MEDICAL SERVICES AGREEMENT BETWEEN SAN MATEO HEALTH COMMISSION AND NURSING FACILITY

This Medical Services Agreement ("Agreement") is entered into this **1st day of October, 2019 (the "Effective Date"),** by and between **the County of San Mateo dba San Mateo Medical Center**, a hospital licensed by the California Department of Public Health ("CDPH") and validly enrolled in the Medi-Cal and/or Medicare programs (hereinafter referred to as "Provider"), and the San Mateo Health Commission dba Health Plan of San Mateo, a public entity (hereinafter referred to as "HPSM" or "PLAN"). HPSM and Provider are sometimes individually referred to as "Party" and collectively referred to as "Parties". The Parties agree as follows:

In addition to this Medical Services Agreement, the following are attached hereto and incorporated by reference herein:

Authorized Representative Addendum
Attachment A Nursing Facility Protocols
Attachment B-1 Medi-Cal Reimbursement
Attachment B-2 CareAdvantage Reimbursement
Attachment C Medical Records Information

This Agreement is applicable to the following lines of business. The lines of business indicated below as not included (box checked "No"), may be added at a future date by mutual Amendment.

Medi-Cal	[X] Yes [ ] No
CareAdvantage	[X] Yes [ ] No

Authorized Representative Addendum

The undersigned entity hereby certifies it is legally authorized to make binding agreements concerning the nursing facilities identified in this Addendum (hereinafter, "Provider Nursing Facilities" or "Nursing Facilities"), and by signing this Agreement, certifies that:

1. Provider Nursing Facilities are duly organized for the express purpose of providing health care services to the public at large; and

2. The undersigned is authorized to enter into this Agreement on behalf of the Nursing Facilities; and

3. Upon reasonable request by PLAN, the Provider agrees to provide certified copies of documents verifying its legal and organizational status and operation, including, but not limited to, hospital license documents and County resolutions and/or ordinances; and

4. This Agreement sets forth the rights and obligations of the Provider with regard to its Nursing Facilities, such that "Provider", for purposes of this Agreement, shall refer to the entity responsible for the Nursing Facilities. The Nursing Facilities shall be subject to the same rights and obligations as afforded to "Provider" as it is used and defined in this Agreement; and

5. Each nursing facility listed below has completed an individual initial credentialing application and will complete individual recredentialing with PLAN.

Name of Nursing Facility	Tax ID Number	NPI Number	License Number
San Mateo Medical Center – 39th Ave Skilled Nursing	94-6000532	1710066634	CDPH License #220000015
San Mateo Medical Center – Burlingame Skilled Nursing	94-6000532	1710066634	CDPH #220000015

MEDICAL SERVICES AGREEMENT

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TERMS AND CONDITIONS

Recitals:

A. WHEREAS, San Mateo Health Commission and Health Plan of San Mateo are public entities and are licensed by the California Department of Managed Health Care ("DMHC") as a health care service plan in the State of California pursuant to Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code Section 1340 et seq.), and the regulations promulgated thereunder (collectively, the "Knox-Keene Act").

B. WHEREAS, HPSM has entered, or intends to enter into agreements with various government agencies under which HPSM agrees to provide or arrange healthcare services to Members. HPSM has entered into an agreement with the California Department of Health Care Services ("DHCS") and the Centers for Medicare and Medicaid Services ("CMS").

C. WHEREAS, Provider shall participate in providing Covered Services to Members and shall receive payment from HPSM for the rendering of those Covered Services.

D. WHEREAS, Provider is licensed as a Distinct Part Skilled Nursing Facility by the California Department of Public Health (CDPH) and also subject to regulation by the California Department of Health Care Services (DHCS);

E. WHEREAS, Both Parties desire to demonstrate that effective and economical health care can be provided through a locally administered program.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein, the Parties agree as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.1 **"Attending Physician"** shall mean (a) any Physician who is acting in the provision of Emergency Services to meet the medical needs of the Member or (b) any Physician who is, through delegation from the Member's Provider, actively engaged in the treatment or evaluation of a Member's condition.

1.2 **"Case Management"** shall mean the coordination and follow up by the Provider, of all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

1.3 **"CMO"** shall mean HPSM's Chief Medical Officer.

1.4 **"CMS"** shall mean the Centers for Medicare & Medicaid Services.

1.5 **"Commission"** shall mean the San Mateo Health Commission.

1.6 **"Co-payment"** shall mean the fee prescribed by State statute and paid by most Members for certain Covered Services.

1.7 **"Correct Coding Initiative Edits"** shall mean the nationally recognized standards for editing claims for accurate coding and reporting of services.

1.8 **"Covered Services"** shall mean those healthcare services, equipment, supplies, and benefits, which are identified as benefits that the Member is entitled to receive under the Medi-Cal and Medicare Programs and described in each's program's Evidence of Coverage.

1.9 **"DHCS"** shall mean the California Department of Health Care Services.

1.10 **"DMHC"** shall mean the California Department of Managed Health Care.

1.11 **"Downstream Entity"** means any party that enters into an acceptable written arrangement below the level of the arrangement between a Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

1.12 **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of such severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the patient's health (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.13 **"Emergency Services"** " means medical screening, examination and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition or active labor exists, and if it does, the care, treatment, or surgery by a physician or other appropriately licensed personnel to evaluate or stabilize the Emergency Medical Condition, within the capability of the facility. Emergency Services also means an additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to evaluate or stabilize the psychiatric Emergency Medical Condition within the capability of the facility.

1.14 **"Evidence of Coverage"** shall mean the document issued by HPSM to Members that describes Covered Services and Non-Covered Services in the PLAN.

1.15 **"Facility Services"** shall mean services that include, but are not limited to, the following services when ordered by a Member's responsible physician or other qualified health practitioner and rendered to Members in accordance with the W&I Codes, applicable sections of 22 CCR for Skilled Nursing Facilities and intermediate care facilities, subject to any exclusions, limitation, exceptions, and conditions as may be set forth in the Agreement and as may be set

forth under Medi-Cal and Medicare guidelines.

1.16 **"First Tier Entity"** means any party that enters into a written arrangement with HPSM to provide administrative services or health care services for a Medicare and Medi-Cal eligible individual.

1.17 **"Health Plan of San Mateo" (HPSM)** shall mean the Health Plan governed by the San Mateo Health Commission.

1.18 **"Hospital(s)"** shall mean any licensed acute general care hospital.

1.19 **"Identification Card"** shall mean that card which is issued by HPSM to each covered Member and that bears the name and symbol of HPSM and contains: Member name, Member's identification number, Member's Provider and other identifying data. The Identification Card is not proof of Member eligibility.

1.20 **"Intermediate Care Facility" or "ICF"** shall mean a facility which is licensed as such by CDPH or is a hospital or Skilled Nursing Facility which meets the standards specified in 22 CCR, § 51212 and has been validly enrolled in the Medi-Cal program.

1.21 "**Intermediate Care Services**" shall mean the services provided in accordance with 22 CCR § 51120 and 22 CCR § 51334.

1.22 **"Interpreter"** shall mean a person fluent in English and in the necessary second language, who has been assessed and is qualified as someone who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language.

1.23 **"Limited English Proficient Member (LEP)"** is a Member who has an inability or limited ability to speak, read, write or understand the English language at a level that permits that individual to interact effectively with health care providers or HPSM employees.

1.24 **"Long Term Care Services" or "LTC"** shall mean any sub-acute level inpatient services, including custodial and extended care services, that do not reach the level of skilled nursing facility level of care.

1.25 **"LTC Per Diem Excluded Professional Services"** shall mean those professional services that are excluded from the Medi-Cal LTC per diem rates as published in the Medi-Cal guidelines.

1.26 **"Medical Interpreter"** shall mean a person fluent in English and in the necessary second language, who is qualified due to having been trained to provide language services at medical points of contact with language proficiency related to clinical setting

1.27 **"Medi-Cal Agreement"** shall mean the Agreement between the California Department of Health Care Services and HPSM, for the provision of Medi-Cal benefits to enrolled Members.

1.28 **"Medicare Agreement"** shall mean the Agreement between CMS, an agency of the United States Department of Health and Human Services, DHCS, and HPSM, for the provision of benefits to dually eligible Medicare-Medicaid Members.

1.29 **"Medi-Cal Rates"** shall mean the prevailing schedule of Medi-Cal rates of payment for Physician and non-Physician services in effect for the Medi-Cal Program at the time the services were rendered.

1.30 **"Medically Necessary"** means health care services which a Member requires as determined and ordered by a treating physician that are: (a) in accordance with generally accepted medical practices and standards prevailing at the time of treatment and (b) clinically appropriate in terms of type, frequency, extent, site, and duration.

1.31 **"Member(s)"** shall mean any person who is enrolled with HPSM who meets all the eligibility requirements for membership in HPSM's Medi-Cal and CareAdvantage programs. Member also includes a child born to a Member for the period of time required by State law and/or applicable Medi-Cal and Medicare Agreements.

1.32 **"Non-Medical Interpreter"** shall mean a person fluent in English and the necessary second language, who is qualified due to having been trained to provide language services at non-medical points of contact with language proficiency related to the specific setting or circumstance.

1.33 **"Nursing Facility"** shall mean a facility that is licensed as either a Skilled Nursing Facility, an Extended Care or Long Term Care Facility, or an Intermediate Care Facility.

1.34 **"Other Services"** shall mean Limited Services and other covered services including, without limitation: chiropractic, acupuncture, family planning services, occupational therapy, speech pathology, audiology, podiatry, physical therapy, durable medical equipment, medical supplies, and, other Covered Services not otherwise covered under any other Agreement with PLAN.

1.35 **"Overpayments"** shall mean the amount of money Provider has received in excess of the amount due and payable under any federal, state, or other health care program requirements.

1.36 **"Participating Hospital(s)"** shall mean a Hospital which has entered into an agreement with HPSM to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.37 **"Participating Physician(s)"** shall mean a Physician, who has entered into an Agreement with HPSM to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.38 **"Physician(s)"** shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law.

1.39 **"Physician Advisory Group"** shall mean the committee of Physicians practicing in San Mateo County who serve on the advisory group appointed by the Commission to provide input on the HPSM's quality program.

1.40 "**Preventive Care**" shall mean health care provided for prevention and early detection of disease, illness, injury or other health condition.

1.41 **"Primary Care Physician(s)"** or **"PCP"** shall mean a Participating Physician or Physician duly licensed in California and certified by the Medi-Cal and Medicare Programs and who has executed an Agreement with the PLAN to provide the services of a Providers.

1.42 **"Prior Authorization"** shall mean the process by which an authorization must be obtained from

HPSM prior to rendering the requested service to ensure reimbursement, subject to the Member's eligibility and covered benefits at the time of service.

