will have the flexibility to design their RAC programs, including the content of and signatories to agreements regarding the States' RAC programs, as well as whether there will be a discussion or comment period, and what interest will apply to overpayments. We are finalizing that States have two options to pay contingency fees to RACs: States may pay RACs from amounts identified and recovered, but not fully adjudicated, but the RAC would be required to return any contingency fee that corresponded to the amount of an overpayment overturned at any level of appeal within a reasonable timeframe as prescribed by the State; alternatively, the State may pay the RAC after the overpayment is fully adjudicated, that is after the exhaustion of all appeals available to

the provider. We leave the States with the flexibility to select the option that works better for their programs.

Comment: One commenter suggested specific recommendations that if the current State appeals process is at the Administrative Law Judge level only, CMS should impose requirements on the States to implement a tiered appeals process to allow review by an independent, non-government entity as a first or second level of appeal. In addition, CMS should require establishment of timeframes both for providers to submit their appeals, prior to recoupment, and for those entities reviewing the appeals to conclude their work and report the outcome to the providers.

Response: We are neither mandating a single appeals process that all States must use for RAC appeals, nor are we dictating the manner of the appeals processes that the States must implement for RAC appeals, including details as timeframes for any part of the appeals process.

Comment: One commenter appreciated our proposed requirement that State Medicaid RACs must use trained medical professionals, and that the RAC programs must have an adequate appeals process and coordinate with other auditors and law enforcement.

Response: We appreciate the comment. We are finalizing the following requirements: States must require their RACs to employ trained medical professionals, as defined by the State, to review Medicaid claims at § 455.508(a); States must provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination at § 455.512; and that States must make referrals of suspected fraud and/or abuse to the MFCU or other appropriate law enforcement agency at § 455.506(d).

Comment: One commenter recommended that we develop a robust and consistent infrastructure to support the Medicaid RAC appeals process, including publishing information about the process online, to reduce confusion and ambiguity experienced by providers.

Response: While we are sensitive to the challenges of multiple States' audits and appeals for providers serving in multiple States' Medicaid programs, we have no plans at this time to establish or implement any online data repository regarding State Medicaid RAC appeals processes.

Comment: One commenter encouraged States to utilize their existing appeals processes rather than to

establish new Medicaid RAC appeals processes that would require a learning curve. The commenter also encouraged CMS to establish timeframes for the RACs to respond to providers during the appeals processes. The commenter believed that the RACs should be held accountable in their response period to ensure timeliness in addressing denials.

Response: The States have the flexibility either to take advantage of an existing appeals process or to establish a separate appeals process for RAC determinations. It is within the States' discretion which option they choose. We are not dictating the manner of the appeals processes, including timeframes for RAC responses during the appeals process.

Comment: One commenter noted that Medicare RACs demonstrated a lack of sufficient review of claims, understanding, and due diligence to take the appropriate amount of time and ensure their information is accurate before submitting a denial letter to the provider. Therefore, the commenter suggested that CMS hold RACs accountable and require them to conduct due diligence, ensuring accurate and timely denial letters are submitted to providers under audit.

Response: We are applying the lessons we have learned in the Medicare RAC program; however, the States have a certain degree of flexibility to design their RAC programs, including the development of RAC audit protocols and the content of its findings. However, we agree with the commenter that the RAC should timely notify providers of its overpayment findings. We have finalized at § 455.508(e)(4) that RACs must notify providers of its overpayment findings within 60 calendar days.

Comment: One commenter suggested that patients not receive a letter regarding an audit until the appeals process has ended and the determination is final. The commenter also recommended that CMS publish written policies and procedures of all processes to promote consistency and provider knowledge, as well as proper understanding of these processes.

Response: In the course of routine Medicaid provider audits, Medicaid beneficiaries are contacted to verify receipt of services. Accordingly, we decline to restrict SMAs in the ordinary conduct of audits. Additionally, Medicaid RACs are individually State operated, administered and procured programs. Therefore, CMS will not publish written policies and procedures about State processes.

Comment: A few commenters supported our proposed approach to

allow States to use existing appeals structures.

Response: We appreciate the commenters' support.

Comment: One commenter had several recommendations for the audit and appeals process regarding notices to providers during the audit; notifications of findings of overpayments or underpayments; time limits for repayment; and information on the right to rebut the findings and the right to appeal. The commenter specifically recommended that the notice to providers should explain the right to appeal, specific requirements for appealing, and the effect of an appeal on the timing of repayment or offset and applicable interest; and that contact information should be provided for both rebuttal and appeal inquiries.

Response: Each State has a certain degree of flexibility with regard to the design of its RAC program, including whether to use an existing appeals process or to establish an alternate appeals process for RAC determinations. We are not mandating those details as part of the content of the RAC's findings. However, we believe that the RAC should timely notify providers of its overpayment findings. We have finalized at § 455.508(e)(4) that RACs must notify providers of its overpayment findings within 60 calendar days.

Comment: One commenter requested that CMS require the Medicaid RAC process mirror the Medicare RAC program to alleviate the stress of managing audits in multiple States and ensure the process is more seamless for providers. The commenter also requested that CMS require an independent decision maker such as an Administrative Law Judge at some level of the appeal process to protect providers and the Medicaid program, providing oversight and an unbiased opinion.

Response: We are sensitive to the challenge that audits in multiple States can present to providers that serve multiple States' Medicaid programs. Nevertheless, we are neither mandating a single appeals process that all States must use for RAC appeals, nor are we dictating the manner of the appeals processes that the States must implement for RAC appeals, including who will be the decision makers in their appeals processes. Given that each State has provided us with assurances through the SPA process that it will comply with the statutory requirement to provide an adequate appeals process for entities to appeal adverse RAC determinations, it would be unreasonably burdensome on the States

for us to impose a single appeals process for RAC appeals.

Comment: One commenter recommended that CMS conduct a thorough review of State appeals processes and establish some level of consistency across States, and include provisions that will require adequate documentation of those processes including establishing time frames in which documentation should be provided by RACs to providers who are interested in filing an appeal. The commenter also recommended that CMS include provisions that would require States to keep appeal processes independent of RAC activities. The commenter was concerned that because RAC fees are based on the amount of the overpayment collected, RACs have an added incentive to avoid potential provider appeals. The commenter suggested that all appeals processes should be done by the State and not the RAC or other entities that may have an interest in the outcome of the appeal.

Response: Each State has a certain degree of flexibility in the design of its RAC program, and we are not mandating a single appeals process that all States must use for RAC appeals, nor are we dictating the manner of the appeals processes, including timeframes for providing documentation to providers for filing an appeal and how the appeals process would be structured. We are requiring that the States operate a RAC program that meets the requirements of the statute, including providing an adequate appeals process: section 1902(a)(42)(B)(ii)(III) of the Act requires an adequate appeals process for providers to appeal any adverse Medicaid RAC determinations. While we appreciate the commenter's concerns that RAC activities be separate from the appeals process, we are not mandating the structure of each State's RAC program.

Comment: One commenter recommended clarification of the rule describing providers' rights to appeal and that we require peer review of overpayments.

Response: Each State has a certain degree of flexibility to design its RAC program, including whether to use an existing appeals process or to establish an alternate appeals process for RAC determinations and how the appeals process will function in that State. While we are requiring that States require their RACs to employ trained medical professionals, as defined by the State, to review medical claims, it is within the States' discretion to determine whether to use medical professionals to review Medicaid RACs'

findings prior to the recoupment of overpayments.

Comment: One commenter recommended that due to an already overburdened system, we should require the establishment of a concrete timeframe for the record requests, the actual audit, and the appeals process.

Response: We are sensitive to the demands of audits on States' and providers' time. However, States have the flexibility with regard to the design of its Medicaid RAC appeals processes. Therefore, we are not mandating those details as timeframes for records requests, the duration of the audit, or the appeals process.

Comment: One commenter noted that the State would have a disincentive to establish a vigorous, unbiased appeals process because it is required to return the Federal share under § 433.312 even if the State is unable to recover the overpayment from the provider.

Response: Under section 1903(d)(2)(C) of the Act and § 433.312, the State will have a year to attempt to recover an overpayment from a provider, except in cases of fraud where the time period may be longer. Then, the State must return the Federal share regardless of whether it does in fact recover the overpayment. However, if a determination is overturned on appeal, the State can request a refund of the Federal share through processes outlined in § 433.320. Thus, we disagree with the commenter that there is a disincentive for States to establish a vigorous, unbiased appeals process. States are required under section 1902(a)(42)(B)(ii)(III) of the Act to establish an adequate process for providers to appeal adverse RAC determinations. We are confident that States will afford providers vigorous and unbiased appeals processes.

Comment: One commenter suggested that CMS review each State's appeals process to determine its reasonableness. The commenter recommended that timeframes for filing appeals and making decisions on the appeals should allow providers to more easily keep track of all the levels of reconsideration and review as well as timely filing dates for all the appeal levels. CMS should very closely monitor the different appeals systems and remain alert to the concerns of providers if unreasonableness, inconsistency and unnecessary complexity overwhelm provider efforts to be compliant.

Response: Each State has the flexibility to design its Medicaid RAC appeals process, including whether to use an existing appeals process or to establish an alternate appeals process for RAC determinations. While we are

requiring States to submit a description and obtain prior approval of any new RAC appeals process that a State will use (not any existing appeals process), we are not dictating the manner of the appeals process that the States must implement for RAC appeals.

H. Payment—General/Federal Share/Administrative Match

Comment: One commenter asserted that CMS should require States to implement automatic positive payment adjustments to providers through the "X12 835 transaction process."

Response: This comment is outside of the scope of the proposed regulation. Therefore, we decline to accept this suggestion.

Comment: One commenter asked for clarification regarding what activities are eligible for administrative matching.

Response: Section 1903(a) of the Act directs payment of FFP, at different matching rates, for amounts "found necessary by the Secretary for the proper and efficient administration of the State plan." The Secretary is the final arbiter of which activities fall under this definition. Claims held under this authority must be directly related to the administration of the Medicaid program.

Comment: A few commenters requested and/or recommended an enhanced FFP rate for implementing the Medicaid RAC program. Other commenters recommended an enhanced FFP match of 90 percent, and one commenter recommended a rate of 75 percent.

Response: Because enhanced Federal match was not specifically authorized by the Affordable Care Act, activities associated with the procurement, operation and administration of a Medicaid RAC do not qualify for enhanced Federal match.

Comment: One commenter requested that CMS clarify whether a State's statute allows the State to directly receive the overpayment instead of delegating the collection responsibility to the RAC.

Response: In the proposed rule, we acknowledged the differences among the States and territories regarding the issue of coordinating with Medicaid RACs for the collection of overpayments. We stated that the statute requires Medicaid RACs to collect overpayments, but some States may not be legally able to delegate the collection of overpayments to contractors. Accordingly, we finalize at § 455.506(b) that States will have the discretion to coordinate the collection of overpayments with their Medicaid RACs.

Comment: One commenter suggested that there is a need for a standard traceable recovery identifier to be used from beginning to end to allow for reconciliation.

Response: We recommend that States explore efficient and innovative processes to detect and/or prevent improper payments. However, we do not require States to implement uniform processing systems for payments to providers.

Comment: One commenter requested that CMS clarify the budget and accounting standards that States must comply with when accounting for transactions with Medicaid RACs.

Response: Estimates of Federal funds on overpayments should be included in the Form CMS-37 reports, following the requirements for reporting of collections and overpayments, not collected within one year, as required by § 433.312.

States should already have an accounting process in place to record overpayments when discovered, as well as the Federal share received, and for recording collections and reporting collections on the Form CMS-64 as they occur, and reporting outstanding overpayments at the end of the one-year period. States should follow those same accounting standards and procedures to account for Medicaid RAC overpayments and collections and the required reporting as indicated above, although they should be identified as RAC overpayments and collections to facilitate determination and reporting of RAC fees.

Comment: One commenter requested that CMS clarify when CMS expects repayment of the Federal share of overpayments. The commenter stated that CMS should give States up to one year to remit the Federal share of the funds recovered. Providing States with up to one year to remit funds will allow States the opportunity to recoup funds from future payments.

Response: Under section 1903(d)(2) of the Act, States have up to one year to recover overpayments before an adjustment is made in the Federal payment to the State to account for that overpayment. The Federal share of collections should be reported when received, if collected within the one-year period. At the end of that period, the Federal share of the uncollected overpayment amount must be refunded to the Federal government.

Comment: One commenter requested clarification regarding proposed language provided at sections 1902(a)(42)(B)(ii)(IV)(bb) and 1903(d) of the Act as it applies to amounts recovered under the Medicaid RAC program. There, the commenter noted

that “[w]e propose that a State must refund the Federal share of the net amount of overpayment recoveries *after* deducting a RAC’s fee payments.” The commenter wanted CMS to assure that there is no potential conflict with interpretation of language from page 75 FR 69041 of the proposed rule discussing repayment of the Federal portion. Additionally, the commenter wanted clarification that the Federal share should be refunded from overpayments or amounts actually recovered.

Response: The reporting will identify the overpayment recoveries received and the RAC fees paid, which will ensure that the fees do not exceed the recoveries. Additionally, overpayments for which the one-year period for collection has expired will be reported to repay the Federal share.

The reporting on the recoveries (collections) will distinguish between recoveries reported within the one-year period to collect (refunded on the current report) and collections for overpayments previously refunded due to the expiration of the one-year period (not refunded on the current report as the amount was previously refunded). The Federal share of overpayment amounts collected within one year from discovery is to be refunded when collected (recovered); the Federal share of overpayment amounts not collected at the end of the one-year period must be refunded at that time.

Comment: One commenter indicated that § 433.312 requires States to refund the Federal share of overpayments, regardless of whether the State actually recovers the overpayments from providers. This commenter sought clarification that there was no conflict with other sections of the proposed rule which stated that RACs are paid from amounts “actually recovered from the provider after all appeals and negotiations are finalized, and not on amounts identified.”

Response: We do not believe that these provisions are in conflict. One concept involves the return of FFP to the Federal Government, whereas the other pertains to the timing of payment to a RAC by a State. In the proposed rule, we indicated that the requirement for States to refund the Federal share of overpayments applied to overpayments that are identified by the RAC. Therefore, if a Medicaid RAC identifies an overpayment, the State is required to refund the Federal share of the overpayment amount if not collected by the expiration of the one-year period. The State’s obligation to return FFP is independent of its obligation to compensate a RAC for the work it

performs. That occurs when an overpayment is collected and a corresponding contingency fee is paid to the RAC.

Comment: One commenter indicated that the initial identification of overpayment amounts may be subject to change because findings are often reversed or revised after additional information is obtained, and some findings are thrown out through the appeals process. If the RAC contractor is not paid until overpayments are actually recovered, it makes sense that the Federal portion of those recovered funds would be repaid to the Federal government after an appeals process is completed.