1.43 **"Prior Authorization Request Form"** shall mean forms completed by Physicians to request a service/treatment that requires prior authorization by the HPSM.

1.44 **"Participating Hospital(s)"** shall mean any hospital which has entered into a general services contract with HPSM. The terms Participating and Contracting may be used interchangeably.

1.45 **"Provider Manual"** shall mean the Manual that contains HPSM's policies and procedures necessary for the proper operation of Participating Physicians and Participating Hospitals, as it relates to Members and all benefit plans.

1.46 **"Quality Program "** shall mean those processes, procedures and projects established by HPSM and designed to optimize the quality of care received by members as well as to improve the overall health status of members.

1.47 **"Referral"** shall mean the process by which Participating Physicians direct a Member to seek or obtain Covered Services from a health professional, hospital or any other Provider of Covered Services.

1.48 **"Referral Authorization Form" (RAF)** shall mean forms generated by the Provider identifying needs based on Member's clinical status. RAFs are used by the Provider to authorize referral to a provider who is not contracted with HPSM.

1.49 **"Referral Provider"** shall mean any qualified Physician, duly licensed in California and certified by the Medi-Cal and Medicare Programs and who has executed an Agreement with the PLAN, to whom the Provider may refer any Member for consultation or treatments

1.50 **"Referral Services"** shall mean any services which are not Primary Care Services and which are provided by Physicians on referral from the Provider or by the Provider.

1.51 **"San Mateo County"** shall also be referred to as "County".

1.52 **"Skilled Nursing Facility"** shall mean any institution, place, building, or agency which is licensed as a Skilled Nursing Facility by CDPH or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR § 51215 (except that the distinct part of a hospital does not need to be licensed as a Skilled Nursing Facility) and has been validly enrolled for participation as a Skilled Nursing Facility in the Medi-Cal and/or Medicare programs. The term "Skilled Nursing Facility" shall include the terms "skilled nursing home", "convalescent hospital", or "nursing home".

1.53 **"Skilled Nursing Facility Level of Care"** means that level of care provided by a Skilled Nursing Facility in accordance with 22 CCR § 51124 and 22 CCR § 51335, and meeting the standards for participation as a provider under the Medi-Cal and/or Medicare programs as set forth in 22 CCR § 51215.

1.54 **"State"** shall mean the State of California.

1.55 **Intentionally Left Blank.**

1.56 **"Surcharge"** shall mean an additional fee which is charged to a Member for a Covered Service which is not authorized by the State or contained in the Evidence of Coverage.

1.57 **"Threshold Language"** shall mean primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible Members residing in a county. Additionally, languages spoken by a population of eligible LEP Members residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county. Threshold languages in each county are designated by the California Department of Health Care Services.

1.58 **"Urgent Care"** shall mean health care for a condition which requires prompt attention.

1.59 **"Utilization Management (UM)"** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or Medically Necessary.

SECTION 2
QUALIFICATIONS

2.1 **Licensure and Certification**

Provider hereby represents and warrants that it is currently, and for the duration of this Agreement shall remain, licensed as a Distinct Part Nursing Facility by CDPH in accordance with applicable licensing provisions of Title 22 of the California Code of Regulations and the California Health and Safety Code, and validly enrolled in the Medi-Cal program. Additionally, Provider hereby represents and warrants that it is currently, and for the duration of this Agreement shall remain, certified under Title XIX of the Social Security Act, and if at any time during the duration of this Agreement, Provider provides Covered Services to Members under Title XVIII, Provider hereby represents and warrants that it shall be certified under Title XVIII at the time said services are provided.

If Provider receives written notice (1) from the State that the State intends to revoke or suspend or has revoked or suspended Provider's license; or (2) from the State that it will impose or has imposed suspension of admissions or denial of payment for new or all admissions, Provider shall notify PLAN of the receipt of such notice by the close of business of the next business day following Provider's receipt of such notice. Upon notice, Provider shall treat all Members consistent with other residents in the Nursing Facility including directives from the State on discharge planning and reimbursement rates.

In the event that Provider receives such a notice, PLAN may impose corrective action plans, and/or take other appropriate action in accordance with this Agreement and PLAN Policies based on the action taken by the State. Provider shall comply with all directives, requirements and/or obligations imposed by the State (and State and Federal law) related to continuity of care and discharge/transfer of Members in such cases. PLAN may take any other action that is consistent

with, and/or required by, such State action.

2.2 Participation Requirements

Provider understands that HPSM is prohibited by CMS and the California Department of Health Care Services from contracting with a provider who itself, its employees, managers, or subcontractors are excluded from participating in the Medicare or Medi-Cal programs. Provider warrants that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If Provider, any employee, manager, or subcontractor is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs. In the event Provider fails to comply with the above, HPSM reserves the right to require Provider to pay immediately to HPSM the amount of any sanctions that may be imposed on HPSM by CMS or DHCS for violation of this prohibition.

SECTION 3
PHYSICIAN/PATIENT RELATIONSHIP

3.1 Provider Directory

HPSM will enter the name of each Provider signing a Medical Services Agreement onto a list of Providers from which Members may seek services. Such a list may contain the following information concerning the Provider in order to allow for an appropriate Provider selection procedure:

- Name
- National Provider Identification
- Gender
- Address
- Days & Hours of Operation
- Phone Number
- Email Address
- Type of Provider
- Specialty
- Medical License Number
- Hospital Affiliation
- Board Certifications
- Provider/Medical Group
- Accepting New Pts
- Provider Languages
- Clinical Staff Languages
- Office Skilled Medical Interpreter Languages

3.1.1 Provider shall update HPSM when any of the above information in Provider's listing changes, or upon HPSM's request for updated information.

3.1.2 Provider shall inform HPSM within five (5) business days when either of the following occurs:
a) The Provider is not accepting new patients, or
b) If the Provider had previously not accepted new patients, the Provider is currently accepting new patients.

3.3 Direct Contact and Coverage Plan

Provider shall be responsible for organizing a pattern of supportive medical resources, so that Members may be appropriately served by medical advice and supervision seven (7) days each week and twenty-four (24) hours per day.

3.4 Eligibility Verification

Provider shall verify the eligibility of Members who present themselves at the time of service. Provider may make such verification by contacting HPSM using the verification options as described in the Provider Manual.

3.5 Discrimination Prohibited

Provider shall not differentiate or discriminate in the treatment of Members, nor shall he/she discriminate on the basis of sex, race, creed, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental or developmental disability, age, medical condition or mental status, except as limited by the scope of services he or she is qualified to provide. Provider shall render health services to Members in the same manner, with the same dignity and respect, in accordance with the same standards and within the same time availability as offered his or her other patients consistent with existing medical/ethical/legal requirements for providing continuity of care to any patient.

3.6 Personnel and Facilities

Throughout the term of this Agreement and subject to the conditions within the Agreement, Provider shall use best efforts to maintain current facilities, equipment, supplies, office personnel, patient service personnel, allied health personnel, as Provider, in his/her/its reasonable discretion, may employ, to meet Provider's obligations under this Agreement.

3.7 List of Participating Physicians

HPSM shall update its online provider directory periodically to include an updated list of all Participating Physicians.

SECTION 4
SERVICES TO BE PROVIDED AND UTILIZATION MANAGEMENT

4.1 Management of Care

It shall be the responsibility of the Provider to determine what care is necessary and appropriate and to manage the care provided and authorized for Members in accord with professionally recognized standards of care and with proper attention to the need for containment of costs, choosing the lowest cost service that meets the Member's medical needs, as per California Administrative Code, Title 22. Provider may freely communicate with Members who are patients about their treatment, regardless of benefit coverage and limitations. Except as otherwise provided herein, it shall be the responsibility of the Provider to provide or authorize a mix of any Covered Services for each Member which seems at that time to be necessary for the control and prevention of disease, illness, or disability. The Provider shall abide by PLAN's case management policies and procedures and the protocols outlined in the Nursing Facility Protocols of this Agreement. In addition, there are specific items or services that require HPSM prior authorization (e.g. durable medical equipment, certain medications, specific procedures, etc.) before rendering the service in order for the service to be reimbursed. The Provider, or the Referral Provider to whom the Provider sends a Member, shall work together to ensure that appropriate prior authorization is obtained from HPSM where necessary, to assist the Member in getting necessary care as expeditiously as possible

4.2 Consultation with the CMO

Provider may at any time seek consultation with HPSM's CMO on any matter concerning the treatment of the Member.

4.3 Covered Services

Provider shall provide Covered Services to each Member when they are medically necessary and appropriate for the care of that Member.

4.4 Prior Authorization

Certain Covered Services require prior authorization from HPSM prior to rendering the Covered Service to ensure reimbursement. Except for Emergency Services, HPSM shall not be obligated to pay Provider for any services provided to a Member unless Provider obtains prior authorization for services in accordance with HPSM's prior authorization procedures set forth in HPSM's Provider Manual. Nothing expressed or implied herein shall require Provider to provide to the Member, or order on behalf of the Member, Covered Services which, in the professional opinion of Provider, are not medically necessary. It should be noted that when Provider determines that a Member-requested service is NOT medically necessary, then the Provider shall inform the Member of his/her HPSM grievance and appeal rights if the Member does not agree with Provider's decision.

Provider shall provide HPSM, along with a request for prior authorization, access to medical records to the extent necessary for HPSM to make the appropriate decision regarding authorization.

4.5 Medical Decision-Making

It is not the intention of HPSM to use the prior authorization and approval provisions set forth herein as a device by which it may practice medicine. Rather, the authorization and approval procedures are used to make benefit and coverage determinations so that the Member and Participating Physicians know, before a course of treatment is initiated, that such course of treatment is covered in full, in part or not at all. If a course of treatment is not covered, e.g., not approved, such determination is not intended to suggest that the course of treatment is medically inappropriate. HPSM will notify Provider of a denial of coverage; however, Provider may choose to provide such course of treatment, so long as prior written notice is given to the Member that the course of treatment is not covered by HPSM.

However this Section 4.5 does not limit or restrict the right of HPSM to require prior authorization prior to the rendering of services and impose utilization controls according to Section 4 of this Agreement. Except in emergencies, Provider shall not be entitled to reimbursement for any services provided to a Member unless Provider has obtained the necessary authorization from HPSM in accordance with HPSM's procedures.

4.6 Imposition of Controls if Necessary

The Provider recognizes the possibility that HPSM may be required to take action requiring consultation with HPSM's CMO or with other Physicians prior to authorization of services or supplies or to terminate this Agreement. In the interest of Program integrity or the welfare of Members, HPSM may introduce utilization controls as may be necessary at any time and without advance notice to the Provider. All utilization controls introduced by HPSM are to encourage appropriate utilization and discourage underutilization but not to encourage barriers to care and service or underutilization. In the event of such change, the change may take effect immediately upon receipt by the Provider of notice from the HPSM's CMO. However, the Provider shall be entitled to appeal such action to the Physician Review Committee, and, if still dissatisfied, then to the Commission.