Response: The refunding of the Federal share is governed by the overpayment regulation at § 433.312, as discussed above. If the appeals process changes the overpayment amount after the expiration of the one-year period for collection and the State reported that overpayment, the overpayment amount can then be adjusted on the Form CMS–64.9ORAC for reporting RAC overpayments that have not been collected at the end of the one-year period.

Comment: One commenter recommended that the final rule should be updated to reflect how recoveries are handled via a payment plan.

Response: If a State provides a payment plan which recovers the total overpayment within one year from discovery, the recoveries are reported as received. If the payment plan exceeds the one-year period, the recoveries are refunded as collected during the one-year period and then the balance is refunded on the overpayments schedule. Subsequent recoveries of that balance would be reported for the purpose of showing that fees paid do not exceed recoveries, but would not be refunded as it would have already been refunded through the reporting on the overpayment schedule.

Comment: One commenter recommended that CMS remove reference to payment when addressing RAC fees in proposed section 1902(a)(42)(B)(ii)(IV)(bb) of the Act: “We propose that a State must refund the Federal share of the net amount of overpayment recoveries after deducting a RAC’s fee payments In other words, a State would take the RAC’s fee ‘off the top’ before calculating the Federal share of the overpayment recovery to be returned to CMS.”

Response: We are uncertain what the commenter is suggesting regarding removing the reference to payment when addressing the RAC fee. The statute requires that the RAC “program

is carried out in accordance with such requirements as the Secretary shall specify including * * * that section 1903(d) [of the Act] shall apply to amounts recovered under the program.” In the proposed rule we indicated that the “State would take a RAC’s fee payment ‘off the top’ before calculating the Federal share of the overpayment recovery to be returned to CMS”. We clarify the reporting in this final rule. In order to adequately identify recoveries and fees paid, States must report both the overpayment recoveries and associated fees using the same Federal share (FMAP rate) that is applicable to the overpayments. Similarly, the fees paid for identifying underpayments will be reported at the same FMAP rate appropriate to the payment of that underpayment amount, or the current FMAP rate if the underpayment is not paid.

Comment: One commenter recommended that the reconciliation process with historical data should be visible to both the RAC and the provider.

Response: States have certain flexibilities in which to design, procure, administer, and operate their RAC programs. While we decline to adopt the commenter’s recommendation, we encourage States to adopt measures that will promote transparency and efficiency in the Medicaid RAC program.

Comment: One commenter suggested that CMS revise its proposed methodology for RAC payment to permit State flexibility, allowing States the option to claim contingency fees for RACs consistent with current administrative FFP claiming protocols for existing TPL and non-TPL overpayment recovery contracts. The State believes that requiring States to run an accounting process for RAC contingency fees that may differ from existing non-RAC overpayment recovery contingency fee claiming processes is administratively burdensome and invites opportunity for error.

Response: In the proposed rule, we considered requiring States to treat RAC contingency fees at the administrative rate of 50 percent. However, we determined that the language in the legislation supported treating the fees at the FMAP rate applicable to the recovery. This provides a higher benefit for States than treating the fees at the administrative rate.

Comment: One commenter indicated that the proposed rule does not specify that providers must request reimbursement for underpayments. The commenter further indicated that providers must be responsible and

accountable for their claims and the State should not be required to make payments without the provider submitting a claim.

Response: As previously stated, we are concerned about provider participation in the Medicaid program as well as States making proper payments to providers. We believe that States should compensate providers for identified underpayments, consistent with State law. We are requiring States, in this final rule at § 455.510(c)(3), to inform providers about underpayments that are identified by their Medicaid RACs.

Comment: One commenter indicated that its Medicaid Management Information System (MMIS) only retains claims available for adjustment for two years. Additionally, it asserted that adjudicating claims or adjustments outside of the regulated time frames creates technical accounting and recording problems.

Response: We understand the commenter's concerns. However, consistent with § 433.322, States are required to maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 45 CFR part 74, subpart D. However, we are finalizing at § 455.508(f) that the maximum look-back period for claims review is three years. If a State's MMIS system only retains adjustable claims data for only two years, a State may request an exception from CMS through the SPA process. We believe this flexibility also enables States to address concerns pertaining to adjudication and adjustments.

I. Exceptions

Comment: Several commenters recommended that CMS clarify its position on whether Medicaid RACs will review Medicaid managed care claims. Most, if not all, of these commenters recommended that CMS provide guidance exempting Medicaid managed care claims from review by Medicaid RACs, and focus only on fee-for-service claims. However, one commenter indicated that it interpreted the proposed rule to include Medicaid managed care claims within the scope of Medicaid RAC review. The commenter made several recommendations, including restating previous recommendations for Parts C and D of the Medicare program.

Response: While the proposed rule was silent on the issue of whether managed care claims would be included in the scope of review by the Medicaid RACs, we clarify in the final rule that States may exclude Medicaid managed

care claims from review by Medicaid RACs. We are finalizing at § 455.506(a)(1) that Medicaid RACs will only be required to review fee-for-service claims until that time as a permanent Medicare managed care RAC program is fully operational or a viable State Medicaid model is identified, at which point, we may engage in future rulemaking with regard to the review of managed care claims by Medicaid RACs.

Comment: One commenter suggested that CMS include an exemption for Medicaid payments made from the "CMMI or other delivery system reform programs."

Response: We appreciate the commenter's suggestion regarding the Center for Medicare and Medicaid Innovation (CMMI) and other delivery reform programs CMS is implementing. States have the discretion to exclude review of claims that are submitted in connection with payment or delivery system reform programs until the time a viable RAC model is identified.

Comment: One State recommended that CMS' final rule should exempt Medicaid RAC programs in States with less than 125,000 enrolled Medicaid beneficiaries. Additionally, other commenters suggested that States with low PERM error rates will experience limited recoveries from the RAC program. Therefore, the States should be exempt from establishing Medicaid RAC programs. Another commenter requested an exception to proposed § 455.510(b)(3) and § 455.510(b)(4) for States with low numbers of Medicaid providers and beneficiaries and/or expenditures. Finally, one commenter expressed its concern about repetitive audits leading to diminished provider access. The commenter continued that it will not be able to attract a RAC for less than 12.5 percent, the contingency fee cap.

Response: The Secretary has discretionary authority to grant exceptions from program requirements and complete exemptions from establishing a Medicaid RAC program, to a State, upon a State's submission of justification for its request. States were advised that they may request exceptions through the SPA process. We emphasize that complete exceptions will be granted rarely and under exceptional circumstances. States are timely notified as to whether their requests will be granted prior to the expiration of the 90 day clock.

J. ICR Comments

Comment: One commenter anticipated that the appeals process will consume 100–200 hours per case at a

minimum, rather than the 60 hours that we estimated.

Response: We appreciated the comment, but each State's appeals process will vary, as will individual cases. Therefore, we have provided estimates in our analysis to capture this variance.

Comment: One commenter asked for details on the elements that must be reported to CMS, and also for clarification on how and when the elements must be reported.

Response: Section 455.502(c) of the final rule requires States to report to CMS certain elements regarding the effectiveness of their RAC programs. These elements include, but are not limited to, general program descriptors and program metrics to evaluate the effectiveness of their Medicaid RAC programs. We are currently developing these elements, and will share them with States via sub-regulatory guidance.

Comment: One commenter estimated the full reporting requirement to take each State 10 through 15 hours per month to query, aggregate, and submit the data to CMS.

Response: We understand the burden associated with this requirement includes the time and effort put forth by the State to aggregate data to report on the effectiveness of its RAC program.

K. RIA Comments

Comment: Several commenters disagreed with our assertion in the proposed rule that most providers will experience limited financial impact from the Medicaid RAC program. The commenters stated that their member organizations have expended significant resources responding to RAC requests and many have hired additional staff to meet the demands of the Medicare RAC program. They anticipate that their costs will be exacerbated if the Medicaid RAC rule is not revised to incorporate policies necessary to avoid aggressive and overzealous RAC denials.

Response: CMS has closely examined many of the lessons learned from the Medicare RAC demonstration in parallel with the current provisions of the permanent Medicare RAC program, and incorporated those best practices into this final rule. As a result, we believe this will limit the burden and associated financial impact on providers. We also clarify that Medicaid RACs will conduct audits of Medicaid providers for overpayments and underpayments, and not deny payments. In addition, we finalize a number of provisions that address providers' concerns, including those related to overzealous RAC auditors. For example, at § 455.506(c), we finalize that States must coordinate

the recovery audit efforts of their RACs with other auditing entities. At § 455.506(e), we require States to set limits on the number and frequency of medical records to be reviewed by the RACs, subject to requests for exceptions from RACs. At § 455.508 (a), (b) and (c), we prescribe mandatory staffing requirements for RACs. At § 455.508(d), we require States and their RACs to develop an education and outreach program which includes notification to providers of audit policies and protocols. At § 455.508(e), we require RACs to provide several mandatory customer service measures in their programs. At § 455.508(f), we prescribe a maximum look back period of 3 years from the date of the claim. At § 455.508(g), we prohibit RACs from auditing claims that have already been audited or that are currently being audited by another entity. At § 455.510(b)(3), we finalize that if a provider appeals a RAC overpayment determination and that determination is reversed, at any level, the RAC must return the contingency fees associated with that payment. We expect that these provisions will encourage RACs to perform their work with diligence and restraint. At § 455.510(c)(2) and (c)(3), we require States to adequately incentivize RACs to detect underpayments and notify providers about underpayments that are identified by RACs, respectively. Lastly, we finalize at § 455.512, the requirement for States to provide an adequate appeals process for providers. We are sensitive to the challenge that responding to audits and appeals in multiple States can present to providers that participate in multiple States' Medicaid programs.

Comment: One commenter requested that CMS reconsider its statement that the proposed rule will have no significant impact on Medicaid providers and consider the resources and time that providers must devote to Medicaid RAC requests for medical records, appeals, etc. The commenter noted that CMS should also consider the exponential impact of this program when combined with other audit programs. The commenter urged CMS to take steps in the final rule to minimize these costs.

Response: We are aware of the challenge of responding to multiple requests for audits for providers that serve in State Medicaid programs. Under section 1902(a)(42)(B)(ii)(IV)(cc) of the Act, States must coordinate their audit efforts with other contractors and entities performing audits or providers, including efforts with law enforcement. In an effort to minimize provider burden, we have included in this final

rule at § 455.508(g) that Medicaid RACs should not audit claims that have already been audited or are currently being audited by another entity as well as a provision at § 455.506(e) requiring the State to set limits on the number and frequency of medical records to be reviewed by its RAC (subject to RAC requests for an exception to this requirement). Lastly, as detailed in the previous response, this final rule modeled several requirements on RACs based on the lessons learned from providers' past experience with the Medicare RAC demonstration. As a result, we believe this will limit the financial impact on providers.

IV. Provisions of the Final Regulations

After consideration of the comments reviewed and further analysis of specific issues, we are adopting the provisions of the proposed rule as final with several revisions. Those provisions of the final rule that differ from the proposed rule are as follows:

- States may exclude Medicaid managed care claims from review by Medicaid RACs (§ 455.506(a)(1)).
- States must coordinate the recovery audit efforts of their Medicaid RACs with other auditing entities (§ 455.506(c)).
- States must make referrals of suspected fraud and/or abuse to the MFCU or other appropriate law enforcement agency (§ 455.506(d)).
- States must set limits on the number and frequency of medical records to be reviewed by the Medicaid RACs subject to requests for exceptions made by the RACs (§ 455.506(e)).
- Each RAC must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval (§ 455.508(b)).
- RACs must hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims (§ 455.508(c)).
- RACs must work with the State to develop an education and outreach program (including notification of audit policies and protocols) (§ 455.508(d)).
- RACs must provide minimum customer service measures including: Providing a toll-free customer service telephone number in all correspondence sent to providers, and staffing the toll-

free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone (§ 455.508(e)(1)); compiling and maintaining provider approved addresses and points of contact (§ 455.508(e)(2)); mandatory acceptance of provider submissions of electronic medical records on CD/DVD or via facsimile at the providers' request (§ 455.508(e)(3)); notifying providers of overpayment findings within 60 calendar days (§ 455.508(e)(4)).

- RACs must not review claims that are older than 3 years from the date of the claim, unless it receives approval from the State (§ 455.508(f)).
- RACs should not audit claims that have already been audited or that are currently being audited by another entity (§ 455.508(g)).

- If a provider appeals a Medicaid RAC overpayment determination and the determination is reversed, at any level, then the Medicaid RAC must return its contingency within a reasonable timeframe as prescribed by the State (§ 455.510(b)(3)).

- States must adequately incentivize the detection of underpayments (§ 455.510(c)(2)).

- States must notify providers of underpayments that are identified by the Medicaid RACs (§ 455.510(c)(3)).
- States must provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination (§ 455.512).

In addition to the inclusion of provisions in the final rule that differ from the proposed rule, we are retaining the following provisions, described below, as published in the proposed rule.

We have retained proposed "Subpart F—Medicaid Recovery Audit Contractors Program" that will implement section 1902(a)(42)(B) of the Act, which sets forth provisions relating to States establishing recovery audit contractor programs in which States will contract with 1 or more Medicaid RACs to audit Medicaid claims and to identify underpayments and identify and recover overpayments. We are also retaining the following sections:

A. Purpose (§ 455.500)

In § 455.500, we set forth the purpose of the new subpart F. The regulations will implement section 1902(a)(42)(B) of the Act that establishes the Medicaid RAC program.

B. Establishment of Program (§ 455.502)

In § 455.502(a), we establish the Medicaid RAC program as a measure for States to promote the integrity of the Medicaid program. At § 455.502(b), we

require that States enter into contracts with one or more RACs to carry out the activities described in § 455.506. At § 455.502(c), we require that States report on certain elements describing the effectiveness of their Medicaid RAC program.

C. Definitions (§ 455.504)

In § 455.504(a), we define the Medicaid RAC program as a recovery audit contractor administered by a State to identify overpayments and underpayments and recoup overpayments. At § 455.504(b), we define the Medicare RAC program as a recovery audit contractor program administered by CMS to identify overpayments and underpayments and recoup overpayments.

D. Activities to be Conducted by Medicaid RACs and States (§ 455.506)

At § 455.506(b), States will have discretion over the manner in which they coordinate with Medicaid RACs' for the recoupment of overpayments.

E. Eligibility Requirements for Medicaid RACs (§ 455.508)

At § 455.508(a), we provide that an entity must have the technical capability to carry out the activities described in § 455.506, including employing trained medical professionals to review Medicaid claims. At § 455.508(i), we provide that RACs must meet other requirements as the State may require.