4.7 Services for Members with Disabilities

4.7.1 Any HPSM Member with a physical or intellectual disability needs to be accommodated by Providers to the best of their ability. Appropriate access (e.g. for wheelchair users), arrangements for sign language interpreters (available through HPSM) and so forth needs to be made available for Members where necessary.

4.7.2 The Provider may request assistance from HPSM in meeting this requirement.

4.8 **Patient Rights**

Provider or any subcontractor performing the obligations of the Provider pursuant to the terms of this Agreement shall adopt and post in a conspicuous place a written policy on patient's rights in accordance with Section 70707 of Title 22 of the California Code of Regulations.

Linguistic Services

4.8.1 Provider shall address the special health care needs of all Members. Provider shall ensure equal access and participation in Medi-Cal and Medicare programs to Members with Limited English Proficiency (LEP) or hearing, speech or vision impairment through the provision of bilingual services. Provider shall in policies, administration, and services practice the values of: (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, fostering in staff and Physician attitudes and interpersonal communication styles which respect Member's cultural backgrounds and are sensitive to their special needs; and (e) referring Members to linguistically and culturally sensitive programs.

4.8.2 Interpreter Services for Limited English Proficient (LEP) Members

The Provider shall ensure equal access to health care services for all LEP Members through the utilization of qualified interpreter services at medical (advice, face-to- face or telephone encounters), and non-medical (appointment services, reception) points of contact. Members should not be subject to unreasonable delays in receiving appropriate interpreter services, when the need for such services is identified by Provider or requested by the Member.

a) Qualified Interpreter services shall be furnished during encounters with Physicians (Physician extenders, registered nurses, or other personnel) who provide medical or health care advice to Members, when identified by Provider or requested by a Member.

- Qualified Interpreter services may be obtained through the HPSM (24) hour telephone language line service, on-site trained interpreters, bilingual or multilingual Physicians. NOTE: The use of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and is only to be used if a Member insists on this after provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

- HPSM contracts with a qualified telephonic interpreter service to assist Provider in complying with this Section. Provider is encouraged to use this service with HPSM members if there is no staff availability of language assistance to the member.

b) Provider must document the patient's preferred language, the request/type of interpreter services provided or refusal of language interpreter services by a Limited English Proficient (LEP) Member in the medical record.

c) Provider should utilize bilingual staff and/or the HPSM's interpreter services

to ensure that Limited English Proficient members receive timely interpretation services at no charge and at all points of contact. This ensures that members are not subjected to unreasonable delays in receiving services.

4.8.3 Additional Linguistic Services for Threshold Language Members

Threshold languages in each county are designated by the Department of Health Care Services. These are primary languages spoken by the LEP population groups meeting a specific numeric threshold or concentration standard. The threshold language(s) for San Mateo County is(/are) published annually.

In addition to interpreter services for LEP Members, as stated in Section 4.8.2, the Provider shall provide the following services for Members whose language proficiency is in a threshold language.

a) Translated signage
b) Translated written materials
c) Referrals to culturally and linguistically appropriate community service programs
d) Information on how to file a grievance and the ability to file a grievance in a non-English language

The Provider may request assistance from HPSM in meeting these requirements. Provider shall comply with all of the requirements related to the provision of linguistic and culturally sensitive services in accordance with this Agreement and PLAN Policies.

Provider shall comply with the standards developed pursuant to California Health and Safety Code Section 1367.04 and shall cooperate with PLAN by providing any information necessary to assess Provider's compliance with California Health and Safety Code Section 1367.04.

4.9 **Hospital Admission Authorization**

Provider shall admit Members only to a Participating Hospital unless an appropriate service is unavailable or in an Emergency. Unless HPSM informs Provider in writing to the contrary, Provider may not admit a Member to any hospital on a non-Emergency basis without first receiving the prior written authorization of HPSM's Medical Director or his/her designee.

4.10 **Exclusions.** In addition to those services not covered under the California Medi-Cal Program, the PLAN shall not make payment for the following services if they are provided to Members:

4.10.1 Services which in the judgment of the Provider (for services requiring referral) and/or the HPSM's CMO (for services requiring prior authorization), are not medically necessary or appropriate for the control and prevention of health related illness, disease, or disability.

4.10.2 Services reimbursed by long term in-home waivered services, Multi-Senior Services, Community-Based Adult Services, Adult Day Health Services, specialty mental health services (except for outpatient pharmaceuticals and laboratory services prescribed by a non-psychiatrist Provider or mental health services specifically related to a medical, not psychiatric diagnosis).

4.10.3 Other services as may be determined by HPSM, and as noticed to the participating Providers.

4.11 **Medi-Cal and Medicare Restrictions**

4.11.1 Services provided shall be subject to the HPSM's most current Medi-Cal Agreement with the State of California and Medicare Agreement with CMS and the State of California.

4.11.2 Services provided shall be subject to the limitations, policies, and procedures of the Medi-Cal and Medicare programs, as applicable.

4.12 **Formulary**

Prescriptions payable by HPSM shall be subject to the restrictions on the State's Medi-Cal Formulary and the CareAdvantage Formulary, except where Formulary changes are authorized by HPSM in accordance with its Medi-Cal Agreement and its Medicare Agreement. Provider is expected to use formulary medications and generic medications preferentially, when clinically appropriate.

4.13 **Intentionally Left Blank.**

4.14 **Utilization Data**

To the extent that Provider is responsible for the coordination of care for Members, PLAN shall share with Provider requested utilization data that DHCS has provided to PLAN that is relevant to the care of the Members seen by Provider and to the extent necessary for care coordination. PLAN shall have sole discretion to determine the relevance of Member utilization data requested by Provider and reserves the right to limit the scope of any such data request as appropriate. Provider shall receive the utilization data provided by PLAN and use it as the Provider is able for the purpose of Member care coordination. Any utilization data exchange between PLAN and Provider, and its subcontractors and designees, shall comply with the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR Part 160, 162, and 164, and the Health Information Technology for Economic and Clinical Health Act (HITECH) requirements, the confidentiality provisions of this Agreement, and PLAN policies regarding privacy and confidentiality

SECTION 5
COMPLIANCE WITH LAWS AND REGULATIONS

5.1 **Compliance with Laws, Regulations, and Contractual Obligations.**

Provider understands that HPSM oversees and is accountable to the State of California, DHCS, DMHC and CMS for any functions or responsibilities that are described in the laws, regulations, and contractual obligations applicable to Medicare and Medi-Cal health plans, and that HPSM may be held accountable by the State of California, DHCS, DMHC, and CMS if PROVIDER and/or any of his/her Downstream Entities (including their agents or subcontractors providing services under this Agreement) violate the provisions of such law, regulations, and

contractual obligations or HPSM's policies in the performance of this Agreement. In furtherance of the foregoing, PROVIDER shall comply with and ensure that any of his/her Downstream Entities (including, their agents or subcontractors providing services under this Agreement) also comply with applicable state and federal laws, regulations, reporting requirements, applicable accreditation requirements, contractual obligations and CMS, DHCS, DMHC instructions, and will cooperate, assist, and provide information, as requested. PROVIDER agrees to the following provisions of this Section 5 to the extent such provisions are required to ensure PROVIDER's compliance with state or federal law or regulations, contractual obligations, and applicable accreditation requirements. PROVIDER shall cooperate in, assist in, and provide information as requested for audits, evaluations, and inspections performed by any and all applicable state and federal agencies and applicable accreditation organizations.

PROVIDER shall comply with the applicable reporting requirements in 42 CFR §422.516 and the requirements in 42 CFR §422.310 for submitting data to CMS for the purposes of reporting costs, utilization, quality, enrollee health status, and fiscal soundness to CMS, as well as of enabling CMS to characterize the context and purpose of each item and service provided to a Member under this Agreement for accurate application of CMS's risk adjustment payment model. PROVIDER also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data. Provider shall submit to PLAN complete, accurate, reasonable, and timely provider data needed by PLAN in order to meet its provider data and encounter data reporting requirements to DHCS. Data provided shall include, without limitation, health care services delivery encounter data and claims data in the format and timeline required by PLAN and DHCS.

PROVIDER understands and agrees that HPSM is responsible for the monitoring and oversight of all duties of PROVIDER under this Agreement, and that HPSM has the authority and responsibility to: (i) implement, maintain and enforce HPSM's policies governing PROVIDER's duties under this Agreement; (ii) conduct audits, inspections and/or investigations in order to oversee PROVIDER's performance of duties described in this Agreement; (iii) require PROVIDER to take corrective action if HPSM, any applicable federal or state regulator, or applicable accreditation organization determines that corrective action is needed with regard to any duty under this Agreement; and/or (iv) revoke the delegation of any duty, if PROVIDER fails to meet HPSM standards in the performance of that duty. PROVIDER shall use reasonable efforts to cooperate with HPSM in its oversight efforts and shall take corrective action, as HPSM determines necessary and applicable to comply with the laws, applicable accreditation agency standards, and HPSM policies governing the duties of PROVIDER or the oversight of those duties.

If PROVIDER gives confidential information including protected health information, as defined in 45 CFR §164.501, received from HPSM, or created or received by PROVIDER on behalf of HPSM, to any of his/her Downstream Entities, including agents and subcontractors, PROVIDER shall require the Downstream Entity, including agents and subcontractors, to agree to the same restrictions and conditions that apply to PROVIDER under this Agreement. PROVIDER shall be fully liable to HPSM for any acts, failures or omissions of the Downstream Entity, including agents and subcontractors, in providing the services as if they were PROVIDER's own acts, failures or omissions, to the extent permitted by law. PROVIDER further expressly warrants that its agents will be specifically advised of, and will comply in all respects with the terms of this Agreement.

PROVIDER agrees that Covered Services are being paid for in whole or in part, with federal funds and, therefore, payments for such Covered Services are subject to laws applicable to individuals or entities receiving federal funds. PROVIDER agrees to comply with all applicable Federal laws, regulations, reporting requirements, CMS instructions, and with HPSM's contractual obligations to CMS, including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR Part 160, 162, and 164, and the Health Information Technology for Economic and Clinical Health Act (HITECH) requirements, and to require any Downstream Entity, including agents and subcontractors, to comply accordingly.