F. Payments to RACs (§ 455.510)

At § 455.510(a), fees paid to RACs must be made only from amounts recovered. At § 455.510(b), we require the State to determine the contingency fee rate paid to a Medicaid RAC for the identification and recovery of overpayments. At § 455.510(b)(1), we require that the contingency fee paid to Medicaid RACs be based on a percentage of the recovered overpayment amount. At § 455.510(b)(2), States must determine at what stage of the audit process Medicaid RACs will receive their contingency fee. At § 455.510(b)(4), except as provided in paragraph (b)(5), we will not provide FFP for any amount of contingency fee that exceeds the then highest contingency fee rate paid to a Medicare RAC. At § 455.510(b)(5), on a case-by-case basis, we will review and consider substantially justified requests from States to pay Medicaid RAC(s) a contingency fee higher than the highest Medicare RAC contingency fee. At § 455.510(c)(1), we require that States determine the fee paid to Medicaid RACs to identify underpayments.

G. Federal Share of State Expense for the Medicaid RAC Program (§ 455.514)

At § 455.514(a), funds expended by States to carry out the Medicaid RAC program must be considered necessary for the proper and efficient administration of the States Plan or waivers of the Plan. Additionally, in § 455.514(a), the Federal share of State expenses does not include fees paid. At § 455.514(b), FFP is available to States for administrative costs of operation and maintenance of Medicaid RACs, subject to CMS' reporting requirements.

H. Exceptions From Medicaid RAC Programs (§ 455.516)

At § 455.516, States that seek to be excepted from any of the requirements of the Medicaid RAC program must submit to CMS a written justification for the request and obtain CMS approval.

I. Applicability to the Territories (§ 455.518)

At § 455.518, the provisions in § 455.500 through § 455.516 are applicable to Guam, Puerto Rico, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the OMB for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We solicited public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding State Submission of Certain Elements Describing the Effectiveness of Their Medicaid RAC Programs (§ 455.502)

Section 455.502(c) requires States to submit certain elements describing the

effectiveness of their Medicaid RAC programs. These elements include, but are not limited to general program descriptors and program metrics that will evaluate effectiveness. The burden associated with this requirement will be the time and effort put forth by the State to aggregate data to report on the effectiveness of its RAC program. We estimate it will take each State 2 hours to perform this task. The estimated annual burden for this requirement is 112 hours (56 States × 2 hours) at an estimated cost of \$3,778.88 (\$33.74/hr labor × 112 hours). The work will be performed by a mid-level analyst whose salary is the average hourly salary as determined by the Bureau of Labor Statistics as of December 2010, not seasonally adjusted. This hourly wage reflects 48 percent fringe benefits and overhead costs.

B. ICRs Regarding State Justifications to Pay Higher Contingency Fees (§ 455.510)

Section 455.510(b)(5) requires States to submit justifications to CMS to pay Medicaid RACs a contingency fee higher than the highest Medicare RAC. The burden associated with this requirement is the time and effort put forth by the State to prepare and submit a justification. We estimate it will take each State 60 hours to perform this task if they submit the justification. The estimated annual burden for this requirement is 3,360 hours (56 States × 60 hours) at an estimated total cost of \$113,366.40 (\$33.74/hr labor × 3,360 hours). The work will be performed by a mid-level analyst whose salary is the average hourly salary as determined by the United States Bureau of Labor Statistics as of December 2010, not seasonally adjusted. This hourly wage reflects 48 percent fringe benefits and overhead costs.

C. ICRs Regarding Medicaid RAC Provider Appeals (§ 455.512)

Section 455.512 requires States to provide administrative appeal procedures for Medicaid providers that seek review of an adverse Medicaid RAC determination. The burden associated with this requirement is the time and effort put forth by the State to prepare and provide administrative appeal procedures. We estimate it will take each State 60 hours to perform these tasks. The estimated annual burden for this requirement is 3,360 hours (56 States × 60 hours) at a cost of \$192,696 (\$57.35/hr labor × 3,360 hours). The work will be performed by an attorney whose salary is the average hourly salary as determined by the United States Bureau of Labor Statistics as of December 2010, not seasonally

adjusted. This hourly wage reflects 48 percent fringe benefits and overhead costs.

D. ICRs Regarding Federal Share of State Expense for the Medicaid RAC Program (§ 455.514)

Section 455.514(b) provides that FFP will be available to States for the Federal share of State expenses for the Medicaid RAC program, subject to CMS' reporting requirements. The burden associated with a State reporting quarterly expenditure estimates is currently approved under OMB control number 0938-0067 with an expiration date of August 31, 2011. CMS recently submitted its request for a 3-year extension of the August expiration date. This rule will not significantly affect the requirements under OMB # 0938-0067. The Form CMS-64 is a collection of forms in which States are already required to report routine Medicaid recoveries to CMS on a quarterly basis. This task is accomplished

electronically. The final rule requires States to account for, separately, Medicaid RAC overpayment recoveries and the corresponding contingency fees associated with the recoveries. We estimate that it will take each State 4 hours/quarterly to meet this requirement; therefore, the total annual burden associated with this requirement is 896 hours (56 States $\times$ 4 hours $\times$ 4 quarters) at an annual total estimated cost of \$43,285.76 (\$48.31/hour labor $\times$ 896 hours). The work will be performed by a computer systems analyst whose salary is the average hourly salary as determined by the United States Bureau of Labor Statistics as of December 2010, not seasonally adjusted. This hourly wage reflects 48 percent fringe benefits and overhead costs.

E. ICRs Regarding Exceptions From Medicaid RAC Programs (§ 455.516)

Section 455.516 requires a State that is seeking an exception from any of the requirements of the Medicaid RAC

program to submit a written justification to CMS. The burden associated with this requirement is the time and effort put forth by the State to prepare and submit a written justification for the request. We estimate it will take each State 20 hours to meet this requirement. During the SPA process, we received exception requests from 14 States. Therefore, the total annual burden associated with this requirement is 280 hours (14 responses $\times$ 20 hours) at a cost of \$9,447.20 (\$33.74/hr labor $\times$ 280 hours). We estimate that the work was performed by a mid-level analyst whose salary is the average hourly salary as determined by the United States Bureau of Labor Statistics as of December 2010, not seasonally adjusted. This hourly wage reflects 48 percent fringe benefits and overhead costs.

TABLE 1: Annual Recordkeeping and Reporting Requirements

Regulation Sections	OMB Control No.	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Hourly Labor Cost of Reporting (\$)	Total Labor Cost of Reporting (\$)	Total Capital/Maintenance Costs (\$)	Total Cost (\$)
§455.502	0938-New	56	56	2	112	33.74	3778.88	11,200	14,978.88
§455.510	0938-New	56	56	60	3360	33.74	113,366.40		113,366.40
§455.512	0938-New	56	56	60	3360	57.35	192,696		192,696
§455.514	0938-0067	56	224	4	896	48.31	43,285.76		43,285.76
§455.516	0938-New	14	14	20	280	33.74	9447.20	3,000	12,447.20
Total		238	406	146	8008	168.70	362,574.24	14,200	376,774.24

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this final rule; or
2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, [CMS-6034-F] Fax: (202) 395-6974; or E-mail: OIRA_submission@omb.eopage.gov.

VI. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this rule as required by Executive Orders 12866 on Regulatory Planning and Review (September 30, 1993) and 13563 on Improving Regulation and Regulatory Review (January 18, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year). This

final rule has been designated an “economically significant” rule under section 3(f)(1) of Executive Order 12866. In addition, this is a major rule under the Congressional Review Act (5 U.S.C. 804(2)). Accordingly, the rule has been reviewed by the Office of Management and Budget.

B. Statement of Need

Section 6411(a) of the Affordable Care Act amended and expanded section 1902(a)(42) of the Act to require States to establish Medicaid RAC programs by December 31, 2010, to contract with 1 or more contractors to audit Medicaid claims, and to identify underpayments and overpayments and collect overpayments. Section 1902(a)(42)(B) of the Act requires all States to establish Medicaid RAC programs, subject to the exceptions and requirements as the Secretary may require.

Medicaid RACs are State programs designed to produce savings in State Medicaid expenditures by detecting improper payments to Medicaid providers. The majority of State expenditures will be derived from the contingency fee payments to Medicaid RACs.

This final rule will: (1) Implements section 6411 of the Affordable Care Act and provides guidance to States related to Federal/State funding of State start-up, operation and maintenance costs of Medicaid RACs and the payment methodology for State payments to Medicaid RACs; (2) requires States to assure that adequate appeal processes

are in place for providers to dispute adverse determinations made by Medicaid RACs; and (3) requires States to coordinate with other contractors and entities auditing Medicaid providers, as well as with State and Federal law enforcement agencies.

C. Overall Impact

This final rule applies to States’ requirement to contract with Medicaid RACs to perform audits of Medicaid providers on a contingency fee basis. The majority of anticipated savings, as a result of the provisions in this rule, are related to improper payments. However, as seen in the Medicare RAC Demonstration period, we expect a limited financial impact on most providers, as significant improper payments are relatively rare. The CMS Office of the Actuary (OACT) estimated the potential impact on Federal Medicaid costs and savings. OACT used the historical experience from the Medicare program to estimate potential savings to Medicaid. The estimates in the final rule differ from those in the proposed rule primarily as a result of the new implementation date of January 1, 2012, versus that of April 1, 2011, in the proposed rule. These estimates are highly uncertain, and as a result we offer estimates for FYs 2012 through 2016 to illustrate the potential effects of this program. As a result, OACT’s estimates for FYs 2012 through 2016 are presented in Table 2.

TABLE 2—ESTIMATED MEDICAID IMPACT RESULTING FROM THE EXPANSION OF THE RECOVERY AUDIT CONTRACTOR PROGRAM
[FYs 2012–2016]

	Estimated savings (\$Millions) FYs 2012–2016					
	2012	2013	2014	2015	2016	2012–2016
Federal share	\$60	\$190	\$280	\$330	\$360	\$1,220
State share	50	140	200	250	270	910
Total	110	330	480	580	630	2,130

D. Detailed Impacts

The Medicaid RACs are part of a significant initiative to reduce waste and improper payments and recoup the improper payments. The estimated impact on the Medicaid program, as presented in Table 2, reflects an aggregate net savings of \$2.13 billion for FYs 2012 through 2016. This includes an estimated net savings of \$1.22 billion to the Federal Medicaid program and a net savings of \$910 million to the State Medicaid program, for the same time

period of FYs 2012 through 2016. Because the Affordable Care Act requires States to contract with RACs on a contingency fee basis, out-of-pocket expenses should be minimized. Therefore, the majority of the program costs will be offset by overpayment recoveries.

CMS experience from the Medicare RAC demonstration has shown that overpayment recoveries by Medicare RACs represented over 96 percent of the improper payments, while underpayments accounted for the

remaining 4 percent of the improper payments. (*Medicare RAC Program: An Evaluation of the 3-Year Demonstration, January 2008*). As a result, we continue to believe that States would not need to maintain a reserve of recovered overpayments to fund Medicaid RAC costs associated with identifying underpayments. We do, however, require States to maintain an accounting of amounts recovered and paid. States must report overpayments to CMS based on the net amount remaining after all fees are paid to the

Medicaid RAC. As discussed earlier, Medicaid RACs may only receive payments through the contingency fee arrangement made in accordance with these requirements and the limitations relating to the maximum contingency fee amount, unless a State receives an exception from CMS. No additional FFP is available for any other State payment made to the RACs. The treatment of the fees and expenditures are linked to specific statutory language implementing the Medicaid RAC requirements and not extended to Medicaid overpayment recoveries in other contexts.

Regarding appeal costs, a State's appeal costs would be an allowable administrative cost under the State's Cost Allocation Plan. A provider's appeal costs are administrative costs that are not allowable under Medicaid. With regard to the impact upon providers, as discussed earlier in the preamble, we closely examined many of the lessons learned from the Medicare RAC demonstration, in parallel with the current provisions of the permanent Medicare RAC program and incorporated those best practices into this final rule. As a result, we believe this will limit the burden and associated financial impact on providers. Furthermore, we finalize a number of measures that address providers' concerns of overzealous RAC auditors. For example, at § 455.506(c), we finalize that States must coordinate the recovery audit efforts of their RACs with other auditing entities. At § 455.506(e), we require States to set limits on the number and frequency of medical records to be reviewed by the RACs, subject to requests for exceptions from RACs. At § 455.508 (a), (b) and (c), we prescribe mandatory staffing requirements for RACs. At § 455.508(d),

we require States and their RACs to develop an education and outreach program which includes notification to providers of audit policies and protocols. At § 455.508(e), we require RACs to provide several mandatory customer service measures. At § 455.508(f), we prescribe a maximum look back period of 3 years from the date of the claim. At § 455.508(g), we prohibit RACs from auditing claims that have already been audited or that are currently being audited by another entity. At § 455.510(b)(3), we finalize that if a provider appeals a RAC overpayment determination and that determination is reversed, at any level, the RAC must return the contingency fees associated with that payment. At § 455.510(c)(2) and (c)(3), we require States to adequately incentivize RACs to detect underpayments and notify underpayments that are identified by RACs, respectively. Lastly, we finalize at § 455.512, the requirement for States to provide an adequate appeals process for providers.

E. Alternatives Considered

In the proposed rule, we stated that States would have complete flexibility with regard to most, if not all, of the Medicaid program elements. We wanted to account for differences in the size of the State, Medicaid population, amount of expenditures, and other State-specific characteristics, for example, allowing smaller States the flexibility to vary the requirements that would otherwise overburden them financially.

For example, North Dakota, Wyoming, Rhode Island and Connecticut may not have the volume of Medicaid expenditures that a State such as California would have. Requiring a Connecticut RAC to hire 1.0 FTE Medical Director, we believe, would

increase the labor costs to a RAC, and subsequently to the State. Initially, we considered allowing States to determine the appropriate personnel for RACs to hire. However, we received a number of comments regarding the need for 1.0 FTE Medical Director to oversee the review of claims in the RAC program due to the high overturn rates found in the Medicare RAC Demonstration period and numerous provider complaints. Accordingly, we decided to include the requirement of a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval.

In addition, we considered giving States complete flexibility with regard to setting their own claims look-back periods based upon State specific laws and regulations regarding their claims look-back periods, which varied from three to seven years. As a result of many stakeholder comments, we reconsidered and now include a 3-year maximum look back period, similar to the Medicare RAC program. States will have the option of requesting exceptions to this provision.

F. Accounting Statement

As required by OMB Circular A-4 available at http://www.whitehouse.gov/omb/circulars_a004_a-4, in Table 3, we have prepared an accounting statement table showing the classification of the impacts associated with the implementation of section 6411 in this final rule.