PROVIDER agrees to permit the California Department of Managed Health Care ("DMHC"), CMS and the U.S. Department of Health and Human Services ("HHS") to conduct on-site evaluations of PROVIDER periodically in accordance with the current state and federal laws and regulations and to comply with the agency's recommendations, if any. PROVIDER shall give CMS, DMHC, HHS, the U.S. General Accounting Office ("GAO"), the Comptroller General, any Peer Review Organization ("PRO"), Quality Improvement Organization ("QIO"), or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of contractors, or subcontractors for a minimum of ten (10) years from the final date of the contract period or the date of completion of the last audit by HHS or the Comptroller General, or their respective designee, whichever is later, unless further extended for the reasons specified in Title 42, Code of Federal Regulations ("42 CFR"), §422.504(e)(4), or its superceding regulation. Provider shall comply with all monitoring provisions of PLAN contracts, including but not limited to PLAN's Medi-Cal Agreement, and any monitoring requests by DHCS.

PROVIDER agrees to include the requirements of this Section 5 in its contracts with any Downstream Entity, including agents and subcontractors. This Agreement shall be governed by and construed in accordance with all laws and applicable regulations governing the contract between DHCS and PLAN. Provider shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program. PLAN shall inform Provider of prospective requirements added by DHCS to PLAN's contract with DHCS before the requirement's effective date. Provider shall comply with the new contractual requirements within 30 days of the effective date, unless otherwise instructed by DHCS, to the extent possible.

5.2 **Compliance with Governing Board Standards**

PROVIDER shall at all times during the term of this Agreement comply with, and have any of its Downstream Entities, including agents and subcontractors, comply with all applicable federal, state and municipal laws, and all applicable standards, rules, and regulations of the appropriate California governing boards for healthcare services, including but not limited to the Medical Board of California, the California Board of Osteopathic Examiners, the American Medical Association, and the California Medical Association.

5.3 **Compliance with HPSM Policies, Procedure, and Programs**

PROVIDER shall cooperate and participate with HPSM in Quality Assessment, Quality Improvement and Utilization Review programs, Grievance and appeals procedures and all HPSM efforts undertaken necessary for HPSM to comply with federal and state legal, regulatory, and contractual requirements and applicable accreditation requirements. PROVIDER shall comply with and, subject to PROVIDER's right to dispute, shall be bound by such utilization review and quality programs.

PROVIDER understands that HPSM has certain obligations including the credentialing of Providers, and that HPSM will have the right to oversee and review the quality of care and services provided to Members by PROVIDER. PROVIDER agrees to be accountable to cooperate and comply with HPSM whenever HPSM imposes such obligations on PROVIDER. Obligations may include, but may not be limited to: on- site review, member transfer from or to referring facilities, cooperation with Healthcare Effectiveness Data Information Sets ("HEDIS") measurements and other internal and external quality review and improvement programs, and risk adjustment programs.

PROVIDER agrees to comply with HPSM's quality improvement program. HPSM's quality improvement program shall be developed in consultation with its Participating Physicians to ensure that practice guidelines of quality improvement and quality management pursuant to CMS regulations and instructions are met. The program may include audits, reviews and surveys performed from time to time upon the request of HPSM.

PROVIDER and its Downstream Entities, including agents and subcontractors, shall fully cooperate with and participate in HPSM's quality improvement program and procedures as described in the Provider Manual. PROVIDER shall immediately notify HPSM of those Members and cases which fall within the catastrophic and targeted case management guidelines set forth in the Provider Manual and shall cooperate with HPSM's case management program for catastrophic and targeted cases. PROVIDER and Participating Physicians shall comply with HPSM's Medical Policy. PROVIDER shall comply with and accept as final, the decisions of the HPSM's quality improvement program, or pending resolution of any dispute through the dispute resolution process, the decisions made through that process.

Although HPSM's quality improvement activities are not delegated to PROVIDER, as defined by HPSM's Medi-Cal Agreement, HPSM may delegate, in whole or in part, such quality improvement activities to PROVIDER.

SECTION 6
PAYMENTS

6.1 **Conditions for Payment**

HPSM will reimburse Provider for services provided to Members in accordance with this Section 6, if the following conditions are met:

6.1.1 The Member was eligible at the time the services were provided by Provider;

6.1.2 The service was a Covered Services according to regulations in effect at the time of services; and

6.1.3 Prior authorization was received by HPSM, if required and subject to Section 4.

6.2 **Billing Procedures**

Provider shall submit initial claims within three hundred sixty five (365) days following the date of discharge (for Inpatients) or date of services (for Outpatients). Claims received after one hundred and eighty (180) days from the date Covered Services are rendered are subject to the Medi-Cal and Medicare reduced reimbursement structure as set forth in the Provider Manual. This requirement is not applicable to TPL claims or those subject to Coordination of Benefits.

6.3 **Form**

Provider shall bill using the guidelines set forth in the Provider Manual. Provider shall submit claims using the industry standard billing forms using a HIPAA compliant and approved electronic format.

6.4 **Payment**

HPSM shall process claims in accordance with Health and Safety Code Section 1371 and the Medicare Managed Care Manual. Medi-Cal reimbursement is set forth in Attachment B-1 to this Agreement. CareAdvantage reimbursement is set forth in Attachment B-2 to this Agreement.

6.5 **Correct Coding Initiative (CCI) Edits**

HPSM will utilize current CCI edits unless superseded by existing Medi-Cal or Medicare payment methodologies.

6.6 **Intentionally Left Blank.**

6.7 **Member Liability**

The Provider shall look only to the HPSM for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services, including but not limited to, nonpayment by HPSM, the HPSM's insolvency, dissolution, bankruptcy or breach of the Agreement. The Provider shall not bill, charge, surcharge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against any Member for any debts owed by HPSM under this Agreement for Covered Services payable by the HPSM. The Provider shall report to HPSM in writing all surcharges and co-payments paid by Members to the Provider. If HPSM receives notice of any

surcharges upon any Member, it shall be empowered to take appropriate action. This provision shall not prohibit billing and collecting from Members for services which are not Covered Services, provided that prior to rendering of a non-covered service, Provider supplies to the Member a written notice informing them of financial responsibility for said services and Member must formally accept financial responsibility in writing, prior to rendering of a non-covered service.

The obligations set forth in this Section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between the Provider and the Member or any persons acting on their behalf.

6.8 **Hold Harmless**

The Provider agrees to hold harmless the Member and the State in the event the HPSM cannot or will not pay for services performed by the Provider pursuant to the terms of the Agreement.

6.9 **Coordination of Benefits (COB) Obligations**

Provider agrees to perform COB with HPSM and to bill and collect from other plans and other financially responsible entities the charges they are responsible for paying when they are the primary payer. Except as otherwise required under applicable federal or state law or regulation (a) when HPSM is the primary payer under applicable coordination of benefit principles, HPSM agrees to pay in accordance with this Agreement; and (b) when HPSM is secondary under said principles, the primary is not Medicare, and payment from the primary payer is less than the total compensation due to Provider without coordination of benefits, then HPSM will pay Provider the amount of the difference between the amount paid by the primary payer and the total compensation due to Provider as required using Medicare and Medi-Cal billing and payment guidelines not to exceed the cost sharing portion assigned by the primary insurer. If Medicare is the primary insurer, HPSM will adopt the lesser of the applied allowable and Medicare's amount and subtract Medicare's payment from the applied allowable to determine the amount due to Provider.

6.10 **Third Party Liability (TPL) and Liens**

Provider shall report to HPSM, when Provider discovers that Covered Services rendered either directly by Provider or through the instrumentality of Provider's subcontractor are covered, in whole or in part, by workers' compensation, tort liability, or casualty insurance. Nothing contained herein shall be construed to reduce or modify HPSM's obligation to reimburse Provider for Covered Services rendered to a Member, subject to Section 4 of this Agreement.

In no event will Provider assert any lien against any third party recovery sought by or on behalf of the Member. Any and all rights to receive reimbursement pursuant to third party liens shall be a right solely of HPSM or DHCS (as set forth in the Medi-Cal and Medicare Agreements). Provider shall provide to HPSM all information in its possession which is necessary to permit HPSM to report Workers' Compensation, tort liability, casualty insurance, and any other third party

liability information to DHCS as may be required by the Medi-Cal and Medicare Agreements.

6.11 **Overpayments**

Provider shall furnish and be paid for Covered Services provided to Members in a manner consistent with and in compliance with all applicable laws, regulations, and guidance, including the contractual obligations of HPSM under federal, state, or county health care programs, and with HPSM policies and procedures.

Provider shall promptly notify HPSM of any Overpayment or other incorrect payment of which Provider becomes aware and shall refund to HPSM, within 30 days after identification, any amount paid to Provider in excess of that to which Provider is entitled under this Agreement. It is Provider's responsibility to maintain an effective billing and reconciliation system to prevent, detect in a timely fashion, and take proper corrective action for program overpayments.

An Overpayment may be the result of non-adherence to federal, state, or county health care program requirements, errors by HPSM personnel, payment processing errors by HPSM or designated payers, or erroneous or incomplete information provided by Provider to HPSM. HPSM shall recover Overpayments, amounts paid to Provider for services that do not meet the applicable benefit or medical necessity criteria established by HPSM, services not documented in Provider's records, any services not received by Member, non-Covered Services, or for services furnished when Provider's license was lapsed, restricted, revoked, or suspended.

HPSM reserves the right to review claims in either a pre-payment or post-payment setting to ensure accuracy, medical necessity, appropriate documentation in medical record, and that regulatory guidelines are followed. Provider is required to cooperate with requests, either from HPSM or a vendor designated by HPSM, for additional claims information, itemized bills, and medical records on a timely basis. Prior authorization does not prohibit HPSM from performing post-service claims review.

HPSM shall recover in accordance with applicable law any Overpayment or other incorrect payment made under this Agreement by offset of the excess amount paid to Provider against current or future amounts due Provider, or by request of an immediate refund by Provider. The Fraud Enforcement and Recovery Act of 2009 (FERA) and the Patient Protection and Affordable Care Act of 2010 (PPACA) make an overpayment which is retained for over 60 days after its identification an obligation which is sufficient for liability under the False Claims Act. False Claims Act liability includes triple damages and significant fines. PPACA also makes unpaid overpayments grounds for Medicaid/Medi-Cal program exclusion.

In the event HPSM determines that it has overpaid a claim, HPSM shall notify the Provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which HPSM believes the amount paid on the claim was in excess of the amount due.

If the Provider does not contest HPSM's notice of overpayment, the Provider shall have 30 working days from the receipt of the notice to reimburse HPSM the amount of the overpayment. If the

Provider contests HPSM's notice of overpayment, the Provider shall have 30 working days from the receipt of the notice to send written notice to HPSM stating the basis upon which the Provider believes that the claim was not overpaid. HPSM will receive and process the contested notice of overpayment of a claim as a provider dispute under HPSM's provider dispute processes.

If Provider does not contest the overpayment and does not reimburse HPSM according to the above timelines, then HPSM may offset the uncontested overpayment against payments made to the Provider's current or future claim submissions. In the event that an overpayment of a claim or claims is offset against Provider's current or future claim or claims, HPSM shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific claim or claims.

HPSM shall take corrective action on Overpayments. Provider shall take remedial steps to correct the underlying cause of the Overpayment within 60 days of identification of the overpayment or within such additional time as may be agreed to by HPSM. The corrective action shall include correcting the underlying cause of the Overpayment and taking remedial action to prevent the Overpayment from recurring.

Notwithstanding the above, notification and repayment of any overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by HPSM shall be handled in accordance with such policies and procedures.

6.12 Coverage and Payment for Emergency Services

PLAN is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the plan. PLAN may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical condition. Further, PLAN may not deny payment for treatment obtained when a representative of the PLAN instructs the enrollee to seek Emergency Services.

PLAN may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room Provider, HOSPITAL, or fiscal agent not notifying the Member's Primary Care Provider or the PLAN of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

PLAN is financially responsible for post- stabilization services obtained within or outside PLAN's network that are pre-approved by a plan provider or other entity representative.

PLAN is also financially responsible for post-stabilization care services obtained within or outside PLAN's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if PLAN does not

respond to a request for pre-approval within 1 hour; PLAN cannot be contacted; or PLAN's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a PLAN physician is not available for consultation. In this situation, PLAN must give the treating physician the opportunity to consult with a PLAN physician and the treating physician may continue with care of the patient until a PLAN physician is reached or one of the criteria of 42 CFR §422.113(c)(3) is met.

PLAN's financial responsibility for post-stabilization care services it has not pre-approved ends when a PLAN physician with privileges at the treating hospital assumes responsibility for the Member's care, a PLAN physician assumes responsibility for the Member's care through transfer, a PLAN representative and the treating physician reach an agreement concerning the enrollee's care; or the enrollee is discharged.

SECTION 7
TERM, TERMINATION, AND AMENDMENT

7.1 Term

This Agreement shall be for a term of one (1) year from the Effective Date and thereafter, shall be automatically renewed for subsequent terms of one (1) year each. This Agreement may be terminated or amended as hereinafter provided.

7.2 Termination

This Agreement may be terminated by either party as follows:

7.2.1 If terminated by the Provider, termination shall require sixty (60) days advance written notice of intent to terminate, transmitted by the Provider to HPSM by Certified U.S. Mail, Return Receipt Requested, addressed to HPSM, as provided in Section 12.3.

7.2.2 If termination is initiated by HPSM, the date of such termination shall be set by consideration for the welfare of Members and necessary allowance for notification of Members, and the Provider shall be notified as hereinafter provided. HPSM may terminate this Agreement at any time and for any reason upon thirty (30) days advance written notice of intent to terminate, transmitted by HPSM to the Provider, as provided in Section 12.3.

7.2.3 Conditions for Termination by HPSM

a) HPSM shall terminate this Agreement effective immediately in the following situations: change in licensure status resulting in restricted licensure or loss; loss of Medi-Cal and/or Medicare Provider certification; medical staff privileges at a Participating Hospital are denied or reduced; professional liability insurance coverage or any other insurance

required under this Agreement is reduced or no longer in effect; change in licensure status to prescribe controlled substances resulting in restricted licensure or loss; any sanctions imposed against Provider under Medi-Cal or Medicare programs; any other professional disciplinary action or criminal action of any kind against Provider that is initiated, in progress, or completed during the term of this Agreement

b) HPSM may terminate this Agreement in the following situations: charges to Members by Provider other than authorized co-payments; the Provider's failure to comply with HPSM's utilization control procedures; the Provider's failure to abide by HPSM or Commission decisions; failure to comply with Corrective Action Plan requirements; failure to provide adequate level of service to Members as demonstrated by inadequate hours of operation; failure to provide minimum scope of services in care delivery; or repeated (two or more) grievances filed by Members that are not adequately addressed in spite of HPSM offers of assistance. HPSM must provide 30 days advance written notice of intent to terminate this Agreement and Provider has within the 30-day notice timeframe to correct the deficiencies outlined in Section 7.2.3(b) that serve as a basis for HPSM's decision to terminate the Agreement. If Provider is unable to correct the deficiency within the 30-day notice timeframe, then HPSM may terminate this Agreement immediately. This 30-day period to cure deficiencies shall not apply to those situations triggering immediate effectiveness of termination listed in 7.2.3(a).

7.2.4 This Agreement shall terminate automatically on the date of termination of HPSM's Medi-Cal or Medicare Agreement. HPSM shall notify Provider as soon as is practical upon receiving or sending such notice of termination.

7.2.5 In the event there are (1) changes effected in the HPSM's contract with the State of California, or (2) changes effected in the Medi-Cal Program, or changes in Federal laws governing the Medi-Cal Program, or (3) changes in the Federal Medicare Program and/or substantial changes under other public or private health and/or hospital care insurance programs or policies which will have a material detrimental financial effect on the operations of Provider or HPSM, Provider or HPSM may terminate this Agreement upon providing the other party with thirty (30) days prior written notice. In any case where such notice is provided, both parties shall negotiate in good faith during such thirty (30) day period in an effort to develop a revised Agreement, which, to the extent reasonably practicable, under the circumstance, will adequately protect the interests of both parties in light of the governmental program or private insurance policy changes which constituted the basis for the exercise of this termination provision.

7.3 Member Notification

HPSM will immediately notify all Members if Provider is terminated or terminates.

7.4 Assignment

Neither the PLAN nor Provider shall assign this Agreement without the prior written consent of the other party and DHCS.

7.5 Amendment

7.5.1 Amendment by Mutual Agreement

This Agreement may be amended at any time by mutual agreement of the Parties and subject to the requirements of Section 12.18 of this Agreement. Any such amendment must be in writing, dated and signed by the Parties and attached to this Agreement.

7.5.2 Knox-Keene Amendments

The terms of this Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended, and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind the Parties as appropriate, whether or not provided herein. If the Director of Department of Managed Health Care or his/her successor requires further amendments to this Agreement, HPSM shall notify the Provider in writing of such amendments. The Provider will have thirty (30) days from the date of the HPSM's notice to reject the proposed amendments by written notice of rejection to HPSM. If HPSM does not receive such written notice of rejection within the thirty (30) day period, the amendments shall be deemed accepted by and binding upon the Provider. Amendments for this purpose shall include, but not be limited to, material changes to the HPSM's Utilization Management, Quality Assessment and Improvement and Grievance programs and procedures and to the health care services covered by this Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and the duties of the parties herein shall be governed by California law.

7.6 Transfer of Care

Upon termination of this Agreement for any reason or in the event Provider terminates its agreement with any subcontractors who provide Covered Services to Members, the Provider shall assist HPSM in the transfer of care of Members, and shall ensure, to the extent possible, continuity of care.

Provider shall continue to provide Covered Services to any Member who is receiving Covered Services from Provider on the effective termination date of this Agreement until the Covered Services being rendered to the Member by Provider are completed, consistent with existing medical, ethical, and legal requirements for providing continuity of treatment to a patient, the episode of illness then being treated for is completed, Member is discharged from the Nursing Facility, or HPSM makes reasonable and medically appropriate provisions for the assumption of such Covered Services by another Participating Physician.

Upon termination of this Agreement, HPSM shall have access to Member medical records either electronically or in paper form.

7.7 Provider Rights Upon Termination

Issues raised about a Provider's performance shall be considered initially by HPSM's CMO, who shall have the broad discretion to determine how to proceed as delegated by the Commission. His/her options shall include but not be limited to maintaining a record of the matter without further investigation or action; referring the matter to HPSM's Peer Review Committee (PRC) or any other quality oversight body for investigation and the preparation of a report to the Chief Executive Officer (CEO) and/or the Commission.

Effective immediately upon notice to the Provider, pending reconsideration and action by the PRC or any other quality oversight body, the Chair of the PRC, or the CMO or CEO may summarily reduce or suspend the Provider's privilege to provide patient care services, in instances where there may be immediate danger to the health of any individual. The Committees may perpetuate the reduction or suspension pending action by the Commission.

In the event that HPSM decides to deny, reduce, suspend, or terminate a Provider for a medical disciplinary cause or reason, the Provider shall be entitled to a hearing with representatives from HPSM's Peer Review Committee.

7.8 Notice of Termination and Amendments to DHCS

PLAN shall provide notice to DHCS in the event this Agreement is terminated or amended, subject to the limitations outlined in this Section 7.8. Notice shall be properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. PLAN shall provide notice to DHCS in the event that an amendment to this Agreement constitutes a material change in the rights and obligations of the parties under state or federal law, with the exception of amendments relating to compensation, services, term, or business operations.

SECTION 8
MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 Medical Record

The Provider shall maintain for each Member who has received services, a legible medical record, kept in detail and accuracy consistent with appropriate medical and professional practice, which permits effective internal professional review and external medical audit process and which facilitates an adequate system for follow-up treatment and maintained in a manner as required by state and federal law and regulations, including but not limited to, Sections 70747-70751 of Title 22 of the California Code of Regulation and Section 51476 of Title 22 of the California Administrative Code. The Provider shall maintain such records for at least ten (10) years from the final date of a particular contract period between HPSM and Provider from the date of completion of any audit, or from the date the service was rendered, whichever is later. Provider will ensure that unauthorized individuals are unable to gain access to or alter physical or electronic patient records. The negligent disposal or destruction of medical records is

prohibited.

Provider shall complete the attached Attachment C of this Agreement which shall document information relating to Provider's maintenance of medical records including, the format, storage mechanism, and name of the custodian of the medical records. In the event that Provider changes the location of storage of medical records, there is a change in the custodian of medical records, or there is a change in format of the records, Provider shall notify HPSM of such changes within thirty (30) business days.

8.2 **Inspection Rights**

8.2.1 The medical records described in this Section 8 shall be and remain the property of Provider and will not be removed or transferred from Provider's possession and/or facility except in accordance with applicable laws and general policies of Provider. The Provider shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement, available for purpose of an audit, inspection, evaluation, examination, copying, and/or monitoring activities by authorized state or federal agencies and agencies' authorized representatives:

8.2.2 By the PLAN, or any entity designated by the PLAN (e.g. for HEDIS data collection), the State Department of Health Care Services (DHCS), the State Department of Managed Health Care (DMHC), and the United States Department of Health and Human Services Inspector General (DHHS), the Comptroller General, Department of Justice (DOJ), Centers for Medicare and Medicaid Services (CMS), and all applicable state and federal agencies, self-regulatory agencies, applicable accrediting organizations, and their designees. Upon reasonable notice and at all reasonable times at the Provider's place of business or at such other mutually agreeable location in California.