TABLE 3—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED NET SAVINGS, FROM FY 2012 TO FY 2016
[in \$Millions]

Category	Transfers			
	Year dollar	Units discount rate		Period covered
Annualized monetized transfers	2010	7%	3%	FYs 2012–2016
From	Primary Estimate	– \$233.9	– \$239.6	
	Federal Government to providers			
From	Primary Estimate	– \$174.5	– \$178.7	
	State Governments to providers			

VII. Regulatory Flexibility Act Analysis

The Regulatory Flexibility Act (RFA) (15 U.S.C. 604), as modified by the

Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA) (Pub. L. 104–121), requires agencies to

determine whether proposed or final rules would have a significant economic impact on a substantial number of small

entities and, if so, to prepare a Regulatory Flexibility Analysis and to identify in the notice of proposed rulemaking or final rulemaking any regulatory options that could mitigate the impact of the proposed regulation on small businesses. For purposes of the RFA, small entities include businesses that are small as determined by size standards issued by the Small Business Administration, nonprofit organizations, and small governmental jurisdictions). Individuals and States are not included in the definition of a small business entity.

For purposes of the RFA, we assume that approximately 75 percent of Medicaid providers are considered small businesses according to the Small Business Administration's size standards (with total revenues of \$35 million or less in any one year), and 80 percent are nonprofit organizations. Medicaid providers are required, as a matter of course, to follow the guidelines and procedures as specified in State and Federal laws and regulations. The Medicaid providers must retain accurate billing records for the requisite period of time. Additionally, Medicaid providers must cooperate in audits conducted by the State and/or Federal Governments and their agents. Lastly, the majority of the economic impacts associated with this final rule are a direct result of the recovery of improper payments. Therefore, the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. For the same reason as Stated above, the Secretary has determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

VIII. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. In 2011, that

threshold is approximately \$136 million. This final rule applies to the States' requirement to procure Medicaid RACs to perform audits of Medicaid providers on a contingency fee basis. State expenditures associated with this final rule will initially involve directing or allocating personnel resources to procurement activities. Per the terms of the contracts, States will not be expending funds over \$136 million for RACs to perform the contracts. Associated costs that may include the operation of RAC programs, collateral State personnel costs, and maintenance of records are not expected to exceed the \$136 million threshold. Therefore, this final rule is not anticipated to have an effect on State, local, or tribal governments in the aggregate, or by the private sector of \$136 million or more.

IX. Federalism Analysis

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have substantial direct effects on the rights, roles, and responsibilities of States, local or tribal governments.

List of Subjects in 42 CFR Part 455

Fraud, Grant programs-health, Health facilities, Health professions, Investigations, Medicaid, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 455—PROGRAM INTEGRITY—MEDICAID

- 1. The authority citation for part 455 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302), section 1902(a)(42)(B) (42 U.S.C. 1396a (a)(42)(B)).

- 2. New subpart F is added to part 455 to read as follows:

Subpart F—Medicaid Recovery Audit Contractors Program

Sec.

- 455.500 Purpose.
- 455.502 Establishment of program.
- 455.504 Definitions.
- 455.506 Activities to be conducted by Medicaid RACs and States.
- 455.508 Eligibility requirements for Medicaid RACs.

- 455.510 Payments to RACs.
- 455.512 Medicaid RAC provider appeals.
- 455.514 Federal share of State expense for the Medicaid RAC program.
- 455.516 Exceptions from Medicaid RAC programs.
- 455.518 Applicability to the territories.

Subpart F—Medicaid Recovery Audit Contractors Program

§ 455.500 Purpose.

This subpart implements section 1902(a)(42)(B) of the Act that establishes the Medicaid Recovery Audit Contractor (RAC) program.

§ 455.502 Establishment of program.

(a) The Medicaid Recovery Audit Contractor program (Medicaid RAC program) is established as a measure for States to promote the integrity of the Medicaid program.

(b) States must enter into contracts, consistent with State law and in accordance with this section, with one or more eligible Medicaid RACs to carry out the activities described in § 455.506 of this subpart.

(c) States must comply with reporting requirements describing the effectiveness of their Medicaid RAC programs as specified by CMS.

§ 455.504 Definitions.

As used in this subpart—

Medicaid RAC program means a recovery audit contractor program administered by a State to identify overpayments and underpayments and recoup overpayments.

Medicare RAC program means a recovery audit contractor program administered by CMS to identify underpayments and overpayments and recoup overpayments, established under the authority of section 1893(h) of the Act.

§ 455.506 Activities to be conducted by Medicaid RACs and States.

(a) Medicaid RACs will review claims submitted by providers of items and services or other individuals furnishing items and services for which payment has been made under section 1902(a) of the Act or under any waiver of the State Plan to identify underpayments and overpayments and recoup overpayments for the States.

(1) States may exclude Medicaid managed care claims from review by Medicaid RACs.

(b) States may coordinate with Medicaid RACs regarding the recoupment of overpayments.

(c) States must coordinate the recovery audit efforts of their RACs with other auditing entities.

(d) States must make referrals of suspected fraud and/or abuse, as

defined in 42 CFR 455.2, to the MFCU or other appropriate law enforcement agency.

(e) States must set limits on the number and frequency of medical records to be reviewed by the RACs, subject to requests for exception from RACs to States.

§ 455.508 Eligibility requirements for Medicaid RACs.

An entity that wishes to perform the functions of a Medicaid RAC must enter into a contract with a State to carry out any of the activities described in § 455.506 under the following conditions:

(a) The entity must demonstrate to a State that it has the technical capability to carry out the activities described in § 455.506 of this subpart. Evaluation of technical capability must include the employment of trained medical professionals, as defined by the State, who are in good standing with the relevant State licensing authorities, where applicable, to review Medicaid claims.

(b) The entity must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant State licensing authorities and has relevant work and educational experience. A State may seek to be excepted, in accordance with § 455.516, from requiring its RAC to hire a minimum of 1.0 FTE Contractor Medical Director by submitting to CMS a written request for CMS review and approval.

(c) The entity must hire certified coders unless the State determines that certified coders are not required for the effective review of Medicaid claims.

(d) The entity must work with the State to develop an education and outreach program, which includes notification to providers of audit policies and protocols.

(e) The entity must provide minimum customer service measures including:

(1) Providing a toll-free customer service telephone number in all correspondence sent to providers and staffing the toll-free number during normal business hours from 8:00 a.m. to 4:30 p.m. in the applicable time zone.

(2) Compiling and maintaining provider approved addresses and points of contact.

(3) Mandatory acceptance of provider submissions of electronic medical

records on CD/DVD or via facsimile at the providers' request.

(4) Notifying providers of overpayment findings within 60 calendar days.

(f) The entity must not review claims that are older than 3 years from the date of the claim, unless it receives approval from the State.

(g) The entity should not audit claims that have already been audited or that are currently being audited by another entity.

(h) The entity must refer suspected cases of fraud and/or abuse to the State in a timely manner, as defined by the State.

(i) The entity meets other requirements as the State may require.

§ 455.510 Payments to RACs.

(a) *General.* Fees paid to RACs must be made only from amounts recovered.

(b) *Overpayments.* States must determine the contingency fee rate to be paid to Medicaid RACs for the identification and recovery of Medicaid provider overpayments.

(1) The contingency fees paid to Medicaid RACs must be based on a percentage of the overpayment recovered.

(2) States must determine at what stage in the Medicaid RAC audit process, after an overpayment has been recovered, Medicaid RACs will receive contingency fee payments.

(3) If a provider appeals a Medicaid RAC overpayment determination and the determination is reversed, at any level, then the Medicaid RAC must return the contingency fees associated with that payment within a reasonable timeframe, as prescribed by the State.

(4) Except as provided in paragraph (5) of this section, the contingency fee may not exceed that of the highest Medicare RAC, as specified by CMS in the **Federal Register**, unless the State submits, and CMS approves, a waiver of the specified maximum rate. If a State does not obtain a waiver of the specified maximum rate, any amount exceeding the specified maximum rate is not eligible for FFP, either from the collected overpayment amounts, or in the form of any other administrative or medical assistance claimed expenditure.

(5) CMS will review and consider, on a case-by-case basis, a State's well-justified request that CMS provide FFP in paying a Medicaid RAC(s) a contingency fee in excess of the then-

highest contingency fee paid to a Medicare RAC.

(c) *Underpayments.* (1) States must determine the fee paid to a Medicaid RAC to identify underpayments.

(2) States must adequately incentivize the detection of underpayments.

(3) States must notify providers of underpayments that are identified by the RACs.

§ 455.512 Medicaid RAC provider appeals.

States must provide appeal rights under State law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination.

§ 455.514 Federal share of State expense of the Medicaid RAC program.

(a) Funds expended by States for the operation and maintenance of a Medicaid RAC program, not including fees paid to RACs, are considered necessary for the proper and efficient administration of the States' plan or waivers of the plan.

(b) FFP is available to States for administrative costs of operation and maintenance of Medicaid RACs subject to CMS' reporting requirements.

§ 455.516 Exceptions from Medicaid RAC programs.

A State may seek to be excepted from some or all Medicaid RAC contracting requirements by submitting to CMS a written justification for the request for CMS review and approval through the State Plan amendment process.

§ 455.518 Applicability to the territories.

The aforementioned provisions in § 455.500 through § 455.516 of this subpart are applicable to Guam, Puerto Rico, U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Authority: (Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: May 6, 2011.

Marilyn Tavenner,

Principal Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Approved: August 9, 2011.

Kathleen Sebelius,

Secretary, Health and Human Services.

[FR Doc. 2011-23695 Filed 9-14-11; 8:45 am]

BILLING CODE 4120-01-P

State of California—Health and Human Services Agency

Department of Health Care Services

DHCS PI AND PHI DATA RELEASE APPROVAL FORM

PROGRAM REQUESTING RELEASE INFORMATION			
DATE:		PRINTED PROGRAM CONTACT NAME:	
UNIT:		TELEPHONE:	
DHCS DIVISION: Audits and Investigations		DHCS BRANCH/SECTION: Medical Review Branch – Research Section	
DATA RECEIVER INFORMATION			
RECEIVER NAME:		TELEPHONE:	
RECEIVER ORGANIZATION:		EMAIL:	
DATA RELEASE AUTHORITY			
DATA APPROVED FOR RELEASE BY THE DRC : ☐		IAA, CONTRACT OR DATA USE AGREEMENT DATE: AGREEMENT NUMBER:	
OTHER AUTHORITY (ATTACH APPROVAL):			
DATA DESCRIPTION			
☐ SENSITIVE ☐ PERSONAL ☐ CONFIDENTIAL ☐ PROTECTED HEALTH INFORMATION ☐ SOCIAL SECURITY NUMBER			
DATA ELEMENTS:			
DATA COVERAGE DATES: FROM: 1996		TO: Present	
NUMBER OF RECORDS:		TYPE OF MEDIA:	
METHOD(S) OF SECURING DATA			
☐ SFTP ☐ [secure] E-MAIL ☐ WINZIP 256BIT AES ☐ SSL ☐ PAPER ☐ OTHER, DESCRIBE:			
DATA RELEASE INFORMATION			
RELEASE FREQUENCY: ☐ 1x ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY ☐ OTHER			
IF OTHER, DESCRIBE:			
RELEASE START DATE :		RELEASE END DATE:	
RELEASE DATE (for one-time release):			
PURPOSE OF DATA RELEASE:			
PROGRAM REQUESTING RELEASE APPROVAL			
PRINTED DIVISION CHIEF NAME (OR DESIGNEE): Bruce Lim, Deputy Director		PHONE: (916) 440-7550	
SIGNATURE:		DATE:	
PRINTED DATA RELEASE COORDINATOR NAME: Teisa King, Staff Services Analyst		PHONE: (916) 319-0993	
SIGNATURE:		DATE:	
DATA OWNER(S) APPROVAL			
☒ ABOVE REQUESTER IS OWNER ☐ OWNER SIGNATURE IS BELOW ☐ OWNER APPROVAL(S) IS ATTACHED			
DATA OWNER NAME:		SIGNATURE:	
DATE:			
DHCS PRIVACY OFFICER (PO) AND INFORMATION SECURITY OFFICER (ISO) APPROVALS			
PRINTED PO NAME:		SIGNATURE:	
DATE:			
PRINTED ISO NAME:		SIGNATURE:	
DATE:			
DATA RELEASER APPROVALS (IF APPLICABLE)			
PRINTED NAME:		SIGNATURE:	
DATE:			
PRINTED NAME:		SIGNATURE:	
DATE:			

DHCS PI AND PHI DATA RELEASE APPROVAL FORM

Instructions

DHCS data for the purpose of this request is any data with Personal Information (PI) or Protected Health Information (PHI) that will be released pursuant to this request. Each Program is responsible for maintaining a record of each release of such data and shall recreate a copy of the release upon demand. **DO NOT SUBMIT THESE INSTRUCTIONS ALONG WITH YOUR REQUEST**

FIELD	DESCRIPTION									
PROGRAM REQUESTING RELEASE INFORMATION										
DATE	Date form was prepared.									
PROGRAM CONTACT	Name of the DHCS program contact for this request.									
CONTROL NUMBER	Unique number assigned by Division or Branch, typically by the assigned data release coordinator. Format is AAA-BBBB-CCCC where AAA is division/branch acronym, BBBB is year, and CCCC is unique sequential number for the year. Use of additional acronyms between AAA and BBBB, to further identify units within the division or branch, is optional.									
UNIT	The name of Program Contact's Unit.									
TELEPHONE	Telephone number (including area code) for the Program Contact.									
EMAIL	The Email address of the Program Contact.									
DHCS DIVISION	The name of the Program Contact's Division.									
DHCS BRANCH/SECTION	The name of the Program Contact's Branch and Section.									
DATA RECEIVER INFORMATION										
RECEIVER NAME	The name of the contact person of the organization that is receiving the encrypted data.									
TELEPHONE	Telephone number (including area code) of the contact person of the organization that is receiving the encrypted data.									
RECEIVER ORGANIZATION	The name of the organization that is receiving the encrypted data.									
EMAIL	The Email address of the contact person of the organization that is receiving the encrypted data.									
DATA RELEASE AUTHORITY										
DATA APPROVED FOR RELEASE BY THE DRC	The DHCS Data and Research Committee (DRC) and the Commission for the Protection of Human Subjects must approve all data releases for the purpose of conducting research.									
IAA, CONTRACT OR DATA USE AGREEMENT DATE	Date the IAA, Contract or Data Use Agreement (DUA) was signed and executed between DHCS and the Recipient Organization. Attach a copy of the fully executed IAA, Contract or DUA.									
IAA, CONTRACT OR DATA USE AGREEMENT NUMBER	The assigned IAA, Contract, or DUA number if known.									
OTHER AUTHORITY	Must be approved by the DHCS Privacy Officer prior to completion of form. Attach a copy of the approval.									
DATA DESCRIPTION										
SENSITIVE	Records closed to the public because of their sensitivity are described by Government Code, Section 6254 as exempt from mandatory disclosure and closed to all but authorized persons by any law or regulations under which the agency operates.									
PERSONAL	Personal information is information that is not public which identifies or describes an individual, including his or her name, social security number, physical description, home address, home telephone number, education, financial matters, and medical or employment history. It includes statements made by, or attributed to, the individual. (Civil Code section 1798.3). Personnel records, medical records, licensing records, and health program payment and operations records which identify an individual are included. Lists of employee names and work phone numbers are not included, as they are public information. Protected Health Information (PHI) as defined by HIPAA is a type of personal information.									
CONFIDENTIAL	Information (whether in oral, written, printed, electronic or any other form) which is marked or notified as being proprietary or confidential or which, in the normal course of business, would be considered to be proprietary or confidential. Records that contain personal information and records closed to the public because of their sensitivity are considered confidential records. Records closed to the public because of their sensitivity are described by Government Code, Section 6254 as exempt from mandatory disclosure and closed to all but authorized persons by any law or regulations under which the agency operates.									
PROTECTED HEALTH INFORMATION (PHI)	Individually identifiable health information that describes the past, present, or future physical or mental health or the condition of an individual. This includes information about the health care services an individual has received or will receive. PHI is made up of information used to collect or request payment for health care services provided in the past, present, or future. The following elements make up PHI: <table border="0" style="width: 100%;"> <tr> <td>Name (any Part)</td><td>Address (City, State)</td><td>Telephone Number</td></tr> <tr> <td>Drivers License Number</td><td>Electronic Mail Address</td><td>Social Security Number</td></tr> <tr> <td>Medical Record Number</td><td>Device Identifiers</td><td>Web Addresses</td></tr> </table>	Name (any Part)	Address (City, State)	Telephone Number	Drivers License Number	Electronic Mail Address	Social Security Number	Medical Record Number	Device Identifiers	Web Addresses
Name (any Part)	Address (City, State)	Telephone Number								
Drivers License Number	Electronic Mail Address	Social Security Number								
Medical Record Number	Device Identifiers	Web Addresses								