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

8.2.4 For a term of at least ten (10) years from the final date of the Medical Services Agreement period or from the date of completion of any audit, whichever is later.

8.2.5 Upon request, Provider shall provide timely copies of such records at no charge to PLAN, or PLAN authorized designees, appropriate regulatory agencies, or Members.

8.2.6 Including all encounter data for a period of at least ten (10) years.

8.2.7 If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time.

8.2.8 Upon resolution of a full investigation of fraud, DHCS, CMS, or the DHHS Inspector General reserves the right to suspend or terminate Provider from participation in the Medi-Cal and/or Medicare programs; seek recovery of payments made to Provider; impose other sanctions provided under the State Plan, and direct PLAN to terminate their Medical Services Agreement due to fraud.

8.2.9 The inspections or reviews described in this Section 8.2 may evaluate the following pertinent to Members:

a) Level and quality of care, and the necessity and appropriateness of the services provided.
b) Internal procedures for assuring efficiency, economy, and quality of care.
c) Grievances relating to medical care and their disposition.
d) Financial records when determined necessary by HPSM to assure accountability for public funds.

8.3 Confidential Information

For the purpose of this Agreement, all information, records, payment information, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by the Provider and his/her staff from unauthorized disclosure as required by Medi-Cal and all applicable state and federal law, including but not limited to "Confidentiality of Medical Information Act", Cal. Civ. Code § 56 et seq., 42 CFR § 422.118, 42 CFR § 431.300 et seq., Section 14100.2 of the Welfare and Institutions Code, and HIPAA. Confidential information includes, without limitation: (a) protected health information, including eligibility lists and any other information containing the names, addresses or telephone numbers, and/or social security numbers of HPSM Members; (b) HPSM's administrative service manuals and all forms related thereto; (c) the financial arrangements between HPSM and any Participating Physician; and (d) any other information compiled or created by HPSM which is proprietary to HPSM and which HPSM identifies as proprietary to Provider in writing. Provider shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Provider may use the confidential information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of HPSM. Upon the effective date of termination of this Agreement, Provider shall promptly return to HPSM the confidential information in its possession.

8.4 Subcontracts

Provider shall maintain and make available to the PLAN, DHCS, CMS, DHHS Inspector General, the Comptroller General, the DOJ, and DMHC, all applicable state and federal agencies, self-regulatory agencies, applicable accrediting organization, or their designees, upon written request, copies of all subcontracts for the performance of any of Provider's obligations under this Agreement. Provider shall further assure that all subcontracts entered into from the effective date of this Agreement are in writing and shall require that the subcontractor:

8.4.1 Make all premises, facilities, equipment, applicable books, records, contracts, computers, or other electronic systems related to the subcontracting agreements, available at all

reasonable times for audit, inspection, examination, or copying by the PLAN, DHCS, CMS, DHHS Inspector General, the Comptroller General, the DOJ, and DMHC, all applicable state and federal agencies, self-regulatory agencies, applicable accrediting organization, or their designees.

8.4.2 Retain such books, records, and documents for a term of ten (10) years from the final date of the subcontracting agreement period or from the date of completion of any audit, whichever is later.

8.5 Reporting Fraud, Waste, and Abuse (FWA)

Provider shall report to HPSM all cases of suspected fraud, waste and/or abuse (FWA), as defined in 42 CFR §455.2, and as it relates to the rendering of Covered Services by Provider or his/her employees and subcontractors. Such reporting to HPSM shall occur within ten (10) working days of the date when Provider first becomes aware of or notified of such activity.

As part of HPSM's obligation to investigate suspected FWA, the Special Investigations Unit within HPSM's Compliance Department may request medical records from Provider in order to determine the appropriateness of suspect billing patterns or to look into complaints from Members. Provider shall supply the requested medical records to HPSM within fifteen (15) working days of HPSM's written request for medical records. If HPSM does not receive the requested medical records within fifteen (15) working days, HPSM will make two (2) additional attempts at requesting medical records from Provider in writing. If Provider fails to deliver the medical records to HPSM within five (5) working days of HPSM's third and final written request, the failure to supply medical records will be presented to HPSM's FWA Committee for further action on the matter.

8.6 Member Access to Records

Provider shall ensure that Members have access to their medical records in accordance with the requirements of State and Federal law.

8.7 Records Related to Recovery for Litigation

Pursuant to a request by DHCS related to record recovery for litigation, Provider shall assist PLAN in timely gathering, preserving, and providing to PLAN, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Provider's possession, relating to threatened or pending litigation by or against DHCS. (If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify PLAN of any subpoenas, document production requests, or requests for records,

received by Provider related to PLAN's Medi-Cal contract with DHCS or related to this Agreement.

SECTION 9
INSURANCE AND INDEMNIFICATION

9.1 Professional Liability Insurance

Provider, and any of its Downstream Entities providing Covered Services for Members, shall carry at his/her/its sole expense professional liability insurance of at least ONE MILLION DOLLARS ($1,000,000) and THREE MILLION DOLLARS ($3,000,000) per person per occurrence/in aggregate, insuring against professional errors and omissions (malpractice) in providing medical services under the terms of this Agreement and for the protection of the interests and property of the Provider, his/her/its Downstream Entities and employees, and HPSM Members.

9.2 Other Insurance Coverage

Comprehensive General Liability and Automobile Liability Insurance. Provider at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the performance of any Covered Services provided hereunder, b) the use of any property of Facility, and c) activities performed in connection with the Agreement. Provider shall maintain comprehensive general liability and automobile liability insurance with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

Workers Compensation Insurance. Provider at its sole cost and expense shall maintain Workers Compensation Insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

9.3 Certificates of Insurance

The Provider at its sole expense, if any, shall provide to HPSM certificates of insurance or verifications of required coverage, and shall notify HPSM of any notice of cancellation for any and all coverage required by this Agreement, and for subsequent renewals of all required coverage.

9.4 Automatic Notice of Termination

The Provider shall arrange with the insurance carrier to have automatic notification of insurance coverage termination given to HPSM.

9.5 Nursing Facility Indemnification

Provider agrees to indemnify, defend and hold harmless HPSM, its agents, officers and employees from and against any and all liability, expense, including defense costs and legal

fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with Provider's operations or its services hereunder. This provision is not intended to nor shall it be construed to require Provider to indemnify HPSM for any HPSM liability independent of that of Provider, nor to cause Provider to be subject to any liability to any third party (either directly, or as an indemnitor of HPSM or its agents, officers, and employees) in any case where Provider liability would not otherwise exist. Rather, the purpose of this provision is to assure that HPSM and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against HPSM or such agents, officers, or employees resulting from the actions or other omissions of Provider in connection with Provider's operations or its services under this Agreement.

SECTION 10
PROVIDER DISPUTES AND MEMBER COMPLAINTS

10.1 Grievances, Appeals and Provider Disputes

It is understood that Provider may have concerns relating to claims payment and HPSM operations which may arise as a health care provider under contract with HPSM. Provider has the right to access HPSM's dispute resolution mechanisms set out in this Section. Such concerns shall be resolved through the mechanisms set out in this Section. Provider and the HPSM shall be bound by the decisions of the HPSM's Grievances and Appeals mechanisms.

10.2 Dispute Procedure

10.2.1 Responsibility

HPSM's Chief Executive Officer has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance, Appeals and Provider Disputes review systems. The Chief Executive Officer shall be assisted by HPSM'S Chief Compliance Officer, Director of Customer Support, Claims Director, Director of Provider Services, Director of Health Services Operations, and the Chief Medical Officer), or their designees.

10.2.2 Disputes Relating to Claims Payment

All disputes relating to claims payment between Provider and HPSM shall be resolved through HPSM's Provider Dispute Resolution (PDR) process, according to procedures set forth in the Provider Dispute Section of the Provider Manual. HPSM may establish and amend the provisions set forth in this section of the Provider Manual from time to time.

10.2.3 Provider Grievances

Provider shall notify HPSM's Provider Services Department in accordance with procedures set forth in the Provider Manual if Provider is dissatisfied with any aspect of HPSM operations or any actions taken by HPSM staff, members, vendors, or other providers. A provider grievance is a complaint stating the providers' dissatisfaction. Providers may submit grievances orally or in writing. HPSM will process all provider grievances, regardless of whether any remedial action is requested by the Provider.

10.2.4 Member Complaints

Provider shall provide contact information to Members informing them how to contact HPSM in the event of a question, concern, or complaint. Provider shall display in a prominent place at their place of service, notice informing Members how to contact HPSM and file a complaint. Provider may file an appeal of a denial of an authorization request for services on behalf of a Member and shall submit the appeal in accordance with the Member Complaints Section of the Provider Manual. However, Provider shall not bill, charge, collect a deposit, or seek payment from the member for filing an appeal on their behalf.

If a Member files an appeal of a denial of an authorization request for services, Provider shall assist in the appeals process, including but not limited to, forwarding relevant medical records to help the HPSM make a decision on an appeal.

Members have the right to submit a grievance expressing dissatisfaction with any aspect of Provider's operations, activities, behaviors, including quality of care concerns. Provider shall participate when requested by HPSM in the resolution of the grievance, in accordance with the Member Complaints Section of the Provider Manual. Participation by Provider shall include, without limitation, providing timely responses to concerns raised by Members and relevant medical records.

If a Member files a complaint with Provider, Provider agrees to notify HPSM of said complaint and work with HPSM for resolution.

SECTION 11
DISPUTES ARISING FROM OR RELATING TO THIS AGREEMENT

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. In the event of any dispute arising out of this Agreement that cannot be resolved through HPSM's PDR process, the Parties shall use their best efforts to meet and confer and consult with each other in good faith, recognizing mutual interests, to attempt to reach a just and equitable solution satisfactory to both Parties. If any dispute is not resolved by meeting and conferring through an informal dispute resolution process, then the dispute shall be venued either in the San Mateo County Superior Court or in the United States District Court for the Northern District of California.

Notwithstanding the foregoing, the Parties may agree in writing to engage in an alternative form of dispute resolution, such as mediation or arbitration, for a particular dispute.

SECTION 12
GENERAL PROVISIONS

12.1 Intentionally Left Blank.

12.2 The waiver by HPSM of any one or more defaults, if any, on the part of the Provider hereunder, shall not be construed to operate as a waiver by HPSM of any other or future default in the same obligation or any other obligation in this Agreement.

12.3 Any notice or other communications required or which may be given relative to this Agreement shall be in writing and shall be delivered or sent postage prepaid by certified, registered or express mail, courier services (Airborne, Federal Express, UPS, etc.), or other means which can provide written proof of delivery, and shall be deemed given two (2) days after the date of mailing unless written proof indicates differently, and is to be addressed as follows:

12.3.1 If served on HPSM, it should be addressed to --

Health Plan of San Mateo
801 Gateway Blvd.
South San Francisco, CA 94080
Attn: Chief Executive Officer

12.3.2 If served on Provider, it should be addressed to -

San Mateo Medical Center
222 - 39th Avenue
San Mateo, CA 94403
Attn: Chief Executive Officer

Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

12.4 It is agreed by these parties that neither this Agreement in its entirety, nor any portion thereof, may be modified, altered or changed in any manner, except as provided in this Agreement.

12.5 None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee or the representative of the other.

12.6 Throughout this Agreement the singular shall include the plural, and the plural the singular; the masculine shall include the neuter and feminine, and the neuter the masculine and feminine.

12.7 This Agreement shall be governed by and construed in accordance with the laws of the State of California, except to the extent that such laws are pre-empted by federal law.

12.8 The provisions of this Agreement shall be interpreted in a reasonable manner to effect the purpose of the Parties.

12.9 In the event any provision of this Agreement is declared void by a court or arbitrator, or rendered invalid by any law or regulation, such portion shall be severed from this Agreement, and the remaining provisions shall remain in effect, unless the effect of such severance would be to materially alter the obligations of either party in such a manner as to cause serious financial hardship to such party, or to place a Party in material violation of its articles of incorporation or bylaws, or any law or regulation, in which case, the Agreement may be terminated by either party in accordance with Section 7.2.

12.10 The recitals, exhibits, and attachments are hereby incorporated into this Agreement by reference.

12.11 Parties shall not be liable nor deemed to be in default for any delay or failure in performance under this Agreement, where such delay or failure results directly or indirectly by acts of God, civil or military authority, acts of public enemy, war, terrorism, accidents, fires, explosions, earthquakes, floods, epidemics, pandemics, vandalism, strikes, riots, or without limiting the foregoing, any other cause beyond the control of the Parties. In the event of such a delay or failure in performance due to the reasons stated in this Section 12.11, Parties shall make good faith efforts to perform their obligations in as timely a manner as possible under the circumstances, but in no event shall HPSM be relieved of its obligation to pay Provider for services rendered to Members prior to or subsequent to an event described herein. If a substantial part of the services which Provider has agreed to provide hereunder be interrupted for a period in excess of thirty (30) days, HPSM shall have the right to terminate this Agreement upon providing ten (10) days prior written notice to Provider.

12.12 Provider shall provide at least sixty (60) days prior written notice to HPSM if Provider plans to shut down all or any part of its facilities and shall use its best efforts to assist HPSM in directing Members to alternate facilities, if alternatives are available.

12.13 This Agreement (together with all Exhibits and Attachments hereto) contains the entire Agreement between the parties relating to the rights herein granted and the obligations herein assumed. It is the express intention of the Provider and HPSM that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

12.14 The headings or titles of articles and sections contained in this Agreement are intended solely for the purpose of facilitating reference, are not a part of the Agreement and shall not affect in any way the meaning or interpretation of this Agreement.

12.15 Provider agrees that it will not: (a) violate any laws and regulations governing the solicitation of HPSM members; (b) encourage or seek to have a Member disenroll from HPSM and/or enroll in (i) a health maintenance organization, including one in which Provider has an ownership interest, (ii) another managed care plan, (iii) a case management arrangement, or (iv) any other similar arrangement, including any other arrangement in which Provider has a direct or indirect ownership interest (collectively referred to as "Alternative Care Plan"); and/or (c) interfere with the enrollment of HPSM Members. Any such activity would constitute a material breach of this contract. The provisions of this Section shall apply to all employees and subsidiaries of Provider, including any such arrangements established after the Effective Date of this Agreement. Nothing in this Section shall prohibit Provider from providing information to the public as to its affiliation with an Alternative Care Plan, so long as such activities do not include any of the prohibited activities set forth above.

12.16 Provider agrees that in connection with all actions taken on behalf of Members and in all

communications with Members in connection with this Agreement, Provider shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member or the public in HPSM or in the quality of care which HPSM provides. The obligations set forth in this Section shall survive termination of this Agreement.

12.17 This Agreement shall be binding upon and shall inure to the benefit of the parties to it and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, Provider may not assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of HPSM.

12.18 This Agreement and any amendment to this Agreement which constitutes a material change in the rights and obligations of the parties, with the exception of amendments relating to compensation, services, term, or business operations, shall become effective upon approval by DHCS or by operation of law where DHCS has acknowledged receipt of the proposed Agreement or amendment and has failed to approve or disapprove the proposed Agreement or amendment. Proposed amendments which are neither approved or disapproved by DHCS, shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the amendment, whichever is later.

12.19 Provider shall be entitled to all protections afforded them under Health Care Providers' Bill of Rights pursuant to Health and Safety Code Section 1375.7.

12.20 Each party agrees to maintain the terms of this Agreement confidential. Disclosure of the terms of the Agreement shall not be made without the prior written approval of the other party, which approval may be withheld in either party's sole and absolute discretion, or unless required to be disclosed by applicable law, state or federal regulatory agencies or accreditation organizations.

12.21 No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Provider and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's PLAN, and the Member's right to appeal any adverse decision made by Provider or PLAN regarding coverage of treatment which has been recommended or rendered. Moreover, Provider and PLAN agree not to penalize nor sanction any health care provider in any way for advising or engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

12.22 Provider understands that HPSM is prohibited by CMS from including in its provider network any Provider that has entered into a private contract with a Medicare beneficiary. In such an event, HPSM reserves the right to terminate this Agreement immediately and require Provider to reimburse HPSM immediately by the amount of any reimbursement that was paid either directly or indirectly to Provider and the amount of any sanctions imposed on HPSM by CMS or Medi-Cal for violation of this prohibition. This provision shall remain in effect for a period of two (2) years from the time that all direct contracts between Provider and Medicare beneficiary were completed or terminated.

SECTION 13
PROVIDER MANUAL

13.1 HPSM will provide to Provider, via HPSM's website and upon request, a copy of HPSM's Provider Manual. The Provider Manual contains those HPSM policies and procedures which describe all benefits plans, including limitations and exclusions offered by HPSM. Provider agrees to comply, and will have any Downstream Entity, including agents and subcontractors, agree to comply with HPSM standards and policies outlined in the Provider Manual.

13.2 HPSM may modify the Provider Manual from time to time and provide prior notice to Provider of material changes in accordance with Health and Safety Code Section 1375.7. Such notice shall be provided in writing and be distributed via standard business processes. Provider shall update HPSM when provider contact information changes in a timely manner. Provider's failure to comply with material changes of which it has not been provided reasonable written notice per the above shall be reviewed via the appropriate dispute resolution processes outlined in Sections 10 and 11 of this Agreement.

13.3 Copies of the Manual will be provided to Provider prior to the execution of this Agreement. To the extent of any conflict between this Agreement and the Provider Manual, the terms of this Agreement will govern.

In witness whereof, the parties specified herein have executed this Agreement and by signing below, both parties have indicated that they have read, understood, and agreed to all the terms and conditions in this Agreement,

SAN MATEO HEALTH COMMISSION DBA HEALTH PLAN OF SAN MATEO

Authorized Signature for Health Plan of San Mateo	Date	Name of Person Signing (please print)
Maya Altman	3/2/2020	MAYA ALTMAN

COUNTY OF SAN MATEO

By:
President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:

Clerk of Said Board

Attachment A
Nursing Facility Protocols

Provider is a Nursing Facility, also known as a Skilled Nursing Facility or long term care facility. Provider shall adhere to the rules and regulations pursuant to the California Health Facilities Licensure Act, and to the rules and regulations of the Medi-Cal and Medicare programs. Nursing Facility represents and warrants that it is currently and for the duration of this Agreement shall remain certified under Title 18 of the Federal Social Security Act.

1. SERVICES

Services shall be provided in accordance with the standards set forth in 22 CCR § 51335, this Medical Services Agreement, applicable Medi-Cal guidelines, and in the Member's Evidence of Coverage (EOC).

2. ACCESS

Nursing Facility shall provide Covered Services to Members, subject to the availability of appropriate skilled nursing care services and/or intermediate care services. Nursing Facility shall additionally adhere to the provisions of the EDS Medi-Cal Long Term Care manual.

3. ADMISSION

(A) On admission to an LTC facility, a Medi-Cal recipient or the recipient's representative must complete the Medi-Cal Long Term Care Facility Admission and Discharge Notification (MC 171) form, Parts I and II.

(B) The MC 171 must have the original signature of the recipient. If the recipient's signature cannot be obtained (for example, in the case of a comatose recipient), the facility representative must indicate the reason the recipient's signature cannot be obtained.

(C) The Nursing Facility must retain a copy of the MC 171 for its files (for use when the patient is discharged from the facility) and send either the original or a copy of the MC 171 to the proper government agencies depending on whether:

- A patient receives Supplemental Security Income/State Supplemental Payment (SSI/SSP). The original MC 171 should be sent to the local Social Security Office. The aid code for these recipients is 10, 20 or 60. A copy of the MC 171 should be forwarded to the local county welfare department.

- A patient receives aid under any program other than SSI/SSP. The original MC 171 should be sent to the San Mateo County Human Services Agency. The aid code for these recipients will be other than 10, 20 or 60.

(D) The Nursing Facility will also attach a copy of the MC 171 to the Long Term Care Treatment Authorization Request (LTC TAR, form 20-1) that is submitted to the Health Plan of San Mateo.

4. AUTHORIZATION

(A) Skilled Nursing Facility Services are covered only after prior Authorization has been obtained from PLAN. The Authorization request shall be initiated by the Nursing Facility and shall be signed by the Attending Physician.
(B) An initial Long Term Care Treatment Authorization Request (LTC TAR form 20-1) shall be required for each Skilled Nursing Facility admission.

- •An initial Authorization may be granted for periods up to one year from the date of admission. PLAN reserves the right, in its sole and absolute discretion, to initiate review of the need for the continued level of care and to reauthorize the services more frequently.
- •An approved initial TAR is required prior to transfer of Members between Skilled Nursing Facilities.
- •A copy of the MC 171 will be attached to the TAR as specified in Section 3 above.

(C) PLAN shall deny a TAR or reauthorization request when services or placement are not appropriate to the needs of the Member.

- •Where the reauthorization request is denied, the Member shall be notified in writing of decision by PLAN to deny ongoing services; the provider will be notified simultaneously. If the Member does not agree with this decision, the Member has the right to appeal this decision following protocols set forth in the Member grievance policy in the Provider Manual.