State of California—Health and Human Services Agency

Department of Health Care Services

	Internet Addresses Account Number Dates (related to an individual, health care, dates of services)	Biometric Identifiers Vehicle Identifier Number Any other uniquely identifying number	Full Face Photographs Certificate/License Number Health Plan Beneficiary Number (including DHCS CIN)
SOCIAL SECURITY NUMBER	Social Security Numbers are subject to special limitations on their use and disclosure, and are included in the list of identifiers protected under the identity theft law. (Civil C., §§ 1798.85, 1798.89, and 1798.92 <i>et seq.</i>)		
DATA ELEMENTS	Description of the data to be released, such as Client Identification Number (CIN), Date of Birth (DOB), Date of Service (DOS), etc.		
DATA COVERAGE DATES, FROM:	Date of the first occurrence of the data to be released (i.e. Date of Service, Enrollment Date, etc.).		
DATA COVERAGE DATES, TO:	Date of the last occurrence of the data to be released (i.e. Date of Payment, etc.).		
NUMBER OF RECORDS	Number of data records. If exact number is not known, indicate (approx) after the number, or indicate a range.		
TYPE OF MEDIA	Indicate the type of media data will be transported on, if applicable. For example, CD, DVD, diskette, or thumbdrive.		
METHOD(S) OF SECURING DATA			
SFTP	SSH File Transfer Program (SFTP) encrypts data with SSH-2.		
[SECURE] EMAIL	Using Outlook's Email for transmitting text messages and small data sets. Must include [secure] somewhere in the subject line to encrypt data.		
WINZIP 256BIT AES	Files containing confidential information stored on removable media shall be encrypted using WinZip v9 or greater before leaving a DHCS site. Must select 256bit AES method.		
SSL	Files can be securely transferred to a website if using SSL/HTTPS.		
PAPER	If data transfer is paper, data encryption is not applicable.		
OTHER, DESCRIBE	Other methods of secure data transfer may be approved. Please describe the method to be used, and the method of encryption it uses, e.g. AES 256bit.		
DATA RELEASE INFORMATION			
RELEASE FREQUENCY	How often will the release be generated. For Other, please explain the frequency (i.e. as requested, pursuant to a subpoena, etc). If you need additional space to write the frequency, attachments are advised.		
RELEASE START DATE	Date that the data will first be released.		
RELEASE END DATE	Date that the data release(s) will cease. If unknown, indicate unknown.		
RELEASE DATE	Date that the expected release of the data associated with this request will occur.		
PURPOSE OF DATA RELEASE	Reasons why the data needs to be released (describe in detail program requirements, subpoena, legislation, etc). If you need additional space to explain the reasons, attachments are advised.		
PROGRAM REQUESTING RELEASE APPROVAL			
DIVISION CHIEF OR DESIGNEE	Division Chief (or his or her designee) approves the release of this data.		
DATA RELEASE COORDINATOR	Program Data Release Coordinator within the requesting program must sign the release, to ensure the form has been reviewed for accuracy and completeness, and that a control number has been assigned. Data Release Coordinator must archive a copy of the fully signed form.		
DATA OWNER APPROVAL			
OWNER IDENTIFICATION	Identify the data owner according to State Administrative Manual (SAM) 5320.1 http://sam.dgs.ca.gov/TOC/5300/5320.1.htm. Check the appropriate box as follows: Above Requester is Owner: Select if the "Program Requesting Release Approval" is also the data owner. No signature is required. Owner Signature is Below: Select if a different data owner is identified and a signature is provided below. Owner Approval(s) is Attached: Select if data owner approval is attached. The attachments must be clearly associated to the data release, either by citing the control number or including sufficient details. This option should be used when multiple data owners are involved.		
DEPARTMENT APPROVALS			
DHCS PRIVACY OFFICER SIGNATURE	DHCS Privacy Officer must review and approve all requests for release of PI and PHI to ensure that the release meets legal requirements, including validating agreements such as IAAs, Contracts, DUAs, and Research Projects.		
DHCS INFORMATION SECURITY OFFICER SIGNATURE	DHCS Information Security Officer must review and approve the methods of securing all PCI and PHI releases.		
DATA RELEASER APPROVALS (IF APPLICABLE)			
APPROVAL SIGNATURE	This section is for internal use by the data releaser, where applicable. This will typically be the Information Technology organization that does the actual data transfer. Information Technology Division staff must obtain signature by their Branch and Division Chief.		

Right Bill Prov Legal				Randomized		Randomized		Randomized		(i) Claim Place	Sequential		Render			Claim Number	Claim Financial	Randomized	Claim Type	Procedure	Procedure
Randomized Bill	Provider Num	Right Billing Business Name	Randomized MedsID	Recipient Birth Date	Randomized Facility Provider Num	Refer/Prescribe Prov Num	Rendering Provider Num	of Service Code	Claim Place of Service Desc	Claim Submitter ID	Service From Date	Right Render Legal Name	Right Render Business Name	Render Provider Type Desc	of Claims Cnt	Program Desc	Reimbursement	Desc	Code	Name	
00208135865	VAN NUYS	TUCKER,	0056489931	03/20/99	?	1236884987	1157589326	8	INDEPENI	A7P	01/01/11	EYAL MD	EYAL MD	PHYSICIA	269	MEDI-CAL	\$ 47,894.97	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00373922800	SHERMAN	HERMAN	0702994414	07/11/92	?	1349007902	0940474731	8	INDEPENI	A7P	01/02/11	EYAL MD	EYAL MD	PHYSICIA	234	MEDI-CAL	\$ 12,916.37	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00816121161	SHERMAN	HERMAN	0342335964	04/18/09	?	1267062342	1490327782	8	INDEPENI	A7P	01/03/11	EYAL MD	EYAL MD	PHYSICIA	48	MEDI-CAL	\$ 97,761.65	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00687194448	SHERMAN	HERMAN	0031473952	05/23/20	?	0128386058	0041182108	8	INDEPENI	A7P	01/04/11	EYAL MD	EYAL MD	PHYSICIA	106	MEDI-CAL	\$ 40,237.71	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00237192545	SHERMAN	HERMAN	0460493757	01/18/78	?	0620970128	0888197256	8	INDEPENI	A7P	01/05/11	EYAL MD	EYAL MD	PHYSICIA	95	MEDI-CAL	\$ 43,690.31	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00506565203	SHERMAN	HERMAN	0616844325	12/21/53	?	0322363487	1890339891	8	INDEPENI	A7P	01/06/11	EYAL MD	EYAL MD	PHYSICIA	58	MEDI-CAL	\$ 11,408.27	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00303300644	SHERMAN	HERMAN	0431722897	01/20/33	?	0975436299	1533113456	8	INDEPENI	A7P	01/07/11	EYAL MD	EYAL MD	PHYSICIA	62	MEDI-CAL	\$ 24,454.85	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00957759294	SHERMAN	HERMAN	0330448920	12/30/47	?	1721308523	0208201768	8	INDEPENI	A7P	01/08/11	EYAL MD	EYAL MD	PHYSICIA	43	MEDI-CAL	\$ 23,142.60	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00895411388	SHERMAN	HERMAN	0462644230	11/09/12	?	1503010941	0320221993	8	INDEPENI	A7P	01/09/11	EYAL MD	EYAL MD	PHYSICIA	39	MEDI-CAL	\$ 11,385.92	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00091617089	SHERMAN	HERMAN	0239513278	10/04/84	?	0682498057	0243686774	8	INDEPENI	A7P	01/10/11	EYAL MD	EYAL MD	PHYSICIA	20	MEDI-CAL	\$ 22,993.44	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00322713128	SHERMAN	HERMAN	0741476451	05/10/87	?	1716358773	0749653690	8	INDEPENI	A7P	01/11/11	EYAL MD	EYAL MD	PHYSICIA	31	MEDI-CAL	\$ 20,191.73	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00627876578	SHERMAN	HERMAN	0789876877	03/07/96	?	1720253436	1831964040	8	INDEPENI	A7P	01/12/11	EYAL MD	EYAL MD	PHYSICIA	39	MEDI-CAL	\$ 11,741.71	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
01086140118	SHERMAN	HERMAN	0971443023	06/25/25	?	0002069340	0999519675	8	INDEPENI	A7P	01/13/11	EYAL MD	EYAL MD	PHYSICIA	42	MEDI-CAL	\$ 6,236.42	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00849030901	SHERMAN	HERMAN	0492687910	06/19/55	?	0485470816	1857161062	8	INDEPENI	A7P	01/14/11	EYAL MD	EYAL MD	PHYSICIA	26	MEDI-CAL	\$ 17,512.58	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00534806749	SHERMAN	HERMAN	0660938412	01/07/07	?	0080285293	0372434521	8	INDEPENI	A7P	01/15/11	EYAL MD	EYAL MD	PHYSICIA	9	MEDI-CAL	\$ 16,531.19	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00657671544	SHERMAN	HERMAN	0140842690	06/14/28	?	0608542566	1941118334	8	INDEPENI	A7P	01/16/11	EYAL MD	EYAL MD	PHYSICIA	25	MEDI-CAL	\$ 6,456.02	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
01100598566	SHERMAN	HERMAN	0486845733	11/03/14	?	0079695348	0662954963	8	INDEPENI	A7P	01/17/11	EYAL MD	EYAL MD	PHYSICIA	11	MEDI-CAL	\$ 12,650.20	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00124402015	SHERMAN	HERMAN	0505710730	05/24/01	?	1734527313	0894429783	8	INDEPENI	A7P	01/18/11	EYAL MD	EYAL MD	PHYSICIA	8	MEDI-CAL	\$ 1,322.26	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00092414179	SHERMAN	HERMAN	0561973598	07/18/96	?	0236168800	1037055267	8	INDEPENI	A7P	01/19/11	EYAL MD	EYAL MD	PHYSICIA	20	MEDI-CAL	\$ 3,525.12	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00452837497	EYAL MD	CH, EYAL	0093789636	09/12/69	0545067360	0175491400	1203545108	21	INPATIEN	?	01/20/11	EYAL MD	EYAL MD	PHYSICIA	33	MEDI-CAL	\$ 1,850.09	MEDICAL	94640	AIRWAY INHALATION TREATMENT	
01098844319	SHERMAN	HERMAN	0297416101	10/11/06	0931016053	0063630023	0125612686	8	INDEPENI	A7P	01/21/11	EYAL MD	EYAL MD	PHYSICIA	6	MEDI-CAL	\$ 3,632.94	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00243518022	SHERMAN	HERMAN	0755021176	08/06/86	0843912231	0319480076	1560838633	8	INDEPENI	A7P	01/22/11	EYAL MD	EYAL MD	PHYSICIA	7	MEDI-CAL	\$ 991.99	OUTPATIE	94640	AIRWAY INHALATION TREATMENT	
00890084018	EYAL MD	CH, EYAL	0034238558	03/29/49	0537681002	0261905830	0492834570	21	INPATIEN	?	01/23/11	EYAL MD	EYAL MD	PHYSICIA	29	MEDI-CAL	\$ 957.77	MEDICAL	94640	AIRWAY INHALATION TREATMENT	
00718950440	EYAL MD	CH, EYAL	0113855263	10/05/13	0458750239	1123666935	0579402806	21	INPATIEN	?	01/24/11	EYAL MD	EYAL MD	PHYSICIA	31	MEDI-CAL	\$ 1,033.95	MEDICAL	94640	AIRWAY INHALATION TREATMENT	
00364014976	EYAL MD	CH, EYAL	0634655505	06/15/38	0612026208	1815208575	1941675818	21	INPATIEN	?	01/25/11	EYAL MD	EYAL MD	PHYSICIA	25	MEDI-CAL	\$ 3,943.95	MEDICAL	94640	AIRWAY INHALATION TREATMENT	
00653331876	EYAL MD	CH, EYAL	0163883763	12/01/43	0702436427	0209542433	0082285499	21	INPATIEN	?	01/26/11	EYAL MD	EYAL MD	PHYSICIA	23	MEDI-CAL	\$ 739.03	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
01177270296	LOGY INC	HROLOGY	0915201323	11/26/00	0209896612	0495713297	1441040641	21	INPATIEN	JQR	01/27/11	EYAL MD	EYAL MD	PHYSICIA	31	MEDI-CAL	\$ 1,447.04	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00679282419	EYAL MD	CH, EYAL	0924270346	05/08/00	0447350441	1371986369	0579020563	21	INPATIEN	?	01/28/11	EYAL MD	EYAL MD	PHYSICIA	23	MEDI-CAL	\$ 2,234.07	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
01125497584	EYAL MD	CH, EYAL	0381229192	12/01/97	0270057810	1019129231	1318828372	21	INPATIEN	?	01/29/11	EYAL MD	EYAL MD	PHYSICIA	21	MEDI-CAL	\$ 3,661.57	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00299632931	SHERMAN	HERMAN	0005434346	04/01/22	0888935402	0991087400	0740681893	8	INDEPENI	A7P	01/30/11	EYAL MD	EYAL MD	PHYSICIA	3	MEDI-CAL	\$ 2,025.20	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE	
00550915739	SHERMAN	HERMAN	0626039967	06/21/81	0487550484	1783890768	0771318350	8	INDEPENI	A7P	01/31/11	EYAL MD	EYAL MD	PHYSICIA	4	MEDI-CAL	\$ 2,749.56	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE	
01022157833	EYAL MD	CH, EYAL	0865550253	03/30/18	0022763698	0678109331	0718394391	21	INPATIEN	?	02/01/11	EYAL MD	EYAL MD	PHYSICIA	20	MEDI-CAL	\$ 3,752.31	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00879610398	SHERMAN	HERMAN	0675965223	11/20/58	0196892619	0478841873	0151964492	8	INDEPENI	A7P	02/02/11	EYAL MD	EYAL MD	PHYSICIA	3	MEDI-CAL	\$ 3,274.84	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE	
00143010904	EYAL MD	CH, EYAL	0726481695	07/18/92	0426593205	0300407835	0874970007	21	INPATIEN	?	02/03/11	EYAL MD	EYAL MD	PHYSICIA	16	MEDI-CAL	\$ 1,543.66	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00240211472	LOGY INC	HROLOGY	0338488427	10/12/32	0485029374	0862797155	0337379631	21	INPATIEN	JQR	02/04/11	EYAL MD	EYAL MD	PHYSICIA	19	MEDI-CAL	\$ 2,854.77	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00295194714	EYAL MD	CH, EYAL	0022918365	04/05/10	0233855175	1557773777	1313415197	21	INPATIEN	?	02/05/11	EYAL MD	EYAL MD	PHYSICIA	15	MEDI-CAL	\$ 224.84	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00275109816	LOGY INC	HROLOGY	0246912619	09/25/82	0953058915	1119239127	0146995669	21	INPATIEN	JQR	02/06/11	EYAL MD	EYAL MD	PHYSICIA	15	MEDI-CAL	\$ 1,749.68	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00515812719	LOGY INC	HROLOGY	0899317837	08/18/41	0303162928	0103612412	0292172135	21	INPATIEN	JQR	02/07/11	EYAL MD	EYAL MD	PHYSICIA	25	MEDI-CAL	\$ 262.56	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00901049215	LOGY INC	HROLOGY	0277695235	07/10/24	0969132219	1497839940	1038057362	21	INPATIEN	JQR	02/08/11	EYAL MD	EYAL MD	PHYSICIA	16	MEDI-CAL	\$ 1,446.21	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00153818188	LOGY INC	HROLOGY	0128461131	08/01/33	0343492614	1759023768	1647359702	21	INPATIEN	JQR	02/09/11	EYAL MD	EYAL MD	PHYSICIA	14	MEDI-CAL	\$ 1,780.87	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00872880333	EYAL MD	CH, EYAL	0393384125	05/31/63	0064105585	0081732199	1382915510	65	END STAC	?	02/10/11	EYAL MD	EYAL MD	PHYSICIA	3	MEDI-CAL	\$ 143.80	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00238081001	EYAL MD	CH, EYAL	0705647993	08/12/74	0060047598	0191837352	1756925483	65	END STAC	?	02/11/11	EYAL MD	EYAL MD	PHYSICIA	3	MEDI-CAL	\$ 724.79	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00461937928	EYAL MD	CH, EYAL	0062800728	01/29/83	0964709507	0648987413	1893937810	21	INPATIEN	?	02/12/11	EYAL MD	EYAL MD	PHYSICIA	15	MEDI-CAL	\$ 1,064.16	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00034848156	LOGY INC	HROLOGY	0845321780	01/11/54	0954311177	1198733805	0418820025	21	INPATIEN	JQR	02/13/11	EYAL MD	EYAL MD	PHYSICIA	18	MEDI-CAL	\$ 1,769.80	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00780717885	EYAL MD	CH, EYAL	0938643451	12/07/68	1004242809	1121216555	1885396037	21	INPATIEN	?	02/14/11	EYAL MD	EYAL MD	PHYSICIA	12	MEDI-CAL	\$ 653.73	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00394670224	EYAL MD	CH, EYAL	0325640833	01/24/03	0240695215	0952870916	0979148484	21	INPATIEN	?	02/15/11	EYAL MD	EYAL MD	PHYSICIA	15	MEDI-CAL	\$ 134.37	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00669260594	EYAL MD	CH, EYAL	0184980084	11/09/02	0647529178	1890077931	0195185997	21	INPATIEN	?	02/16/11	EYAL MD	EYAL MD	PHYSICIA	13	MEDI-CAL	\$ 1,080.33	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00671603380	EYAL MD	CH, EYAL	0159794875	10/11/01	0183584212	0312366997	0256991721	21	INPATIEN	?	02/17/11	EYAL MD	EYAL MD	PHYSICIA	12	MEDI-CAL	\$ 816.08	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00953841440	LOGY INC	HROLOGY	0805272917	08/30/81	0163853881	1132514152	0237022850	21	INPATIEN	JQR	02/18/11	EYAL MD	EYAL MD	PHYSICIA	15	MEDI-CAL	\$ 118.80	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00346978710	SHERMAN	HERMAN	0274620049	03/17/14	0530389310	1798823183	0144315616	8	INDEPENI	A7P	02/19/11	EYAL MD	EYAL MD	PHYSICIA	3	MEDI-CAL	\$ 2,228.73	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE	
00537059684	EYAL MD	CH, EYAL	0562342936	12/01/68	0582154797	0904064681	0148673215	21	INPATIEN	?	02/20/11	EYAL MD	EYAL MD	PHYSICIA	13	MEDI-CAL	\$ 1,316.47	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00373031786	EYAL MD	CH, EYAL	0207120476	09/09/08	0768713280	0134871213	1087825955	21	INPATIEN	?	02/21/11	EYAL MD	EYAL MD	PHYSICIA	10	MEDI-CAL	\$ 670.52	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	
00277776712	EYAL MD	CH, EYAL	0274866233	08/30/01	0335130750	1812026602	0889468586	21	INPATIEN	?	02/22/11	EYAL MD	EYAL MD	PHYSICIA	12	MEDI-CAL	\$ 1,434.69	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE	

00248513140	EYAL MD	CH, EYAL	0495514305	04/20/81	0480404714	0781297028	0617443731	21	INPATIEN'	?	02/27/11	EYAL MD	EYAL MD PHYSICIA	9	MEDI-CAL	\$	569.07	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01151249090	EYAL MD	CH, EYAL	0162081590	09/08/65	0974856577	0502840568	0235973061	21	INPATIEN'	?	02/28/11	EYAL MD	EYAL MD PHYSICIA	10	MEDI-CAL	\$	564.27	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00691378789	EYAL MD	CH, EYAL	0660862261	12/04/33	0871818800	1324920040	1080475283	65	END STAC	?	03/01/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	1,247.88	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00130580325	EYAL MD	CH, EYAL	0525511110	07/28/99	0569057871	0368520922	1840666331	65	END STAC	?	03/02/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	1,161.18	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00596536584	LOGY INC	HROLOGY	0750380370	10/27/66	0176771046	0591442484	1041187253	21	INPATIEN'	JQR	03/03/11	EYAL MD	EYAL MD PHYSICIA	12	MEDI-CAL	\$	619.75	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01038483426	EYAL MD	CH, EYAL	0497500976	01/19/24	0578272498	1227590753	0693749076	21	INPATIEN'	?	03/04/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	1,007.41	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00448235360	EYAL MD	CH, EYAL	0529549730	05/29/58	0467450842	0969525033	1394325890	21	INPATIEN'	?	03/05/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	1,201.53	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00718302197	EYAL MD	CH, EYAL	0704782596	06/13/87	0394781523	0406736026	1245051641	21	INPATIEN'	?	03/06/11	EYAL MD	EYAL MD PHYSICIA	10	MEDI-CAL	\$	1,466.55	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00006007755	EYAL MD	CH, EYAL	0686737145	05/03/35	0926405823	1850455800	0308292772	21	INPATIEN'	?	03/07/11	EYAL MD	EYAL MD PHYSICIA	10	MEDI-CAL	\$	300.25	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00501798545	EYAL MD	CH, EYAL	0077465011	03/22/11	0349965661	1464406468	0319959412	21	INPATIEN'	?	03/08/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	767.88	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00221590517	EYAL MD	CH, EYAL	0315780404	02/22/07	0061570357	1473356323	0274271843	21	INPATIEN'	?	03/09/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	255.41	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00845634761	LOGY INC	HROLOGY	0476107963	08/19/00	0604844954	1201061087	1176470817	65	END STAC	JQR	03/10/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	69.69	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00601942440	LOGY INC	HROLOGY	0416050650	05/17/01	0579647461	0190378777	1133094501	21	INPATIEN'	JQR	03/11/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	1,307.93	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00318668854	EYAL MD	CH, EYAL	0041656506	04/23/07	0085703246	0130896596	1121541183	21	INPATIEN'	?	03/12/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	1,268.06	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00664160906	LOGY INC	HROLOGY	0140078332	03/08/34	0147774639	0774701906	0526861932	21	INPATIEN'	JQR	03/13/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	578.89	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00025547655	LOGY INC	HROLOGY	0811877261	07/02/98	0144365433	0287046180	1026924629	21	INPATIEN'	JQR	03/14/11	EYAL MD	EYAL MD PHYSICIA	10	MEDI-CAL	\$	612.21	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00919912602	EYAL MD	CH, EYAL	0489228913	10/31/15	0605826374	0316326422	0020022122	21	INPATIEN'	?	03/15/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	72.90	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00198882501	LOGY INC	HROLOGY	0305996168	12/10/84	0297251466	1511237459	0399258723	21	INPATIEN'	JQR	03/16/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	567.11	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01166716215	EYAL MD	CH, EYAL	0629822693	03/07/65	1001873745	0389927785	1555372578	21	INPATIEN'	?	03/17/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	106.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00630772357	EYAL MD	CH, EYAL	0285348921	07/09/08	0646770348	0988822884	0327163596	21	INPATIEN'	?	03/18/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	182.78	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00711349117	EYAL MD	CH, EYAL	0919043629	02/27/34	0008646766	0680904590	1221200695	21	INPATIEN'	?	03/19/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	1,003.17	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00638760574	EYAL MD	CH, EYAL	0657544542	04/01/04	0588912052	0447321765	0001801273	21	INPATIEN'	?	03/20/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	1,226.63	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00816407711	LOGY INC	HROLOGY	0839570126	02/01/61	0890440974	0172087732	0894453293	21	INPATIEN'	JQR	03/21/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	1,254.35	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00089281938	LOGY INC	HROLOGY	0774651471	08/03/67	0466327953	1623125576	0778422178	21	INPATIEN'	JQR	03/22/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	197.63	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01150874561	EYAL MD	CH, EYAL	0338785280	01/02/25	0018264703	1681175489	1306947815	21	INPATIEN'	?	03/23/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	1,100.07	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00188951424	LOGY INC	HROLOGY	0466245764	07/09/79	0348970175	1071211596	1080595981	21	INPATIEN'	JQR	03/24/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	671.71	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00993371364	EYAL MD	CH, EYAL	0670883806	12/28/80	0126348196	1392284504	1598774697	21	INPATIEN'	?	03/25/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	579.01	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00918087591	EYAL MD	CH, EYAL	0236533726	05/24/71	0209854050	0043902171	0842721018	21	INPATIEN'	?	03/26/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	448.48	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00262320933	SHERMAN	HERMAN (	0824803317	11/23/06	0054451413	0547273143	0057667063	8	INDEPENI	A7P	03/27/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	5.55	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE
00426998241	LOGY INC	HROLOGY	0798630625	02/10/26	0142869165	0345130915	1003326559	21	INPATIEN'	JQR	03/28/11	EYAL MD	EYAL MD PHYSICIA	9	MEDI-CAL	\$	227.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00512699612	LOGY INC	HROLOGY	0316801289	11/27/86	00988574724	1440404232	0146209958	21	INPATIEN'	JQR	03/29/11	EYAL MD	EYAL MD PHYSICIA	12	MEDI-CAL	\$	31.97	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00598584666	EYAL MD	CH, EYAL	0853429560	02/02/70	0981027783	0207711125	0707741655	21	INPATIEN'	?	03/30/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	793.04	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00216569886	EYAL MD	CH, EYAL	0841593502	02/20/98	0942745298	1000713541	0417845849	21	INPATIEN'	?	03/31/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	691.09	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00283817285	EYAL MD	CH, EYAL	0527663611	07/08/02	0192916349	0113965159	0752482722	21	INPATIEN'	?	04/01/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	132.58	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00981148606	EYAL MD	CH, EYAL	0125936840	07/07/24	0764555166	1890270819	1762790540	21	INPATIEN'	?	04/02/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	40.46	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00577848283	EYAL MD	CH, EYAL	0106932677	09/05/48	0652923092	1044179816	1829369774	21	INPATIEN'	?	04/03/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	406.25	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00133523096	LOGY INC	HROLOGY	0641503914	08/25/16	0876626801	1384577811	1810741327	21	INPATIEN'	JQR	04/04/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	480.25	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00869036111	LOGY INC	HROLOGY	0774866514	10/12/24	1006954209	1236080127	0728551546	21	INPATIEN'	JQR	04/05/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	887.59	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00670203369	EYAL MD	CH, EYAL	0985289713	06/12/73	0811373227	0975152786	1618681734	21	INPATIEN'	?	04/06/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	364.47	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00113437723	LOGY INC	HROLOGY	0414325349	08/18/67	0988732625	1529261426	0736058893	21	INPATIEN'	JQR	04/07/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	74.04	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01061710920	EYAL MD	CH, EYAL	0064703955	11/15/89	0934593897	1746692056	0902614306	21	INPATIEN'	?	04/08/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	447.12	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00085278903	EYAL MD	CH, EYAL	0539950273	07/26/05	0108126233	0868990642	0119049393	21	INPATIEN'	?	04/09/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	891.85	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00306671747	EYAL MD	CH, EYAL	0249110003	07/07/26	0408373596	0632214314	0965859754	21	INPATIEN'	?	04/10/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	557.59	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00374004193	LOGY INC	HROLOGY	0327448124	03/07/95	0355120834	1214105613	0409969885	21	INPATIEN'	JQR	04/11/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	283.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01124807853	LOGY INC	HROLOGY	0071655492	11/23/35	0424067853	1366610192	0146939761	21	INPATIEN'	JQR	04/12/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	929.27	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00397806753	LOGY INC	HROLOGY	0791664987	06/13/99	0653994953	0745931922	1013611551	21	INPATIEN'	JQR	04/13/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	148.77	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00913782500	EYAL MD	CH, EYAL	0674786823	10/16/16	0651022512	1874163690	1683186516	21	INPATIEN'	?	04/14/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	158.95	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00610168341	EYAL MD	CH, EYAL	0096384096	03/03/51	0205638011	1472372662	1506218403	21	INPATIEN'	?	04/15/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	663.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00692508729	EYAL MD	CH, EYAL	0962338886	08/05/41	0535984953	0388403619	1553862593	21	INPATIEN'	?	04/16/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	870.63	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00750266613	EYAL MD	CH, EYAL	0314349077	07/14/22	0727912770	0018676178	0064538483	21	INPATIEN'	?	04/17/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	546.67	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00312625757	LOGY INC	HROLOGY	0870171247	07/05/71	0473337715	0108272832	0775937829	21	INPATIEN'	JQR	04/18/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	594.60	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00420451813	LOGY INC	HROLOGY	0692694490	07/23/07	0390047188	1606674207	1132752738	21	INPATIEN'	JQR	04/19/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	248.45	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00242056931	LOGY INC	HROLOGY	0089661142	05/07/76	0095440461	0985067322	0134705857	21	INPATIEN'	JQR	04/20/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	889.58	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00420885927	EYAL MD	CH, EYAL	0361052678	08/20/03	0930321302	0263790372	1024210376	65	END STAC	?	04/21/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	544.06	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00148891901	EYAL MD	CH, EYAL	0306691989	09/26/55	0491849878	1616327007	1531393553	65	END STAC	?	04/22/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	287.96	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00951993034	EYAL MD	CH, EYAL	0430951062	08/14/14	0243203862	0099295121	1176840463	65												