(D) The Attending Physician must recertify, at least every sixty (60) Days, the Member's need for continued care in accordance with specified procedures. The Attending Physician must comply with this requirement prior to the start of the sixty (60) Day period for which the Member is being recertified. The facility must present proof of this recertification at the time of billing for services rendered.
(E) Members in the facility shall be visited by their Attending Physician no less often than once every thirty (30) Days for the first ninety (90) Days following admission. Subsequent to the 90th Day, an alternative schedule of visits may be proposed. At no time, however, shall an alternative schedule of visits result in more than sixty (60) Days elapsing between Physician visits.
(F) Services are not covered unless provided on the signed order of the physician responsible for the care of the Member.
(G) There shall be a periodic medical review, not less often than annually, of all Members receiving Skilled Nursing Facility services by a medical review team as defined in 22 CCR, § 50028.2.
(H) Leave of absence from Skilled Nursing Facilities is reimbursed in accordance with 22 CCR § 51535 and is covered for the maximum number of Days per calendar year as indicated below:

(1) Developmentally disabled patients: 73 days
(2) Patients in a certified special treatment program for mentally disordered person, or patients in a mental health therapeutic program approved and certified by a local mental health director: 30 days.
(3) All other patients: Eighteen (18) Days, unless specifically qualified for additional Days. Up to twelve (12) additional Days of leave per year may be approved in increments of no more than two (2) consecutive Days when specific conditions are met. Approval of a request for additional days of leave shall be in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient. At least five days of inpatient care must be provided between each approved leave of absence.

5. DISCHARGE

(A) When a patient expires or is discharged from an LTC facility, the Nursing Facility must complete Part III of the MC 171 and submit the MC 171 to the San Mateo County Human Services Agency.

(B) The Nursing Facility must also send a copy of the MC 171 to the Health Plan of San Mateo.

6. MEMBER VISITS

Nursing Facility shall ensure that, pursuant to Health and Safety Code section 1250, it permits a Member, at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Nursing Facility shall include the requirement of this section in its Downstream Entity contracts.

7. EMERGENCY SERVICES

Nursing Facility shall seek Emergency Services for Members when Medically Necessary.

8. STANDARDS OF CARE

Nursing Facility shall, in rendering services to Members, provide care in accordance with recognized Nursing Facility and professional standards and applicable State and Federal licensing laws and regulations.

This following is only applicable if Nursing Facility also provides ICF services

Provider is a Nursing Facility that provides Intermediate Care Services for PLAN Members. Provider shall adhere to the rules and regulations pursuant to the California Health Facilities Licensure Act, and to the rules and regulations of the Knox Keene Act of 1975, as amended, and Medicare programs.

1. DEFINITIONS

"Intermediate Care Facility" or "ICF" means a facility which is licensed as such by the State or is a hospital or Skilled Nursing Facility which meets the standards specified in the California Code of Regulations (CCR) and has been certified by the State.

2. SERVICES

ICF coverage shall be provided in accordance with the standards set forth in 28 CCR, this Medical Services Agreement, applicable Medi-Cal guidelines, and in the Member's Evidence of Coverage (EOC).

3. AUTHORIZATION

(A) ICF services are covered only after prior Authorization has been obtained from PLAN. The Authorization request shall be initiated by the ICF and shall be signed by the attending physician.

- An initial Treatment Authorization Request (TAR) shall be required for each admission.
- An initial Authorization may be granted for periods up to one year from the date of admission. PLAN reserves the right, in its sole and absolute discretion, to initiate review of the need for the continued level of care and to reauthorize the services more frequently.

(B) A request for reauthorization from the Nursing Facility must be received by PLAN on or before the first working Day following the expiration of a current authorization. Reauthorizations may be granted for periods up to six months.

(C) PLAN shall deny a TAR or reauthorization request when services or placement are not appropriate to the needs of the Member.

In the case of denial of a reauthorization request, the Member shall be notified in writing of the decision by PLAN to deny ongoing services; the provider will be notified simultaneously. If the Member does not agree with this decision, the Member has the right to appeal this decision following protocols set forth in the Member grievance policy in the Provider Manual.

(D) The attending physician must recertify, at least every sixty (60) Days, the Member's need for continued care in accordance with specified procedures. The attending physician must comply with this requirement prior to the sixty (60) Day period for which the Member is being recertified. Nursing Facility must present proof of this recertification at the time of billing for services rendered.

(E) Prior to the transfer of a Member between facilities, a new initial TAR shall be initiated by the receiving facility and signed by the attending physician. No transfer shall be made unless it is approved in advance by PLAN.

(F) Members in the facility shall be visited by their attending physician no less often than every sixty (60) Days. An alternative schedule of visits may be proposed, subject to approval by PLAN. At no time, however, shall an alternative schedule of visits result in more than ninety (90) Days elapsing between physician visits.

(G) There shall be a periodic medical review, not less often than annually, of all Members receiving ICF services by a medical review team.

(H) Leave of absence from an ICF is reimbursable and is covered for the maximum number of Days per calendar year as indicated below:

Eighteen (18) Days, unless specifically qualified for additional Days. Up to twelve (12) additional Days of leave per year may be approved in increments of no more than two (2) consecutive Days when specific conditions are met.

(I) Provisions for those with special needs are set forth as follows:

- In order to qualify for an ICF services, a Member shall have a medical condition which needs an out-of-home protective living arrangement with twenty-four (24) hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual Member independence to the extent of his ability. As a guide in determining the need for intermediate care services, the following factors may assist in determining appropriate placement:
- The complexity of the Member's medical problems is such that the Member requires skilled nursing care or observation on an ongoing intermittent basis and twenty-four (24) hour supervision to meet his health needs.
- Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis. Patients on daily injectable medications or regular doses of pro re nata (PRN) or "as needed" narcotics may not qualify.
- Diet may be of a special type, but Member needs little or no assistance in feeding himself.
- The Member may require minor assistance or supervision in personal care, such as in bathing or dressing.
- The Member may need encouragement in restorative measures for increasing and strengthening his functional capacity to work toward greater independence.
- The Member may have some degree of vision, hearing or sensory loss.
- The Member may have some limitation in movement, but must be ambulatory with or without an assistive device such as a cane, walker, crutches, prosthesis, wheelchair, etc.
- The Member may need some supervision or assistance in transferring to a wheelchair, but must be able to ambulate the chair independently.
- The Member may be occasionally incontinent of urine; however, patient who is incontinent of bowels or totally incontinent of urine may qualify for intermediate care service when the Member has been taught and can care for himself.

•The Member may exhibit some mild confusion or depression; however, his behavior must be stabilized to such an extent that it poses no threat to himself or others.

Attachment B-1
Medi-Cal Reimbursement

1. **Long-Term Care Services**: PLAN shall reimburse Provider at 100% of the prevailing Medi-Cal per diem rate in effect for the Medi-Cal Program.

   For those eligible services that are excluded from the Medi-Cal LTC per diem, PLAN shall pay as follows:

   A. **Legend Drugs Pricing**: Medi-Cal Drugs shall be reimbursed at Medi-Cal Fee-For-Service (FFS) rates. If a Medi-Cal FFS rate is not available, then reimbursement shall be based on PLAN's network standard pricing.

   B. **Durable Medical Equipment (DME) and LTC Per Diem Excluded Professional Services**:

   - DME: 100% of the Medi-Cal FFS rates
   - LTC Per Diem Excluded Professional Services: 123% of the Medi-Cal FFS rates

2. **Intermediate Care Services**: PLAN shall reimburse Provider at 100% of the prevailing Medi-Cal ICF per diem rates in effect for the Medi-Cal Program. Provider shall bill for intermediate care services with accommodation codes 21 or 22.

21	Nursing Facilities Level A	Regular Services
22	Nursing Facilities Level A	Leave Days (non developmentally disabled patient)

3. **Skilled Nursing Facility Level of Care**: PLAN shall reimburse Provider at 85% of the prevailing Medicare allowed amount for authorized Covered Services subject to the federally mandated Medicare payment reduction of two percent (2%), for as long as the two percent (2%) payment reduction is in effect.

PLAN will not enter into Letters of Agreement with Provider for any services covered by this Agreement.

4. If PLAN offers any value-based/quality/incentive payment programs, Provider shall be eligible to participate in Plan's value-based/quality/incentive payment program contingent upon Provider meeting all the requirements and obligations outlined in this Agreement and applicable state and federal regulatory compliance requirements. Value-based/quality/incentive program payments are contingent upon Provider meeting Plan-designated performance metrics and compliance with Agreement and regulatory requirements.

Participation in Plan's value-based/quality/incentive payment program, as well as acceptance of performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between Plan and Provider. There is no guarantee of future funding or payment under any Plan value-based/quality/incentive payment program.

Attachment B-2
CareAdvantage Reimbursement

1. **Skilled Nursing Facility Level of Care**: PLAN shall reimburse Provider at 85% of the prevailing Medicare allowed amount for authorized Covered Services subject to the federally mandated Medicare payment reduction of two percent (2%), for as long as the two percent (2%) payment reduction is in effect.

2. Eligible Part B services shall be paid at 100% of the prevailing Medicare allowed amount for authorized Covered Services subject to the federally mandated Medicare payment reduction of two percent (2%), for as long as the two percent (2%) payment reduction is in effect.

   PLAN will not enter into Letters of Agreement with Facility for any services covered by this Agreement.

4. If PLAN offers any value-based/quality/incentive payment programs, Provider shall be eligible to participate in Plan's value-based/quality/incentive payment program contingent upon Provider meeting all the requirements and obligations outlined in this Agreement and applicable state and federal regulatory compliance requirements. Value-based/quality/incentive program payments are contingent upon Provider meeting Plan-designated performance metrics and compliance with Agreement and regulatory requirements.

Participation in Plan's value-based/quality/incentive payment program, as well as acceptance of performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between Plan and Provider. There is no guarantee of future funding or payment under any Plan value-based/quality/incentive payment program.

Attachment C
Medical Records Information

_____, is the custodian of records ("Custodian of Records") for _____.

The records will be stored at_____, using the following storage mechanism(s) (e.g., office-based, off-site, combination):_____, and in the following format(s) (e.g., paper charts, EHR and type, combination):_____.

Contact information for Custodian of Records:

Phone: _____
Fax: _____
Mailing Address: _____
_____
_____
Email: _____

At the time of providing records, the Custodian of Records shall provide requested records to HPSM with an affidavit certifying the following:

1. Name of Custodian of Records, duly sworn on his/her oath.
2. Records attached are true and exact copies of the reports and records for treatment of patient, along with patient's name, patient's contracted lines of business, treatment dates of service.
3. Records attached were made in the routine course of business at or near the time of the event recorded.
4. Records attached were made by the physicians and/or staff who had personal knowledge of the facts recorded.
5. The records are of a type regularly kept and maintained by Provider.
6. Identify how many pages are accompanied with the affidavit.
7. Include the statement, "I affirm under the penalties of perjury that the foregoing representations are true and accurate to the best of my knowledge and belief.
8. Contact information for Custodian of Records