01016494971	LOGY INC	HROLOGY	0000996334	01/25/07	0646243942	0644087093	0303816614	65	END STAC	JQR	04/29/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	726.59	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00474148260	EYAL MD	CH, EYAL	0135610371	08/21/24	0323157119	0552923238	1936469550	65	END STAC	?	04/30/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	682.28	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01162657859	EYAL MD	CH, EYAL	0463146029	12/25/02	0310339794	1049338653	0962284520	65	END STAC	?	05/01/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	147.42	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00183305797	EYAL MD	CH, EYAL	0651689806	04/15/07	0884016595	0177400146	1121837232	65	END STAC	?	05/02/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	441.54	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00561615759	EYAL MD	CH, EYAL	0704670088	11/23/35	0506603221	1159893773	1540242662	65	END STAC	?	05/03/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	599.65	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00341772110	EYAL MD	CH, EYAL	0089873632	08/20/19	0341192118	1682321921	0711723447	65	END STAC	?	05/04/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	706.49	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01025682289	EYAL MD	CH, EYAL	0944566653	02/02/15	0818255515	0352720039	1212454834	65	END STAC	?	05/05/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	213.39	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00743411993	EYAL MD	CH, EYAL	0750797595	09/16/95	0395282860	1825602438	0019687286	65	END STAC	?	05/06/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	694.30	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00080169195	EYAL MD	CH, EYAL	0943132242	08/26/74	0240836778	0442520010	0965426761	65	END STAC	?	05/07/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	741.81	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00426127184	EYAL MD	CH, EYAL	0867098917	10/05/61	0364736738	0667054679	0316618833	65	END STAC	?	05/08/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	282.93	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01087450020	EYAL MD	CH, EYAL	0509542773	09/13/34	0668262499	0986407832	0058728911	65	END STAC	?	05/09/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	622.41	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00286470788	EYAL MD	CH, EYAL	0328636168	06/01/02	0539007707	1527409075	0498726494	21	INPATIEN'	?	05/10/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	577.37	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00478177191	EYAL MD	CH, EYAL	0829972164	12/25/12	0717292707	0720194472	1852728624	21	INPATIEN'	?	05/11/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	785.22	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00269836797	LOGY INC	HROLOGY	0379305296	01/06/61	0476094783	1235830500	1662411377	21	INPATIEN'	JQR	05/12/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	232.68	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00729721280	LOGY INC	HROLOGY	0756147814	09/01/38	0777491652	0495841543	1676869721	21	INPATIEN'	JQR	05/13/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	265.94	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01130457643	EYAL MD	CH, EYAL	0803032927	02/26/97	0441668400	0991622857	0020475986	21	INPATIEN'	?	05/14/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	594.94	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01006376161	EYAL MD	CH, EYAL	0135946905	12/06/49	0404763039	0416288174	0611370627	21	INPATIEN'	?	05/15/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	418.03	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00761201776	EYAL MD	CH, EYAL	0422732390	03/06/43	0826487662	0262043769	0143643276	21	INPATIEN'	?	05/16/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	544.18	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00749877271	EYAL MD	CH, EYAL	0400990328	07/14/00	0984881905	0756782386	1296206762	21	INPATIEN'	?	05/17/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	267.77	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00135786274	LOGY INC	HROLOGY	0798994604	01/12/04	0177518261	1334580577	1451462699	21	INPATIEN'	JQR	05/18/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	186.22	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00324031848	EYAL MD	CH, EYAL	0188811803	02/17/39	0922856406	1620019585	0252253894	21	INPATIEN'	?	05/19/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	173.47	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00228060993	EYAL MD	CH, EYAL	0925558575	11/17/98	0797191844	0495171491	0907190545	21	INPATIEN'	?	05/20/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	807.07	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00694480547	LOGY INC	HROLOGY	0788665906	01/20/69	1008741494	0647248060	1853788811	21	INPATIEN'	JQR	05/21/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	72.35	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00220327788	EYAL MD	CH, EYAL	0985927773	01/10/23	0188955840	0469060522	0820839230	21	INPATIEN'	?	05/22/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	512.32	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01101366290	EYAL MD	CH, EYAL	0374074450	09/07/01	0423527761	0160333021	1381627859	21	INPATIEN'	?	05/23/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	259.23	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00821180893	EYAL MD	CH, EYAL	0813352740	10/12/46	0385376168	1574067745	1170712513	21	INPATIEN'	?	05/24/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	396.74	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00797745339	EYAL MD	CH, EYAL	0921368797	08/26/66	0214352333	0539305289	1330639281	21	INPATIEN'	?	05/25/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	146.57	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01111437645	LOGY INC	HROLOGY	0746071887	12/14/09	0152234411	1545627450	1124525444	21	INPATIEN'	JQR	05/26/11	EYAL MD	EYAL MD PHYSICIA	9	MEDI-CAL	\$	155.08	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00535581434	EYAL MD	CH, EYAL	0195930541	12/22/53	1020010607	0608088632	1548071373	21	INPATIEN'	?	05/27/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	514.38	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01118673255	EYAL MD	CH, EYAL	0835742082	08/18/45	0524580950	1070463987	0558045639	21	INPATIEN'	?	05/28/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	661.81	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00926592854	EYAL MD	CH, EYAL	0396762239	12/09/10	0436531798	0474994921	0364553804	21	INPATIEN'	?	05/29/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	449.44	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00175715490	EYAL MD	CH, EYAL	0810369170	06/22/35	0430815448	0922655283	0178653022	21	INPATIEN'	?	05/30/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	400.74	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00202236386	LOGY INC	HROLOGY	0621874573	01/23/27	0666727392	0807161410	0596970772	21	INPATIEN'	JQR	05/31/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	600.72	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01010539944	LOGY INC	HROLOGY	0285250990	11/02/30	0595633061	0129827762	1855478737	21	INPATIEN'	JQR	06/01/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	229.15	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00557465131	LOGY INC	HROLOGY	0341394975	05/18/52	0295924165	1426696109	0873747865	21	INPATIEN'	JQR	06/02/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	455.94	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01059237908	EYAL MD	CH, EYAL	0586673124	12/12/14	0085055205	0938813995	0269656780	21	INPATIEN'	?	06/03/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	194.25	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01143686754	LOGY INC	HROLOGY	0039303145	12/22/52	0553619953	0849361102	0575651008	21	INPATIEN'	JQR	06/04/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	32.23	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00784078414	EYAL MD	CH, EYAL	0562635734	06/14/11	0229076596	0256835284	1525921530	21	INPATIEN'	?	06/05/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	273.95	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00236825906	LOGY INC	HROLOGY	0243189785	11/21/92	0351730040	0187398704	1400310358	21	INPATIEN'	JQR	06/06/11	EYAL MD	EYAL MD PHYSICIA	8	MEDI-CAL	\$	384.67	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00712153273	LOGY INC	HROLOGY	0698965536	05/02/51	0203589337	1052666543	0541763896	11	OFFICE	JQR	06/07/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	138.28	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00847606797	EYAL MD	CH, EYAL	0247792380	08/23/81	0562982190	0135793477	1301887870	21	INPATIEN'	?	06/08/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	339.03	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00404789797	LOGY INC	HROLOGY	0085263875	08/23/11	0999388119	0981107536	1724261962	21	INPATIEN'	JQR	06/09/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	581.26	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00182901521	EYAL MD	CH, EYAL	0763488226	08/19/53	0599148744	0954572612	0261154811	21	INPATIEN'	?	06/10/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	194.61	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00598355115	LOGY INC	HROLOGY	0677070881	12/20/49	0396084551	0824517446	0861611503	21	INPATIEN'	JQR	06/11/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	469.40	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00208217196	EYAL MD	CH, EYAL	0585108543	12/02/36	0109445151	1707692019	0053945787	11	OFFICE	?	06/12/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	176.54	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01120451359	EYAL MD	CH, EYAL	0166761428	01/21/56	0161141490	0477378278	1000577946	21	INPATIEN'	?	06/13/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	194.31	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00124618422	EYAL MD	CH, EYAL	0964998499	11/24/58	0647106658	0197104782	1701221709	21	INPATIEN'	?	06/14/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	155.85	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01051799070	EYAL MD	CH, EYAL	0981807554	12/31/80	0667146380	0684675727	0260554583	21	INPATIEN'	?	06/15/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	167.15	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00685819483	LOGY INC	HROLOGY	0677800221	03/17/43	0914816838	0809558328	1775186067	21	INPATIEN'	JQR	06/16/11	EYAL MD	EYAL MD PHYSICIA	5	MEDI-CAL	\$	513.25	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00330260952	LOGY INC	HROLOGY	0946525835	05/08/33	0575403363	1677737421	0912040080	21	INPATIEN'	JQR	06/17/11	EYAL MD	EYAL MD PHYSICIA	7	MEDI-CAL	\$	496.94	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00849902293	LOGY INC	HROLOGY	0515189642	03/01/78	0248525277	0907872643	1553500655	11	OFFICE	JQR	06/18/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	358.32	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01066775920	EYAL MD	CH, EYAL	0060832435	08/09/88	0053430872	0347237691	1668882429	21	INPATIEN'	?	06/19/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	111.73	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01144089909	EYAL MD	CH, EYAL	0261539594	11/09/06	0024642765	0443782145	1352871025	21	INPATIEN'	?	06/20/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	44.41	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00897498572	LOGY INC	HROLOGY	0272591292	01/21/98	0986678883	0235443388	1517044097	21	INPATIEN'	JQR	06/21/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	4.86	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00103922142	LOGY INC	HROLOGY	0606493833	06/05/04	0332336032	0090302859	1807727921	21	INPATIEN'	JQR	06/22/11	EYAL MD	EYAL MD PHYSICIA	6	MEDI-CAL	\$	381.33	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00959768163	EYAL MD	CH, EYAL	0249925162	03/20/59	0208004623	1009941175	1901268533	21	INPATIEN'	?	06/23/11	EYAL MD								

01038410604	EYAL MD	CH, EYAL	0535975028	06/26/01	0783084568	0979492747	0715286275	21	INPATIEN'	?	06/29/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	325.74	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00582298709	EYAL MD	CH, EYAL	0749036208	07/25/96	0617677646	0462684806	1670125000	21	INPATIEN'	?	06/30/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	448.02	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00663780279	EYAL MD	CH, EYAL	0976555503	02/14/87	0893352838	1932856106	0426702233	21	INPATIEN'	?	07/01/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	328.00	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00256506087	EYAL MD	CH, EYAL	0393911418	01/04/16	0198046138	1381767825	0367483275	21	INPATIEN'	?	07/02/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	243.18	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00242381374	EYAL MD	CH, EYAL	0764344091	03/18/10	0194072557	0603881046	0054573021	21	INPATIEN'	?	07/03/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	290.82	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00710902764	LOGY INC	HROLOGY	0120253316	02/19/07	0267661241	1017425318	1046547282	21	INPATIEN'	JQR	07/04/11	EYAL MD	EYAL MD PHYSICIA	5 MEDI-CAL	\$	229.87	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00057560888	LOGY INC	HROLOGY	0937470891	12/09/28	0260216334	0442926476	0219400561	21	INPATIEN'	JQR	07/05/11	EYAL MD	EYAL MD PHYSICIA	5 MEDI-CAL	\$	333.87	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01139576669	LOGY INC	HROLOGY	0720888764	08/04/20	0182911648	0659929186	1250752023	21	INPATIEN'	JQR	07/06/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	470.77	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00095729539	LOGY INC	HROLOGY	0788812533	06/16/80	0171832577	1349599200	1467729656	21	INPATIEN'	JQR	07/07/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	288.71	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00726499820	LOGY INC	HROLOGY	0215674599	12/07/93	0974779772	0207817746	1331081868	21	INPATIEN'	JQR	07/08/11	EYAL MD	EYAL MD PHYSICIA	6 MEDI-CAL	\$	354.12	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00903421320	LOGY INC	HROLOGY	0551604172	07/04/01	0387757552	0723232599	0599200046	21	INPATIEN'	JQR	07/09/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	190.98	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01120471840	LOGY INC	HROLOGY	0042569517	10/03/54	0121650368	0827519598	0042649609	21	INPATIEN'	JQR	07/10/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	451.41	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00978673259	LOGY INC	HROLOGY	0803053554	11/26/62	0804731980	0612237584	1574045675	65	END STAC	JQR	07/11/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	268.85	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00444809313	EYAL MD	CH, EYAL	0780970127	10/10/86	0842937010	1817943130	1098977076	21	INPATIEN'	?	07/12/11	EYAL MD	EYAL MD PHYSICIA	4 MEDI-CAL	\$	12.93	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00967177466	LOGY INC	HROLOGY	0513790409	03/13/87	0464105295	1271893149	0735679199	21	INPATIEN'	JQR	07/13/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	164.74	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00828234134	LOGY INC	HROLOGY	0835545647	02/18/49	0182019320	0173703829	1245293832	21	INPATIEN'	JQR	07/14/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	248.32	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00894528199	LOGY INC	HROLOGY	0281168321	06/12/20	0098466262	0880096472	0795579731	21	INPATIEN'	JQR	07/15/11	EYAL MD	EYAL MD PHYSICIA	4 MEDI-CAL	\$	274.17	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00507643839	SHERMAN	HERMAN (	0838676897	09/12/46	0248827652	0418870102	1159782691	8	INDEPENI	?	07/16/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	56.57	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE
00252228979	LOGY INC	HROLOGY	0876188108	03/28/07	0692221330	0306893115	1550280933	21	INPATIEN'	JQR	07/17/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	282.59	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01081175357	EYAL MD	CH, EYAL	0603326562	06/21/27	0870755203	1770494898	0133454445	21	INPATIEN'	?	07/18/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	72.70	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00716409495	LOGY INC	HROLOGY	0586072496	01/26/57	0941727515	1542550428	0327646246	21	INPATIEN'	JQR	07/19/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	132.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00897882106	EYAL MD	CH, EYAL	0905573175	01/21/90	0404317649	1502373235	1613986013	21	INPATIEN'	?	07/20/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	119.72	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00995013658	LOGY INC	HROLOGY	0266530591	03/22/44	0590266763	0136888001	1779435605	21	INPATIEN'	JQR	07/21/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	380.62	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00870053034	LOGY INC	HROLOGY	0516338143	04/13/87	0143745287	1939357902	0848735007	21	INPATIEN'	JQR	07/22/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	84.73	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00671295489	LOGY INC	HROLOGY	0320831880	06/08/41	0848823507	0341115580	1522807181	21	INPATIEN'	JQR	07/23/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	170.56	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00633780570	EYAL MD	CH, EYAL	0920308773	02/19/14	0821247494	1243932824	0739491759	11	OFFICE	?	07/24/11	EYAL MD	EYAL MD PHYSICIA	5 MEDI-CAL	\$	354.79	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00640118073	LOGY INC	HROLOGY	0705432646	03/15/03	0514312722	0422669041	1074886734	21	INPATIEN'	JQR	07/25/11	EYAL MD	EYAL MD PHYSICIA	4 MEDI-CAL	\$	122.57	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00333679343	LOGY INC	HROLOGY	0117142957	02/14/92	0186242349	1626001474	1511888743	21	INPATIEN'	JQR	07/26/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	188.05	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00961803216	LOGY INC	HROLOGY	0919669957	06/08/37	0632483027	0157454855	1768306655	21	INPATIEN'	JQR	07/27/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	168.35	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00309603363	LOGY INC	HROLOGY	0716177743	12/29/48	0873607776	0997641269	1804812959	21	INPATIEN'	JQR	07/28/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	209.71	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00151779078	EYAL MD	CH, EYAL	0449495143	03/16/46	0345670113	0247345460	1088643469	21	INPATIEN'	?	07/29/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	201.76	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00414014038	LOGY INC	HROLOGY	0540100490	05/08/12	0407764214	1130466793	0857410536	21	INPATIEN'	JQR	07/30/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	214.00	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01040684374	LOGY INC	HROLOGY	0649309465	04/25/20	0752105261	0803482142	1537278596	21	INPATIEN'	JQR	07/31/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	89.81	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00054181107	EYAL MD	CH, EYAL	0724561974	06/26/82	0652385674	0115868489	1041556166	21	INPATIEN'	?	08/01/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	328.68	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00175105869	EYAL MD	CH, EYAL	0835948382	01/05/89	0608724519	1106938600	0448633729	21	INPATIEN'	?	08/02/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	136.67	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00615115012	EYAL MD	CH, EYAL	0598340030	02/24/96	0998314029	0439947844	0832462460	11	OFFICE	?	08/03/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	210.94	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00239318112	LOGY INC	HROLOGY	0789067374	03/08/07	0282279982	0391919769	1290231582	21	INPATIEN'	JQR	08/04/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	215.55	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01076145238	LOGY INC	HROLOGY	0331341616	09/10/67	0489257331	0591780145	0659161055	21	INPATIEN'	JQR	08/05/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	307.02	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00137767440	LOGY INC	HROLOGY	0229666627	08/09/11	0718462831	0250587114	1192082402	21	INPATIEN'	JQR	08/06/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	331.10	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00722031557	LOGY INC	HROLOGY	0480793437	10/21/55	0884137376	1735728573	1518151501	21	INPATIEN'	JQR	08/07/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	77.68	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00681796580	EYAL MD	CH, EYAL	0862693483	11/30/14	0209531745	0301465554	0443810473	11	OFFICE	?	08/08/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	40.29	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00304509805	EYAL MD	CH, EYAL	0089372891	06/04/89	0889304031	0834879837	0162570769	11	OFFICE	?	08/09/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	262.56	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00597250203	EYAL MD	CH, EYAL	0890989946	05/17/85	0400663782	1274120613	1388852021	21	INPATIEN'	?	08/10/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	258.57	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00780543701	LOGY INC	HROLOGY	0963811368	07/07/10	0200468505	0766002344	0857532093	21	INPATIEN'	JQR	08/11/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	106.06	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00783511786	E SVS II	N OAKS H	0760803409	05/28/66	0181909556	1408503945	0172423341	5	OUTPATIE	A7P	08/12/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	155.82	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE
00794330985	EYAL MD	CH, EYAL	0785262813	06/03/20	0836481209	0496432026	1396266366	21	INPATIEN'	?	08/13/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	6.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00900290213	LOGY INC	HROLOGY	0515924623	12/21/88	0639029369	1130572580	0454882560	21	INPATIEN'	JQR	08/14/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	302.73	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00441339604	LOGY INC	HROLOGY	0649189604	11/29/62	0533336556	0879612727	0152019506	21	INPATIEN'	JQR	08/15/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	24.01	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00440114058	LOGY INC	HROLOGY	0790150680	04/26/17	0017083248	1588961528	0826826272	21	INPATIEN'	JQR	08/16/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	160.10	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01182446631	LOGY INC	HROLOGY	0515266726	02/26/41	0186273924	0641095659	1865407824	21	INPATIEN'	JQR	08/17/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	112.61	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00088449516	EYAL MD	CH, EYAL	0526839552	02/27/38	0117014077	1455599024	1342102468	11	OFFICE	?	08/18/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	187.41	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00126248203	EYAL MD	CH, EYAL	0040266219	02/01/90	0646218444	0992063322	1699610490	11	OFFICE	?	08/19/11	EYAL MD	EYAL MD PHYSICIA	1 MEDI-CAL	\$	237.16	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00909491308	LOGY INC	HROLOGY	0328680902	09/24/00	0993742397	1890014382	1619655734	21	INPATIEN'	JQR	08/20/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	117.66	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00567066475	LOGY INC	HROLOGY	0012415318	02/04/58	0378498537	0241988847	0589836849	21	INPATIEN'	JQR	08/21/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	212.19	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00388089808	LOGY INC	HROLOGY	0029038258	10/09/75	0814067397	0225583447	1549820264	11	OFFICE	JQR	08/22/11	EYAL MD	EYAL MD PHYSICIA	3 MEDI-CAL	\$	166.42	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01089664564	LOGY INC	HROLOGY	0396156809	02/10/16	0384441940	1374120833	1677607811	21	INPATIEN'	JQR	08/23/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	48.29	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00161405247	LOGY INC	HROLOGY	0886780633	09/01/89	0744773030	0426491260	0575647164	21	INPATIEN'	JQR	08/24/11	EYAL MD	EYAL MD PHYSICIA	2 MEDI-CAL	\$	106.63	MEDICAL	65220	

00417101390	LOGY INC	HROLOGY	0400079074	06/07/73	0149249597	0671143062	1146414309	21	INPATIEN'	JQR	08/29/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	205.44	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00134065066	LOGY INC	HROLOGY	0549914386	07/03/98	0799582826	0358309903	1791752825	21	INPATIEN'	JQR	08/30/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	83.04	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00841880110	LOGY INC	HROLOGY	0604401159	09/23/49	0862869994	1830090557	0289398449	21	INPATIEN'	JQR	08/31/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	2.82	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00091782233	LOGY INC	HROLOGY	0493708192	03/17/51	0572872014	1512594203	0509686738	11	OFFICE	JQR	09/01/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	171.58	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00546940230	LOGY INC	HROLOGY	0752415523	09/27/22	0146895801	1588804848	0260506484	21	INPATIEN'	JQR	09/02/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	105.55	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00713306436	EYAL MD	CH, EYAL	0061494707	04/25/80	0690857762	0731357226	1088296099	21	INPATIEN'	?	09/03/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	57.50	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00552711520	EYAL MD	CH, EYAL	0793310176	06/14/63	0881135702	0270394814	0086092834	21	INPATIEN'	?	09/04/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	140.92	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00178124073	EYAL MD	CH, EYAL	0990071363	06/19/92	0892450300	0949764745	1572924392	21	INPATIEN'	?	09/05/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	165.62	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00521814918	EYAL MD	CH, EYAL	0867267234	07/20/55	0037749479	0672961282	1822368750	21	INPATIEN'	?	09/06/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	135.61	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00151158196	EYAL MD	CH, EYAL	0022146055	04/15/59	0357786157	0968471023	0431860132	11	OFFICE	?	09/07/11	EYAL MD	EYAL MD PHYSICIA	4	MEDI-CAL	\$	102.46	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00933881337	EYAL MD	CH, EYAL	0089187915	04/05/02	0465754819	0887445721	0016126885	21	INPATIEN'	?	09/08/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	1.24	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00008847060	EYAL MD	CH, EYAL	0367748936	09/25/63	0617514750	1882665983	0927299583	21	INPATIEN'	?	09/09/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	22.52	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00226194833	LOGY INC	HROLOGY	0568990410	05/19/80	0135428343	0292608272	0303172698	21	INPATIEN'	JQR	09/10/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	16.52	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00525541136	LOGY INC	HROLOGY	0238744099	02/12/77	0958890449	1313128069	1440422164	21	INPATIEN'	JQR	09/11/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	106.14	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00932252857	LOGY INC	HROLOGY	0643587485	07/25/23	0717731014	1807099771	1616989301	21	INPATIEN'	JQR	09/12/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	146.20	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00120259722	EYAL MD	CH, EYAL	0343975499	08/27/79	0735574575	0652535225	1123133946	21	INPATIEN'	?	09/13/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	32.37	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00754701736	EYAL MD	CH, EYAL	0468098817	12/14/61	0935137776	1540252739	0324464575	11	OFFICE	?	09/14/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	74.33	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00496460120	LOGY INC	HROLOGY	0517286896	11/26/20	0973741167	0298182171	0836661600	11	OFFICE	JQR	09/15/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	74.29	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00370424797	LOGY INC	HROLOGY	0751725669	08/16/26	1002848917	0021646175	0520103956	21	INPATIEN'	JQR	09/16/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	100.96	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00654628659	LOGY INC	HROLOGY	0235101392	03/12/37	0970424514	1734054235	0280972591	21	INPATIEN'	JQR	09/17/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	30.98	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01119545091	EYAL MD	CH, EYAL	0573870729	07/11/17	0100857112	1613648319	0432476369	21	INPATIEN'	?	09/18/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	103.89	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00118338615	EYAL MD	CH, EYAL	0720247622	03/16/92	0774603589	1591147785	1837937010	11	OFFICE	?	09/19/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	36.16	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00395123226	EYAL MD	CH, EYAL	0094471974	09/21/65	0296414708	1465840348	0275513353	11	OFFICE	?	09/20/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	94.46	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00977734603	EYAL MD	CH, EYAL	0002973882	04/23/11	0375682198	1136541100	0181239703	11	OFFICE	?	09/21/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	4.38	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00718127811	EYAL MD	CH, EYAL	0747946860	12/04/84	0797626622	1703666184	1611369274	11	OFFICE	?	09/22/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	124.64	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01110796348	EYAL MD	CH, EYAL	0133591005	06/15/05	0167474262	1360646640	0149426912	11	OFFICE	?	09/23/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	139.18	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00439828880	EYAL MD	CH, EYAL	0108847492	03/16/62	0066485299	0842704560	0677704505	11	OFFICE	?	09/24/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	115.22	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00201072072	EYAL MD	CH, EYAL	0034743908	03/13/89	0009901623	0228502704	1179326349	11	OFFICE	?	09/25/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	35.29	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00201823471	LOGY INC	HROLOGY	0318156329	02/21/44	0245987703	0207221429	0008573404	21	INPATIEN'	JQR	09/26/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	64.34	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00956447035	LOGY INC	HROLOGY	0450089887	07/02/76	0127727328	1446946126	0766917088	21	INPATIEN'	JQR	09/27/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	17.14	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01064346704	LOGY INC	HROLOGY	0605324320	01/04/34	0507934058	1449338472	1142890040	21	INPATIEN'	JQR	09/28/11	EYAL MD	EYAL MD PHYSICIA	2	MEDI-CAL	\$	31.48	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00192952669	EYAL MD	CH, EYAL	0498460098	09/18/17	0607310663	0734954701	0503944773	11	OFFICE	?	09/29/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	44.12	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00257354268	EYAL MD	CH, EYAL	0433731256	09/29/03	0751044074	1166676003	0565982111	11	OFFICE	?	09/30/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	93.85	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00067973532	EYAL MD	CH, EYAL	0117840514	12/31/11	0433643725	1853122713	1088341335	11	OFFICE	?	10/01/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	13.83	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00538622754	EYAL MD	CH, EYAL	0266701376	05/07/73	0274475290	1209888350	0380141659	11	OFFICE	?	10/02/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	51.83	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00600200378	EYAL MD	CH, EYAL	0939440118	06/20/09	0968429416	0016047436	0442504541	11	OFFICE	?	10/03/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	58.30	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00554876067	LOGY INC	HROLOGY	0371797595	03/11/37	0995915665	1541053675	0374938076	21	INPATIEN'	JQR	10/04/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	66.97	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
01179440064	E SVS II	N OAKS H	0849211722	03/22/12	0759572042	0653517039	1842272365	5	OUTPATIE	A7P	10/05/11	EYAL MD	EYAL MD PHYSICIA	3	MEDI-CAL	\$	7.72	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE
01099215712	LOGY INC	HROLOGY	0830984036	01/19/10	0997543039	1067187131	0006117144	11	OFFICE	JQR	10/06/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	41.79	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00738267435	LOGY INC	HROLOGY	0382366647	07/21/75	0057249087	0844603341	0854988780	21	INPATIEN'	JQR	10/07/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	38.18	MEDICAL	65220	REMOVE FOREIGN BODY FROM EYE
00776692828	E SVS II	N OAKS H	0396699722	03/10/08	0739830999	0223654683	0206881228	5	OUTPATIE	A7P	10/08/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	24.13	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE
00512310404	E SVS II	N OAKS H	0281823743	12/24/57	0303424901	1891462832	1288761133	5	OUTPATIE	A7P	10/09/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	20.33	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE
00350493880	E SVS II	N OAKS H	0876208475	09/24/64	0816737431	0743907964	0402273527	5	OUTPATIE	A7P	10/10/11	EYAL MD	EYAL MD PHYSICIA	1	MEDI-CAL	\$	38.81	OUTPATIE	65220	REMOVE FOREIGN BODY FROM EYE

Sum: 2522 Sum:

Question and Answers for Bid #10-87242 - Recovery Audit Contractor

OVERALL BID QUESTIONS

There are no questions associated with this bid. If you would like to submit a question, please click on the "Create New Question" button below.

Question Deadline: Oct 18, 2011 4:00:00 PM PDT