

**COMMUNITY SUPPORTS SERVICES AGREEMENT  
BETWEEN  
SAN MATEO HEALTH COMMISSION  
AND  
COUNTY OF SAN MATEO**

This Community Supports Services Agreement ("Agreement") is entered into this **May 20, 2026** (the "**Effective Date**") by and between County of San Mateo, a provider of Community Supports services ("Provider"), and the San Mateo Health Commission dba the Health Plan of San Mateo, an independent public agency established by the San Mateo County Board of Supervisors, pursuant to CA Welfare and Institutions Code Section 14087.51 ("HPSM"). 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 Community Supports Services Agreement, the following are attached hereto and incorporated by reference herein:

- Community Supports Services Agreement
- Attachment A Scope of Services
- Attachment B Reimbursement
- Attachment C Locations
- Attachment D Claims Submission
- Attachment E Community Supports Provisions
- Exhibit D Respite Services
- Attachment F DHCS Subcontractor Requirements
- Attachment G DMHC Administrative Services Requirements

This Agreement is applicable to the following health plan lines of business.

Lines of Business	Contract Status
Medi-Cal	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

**Provider**

Executed by:

**Health Plan of San Mateo**

Executed by:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Title

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Date

# COMMUNITY SUPPORTS SERVICES AGREEMENT

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<https://www.hpsm.org/provider/resources/manual>

## TERMS AND CONDITIONS

### Recitals:

- A. HPSM is a public entity and is 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. HPSM entered into agreements with various government agencies under which HPSM agrees to provide or arrange healthcare services to Members. HPSM entered into an agreement with the California Department of Health Care Services (“DHCS”), the Centers for Medicare and Medicaid Services (“CMS”), and with the San Mateo County Public Authority.
- C. Provider shall participate in providing Community Supports Services to Members and shall receive payment from HPSM for the rendering of those Community Supports Services.
- D. 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 **“CMO”** shall mean HPSM’s Chief Medical Officer or his/her designee.
- 1.2 **“CMS”** shall mean the Centers for Medicare & Medicaid Services.
- 1.3 **“Community Supports” or Community Support Services** shall mean services or settings that are offered in place of services or settings covered under Medi-Cal and are medically appropriate, cost-effective alternatives to services or settings under Medi-Cal. Community Support services are optional for HPSM to offer and for Members to utilize. HPSM may not require Members to use Community Supports instead of a service or setting covered under Medi-Cal.
- 1.4 **“Community Supports Provider”** means a contracted provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and/or training providing one or more of the Community Supports approved by DHCS.
- 1.5 **“Covered Services”** shall mean those Medically Necessary healthcare services, equipment, supplies, and benefits, which are identified as benefits that the Member is entitled to receive under Member’s Evidence of Coverage.

- 1.6 **“Downstream Entity”** means any party subcontracted by Provider and approved by HPSM to provide services under this Agreement.
- 1.7 **“Evidence of Coverage EOC”** shall mean the document issued by HPSM to Members that describes Covered Services and Non-Covered Services.
- 1.8 **“Identification Card”** shall mean the 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.
- 1.9 **“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.
- 1.10 **“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.
- 1.11 **“Medically Necessary”** means a health care service that is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, in accordance with generally accepted medical standards and clinically appropriate as determined by Participating Provider and HPSM’s Utilization Management Program. “Medically Necessary” or “Medical Necessity” means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
- For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member’s current health condition. HPSM will determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
- 1.12 **“Member(s)”** shall mean any person who is enrolled with HPSM who meets all the eligibility requirements for membership.
- 1.13 **Model of Care (MOC)”** means HPSM’s framework for providing ECM and Community Supports, including its policies and procedures for partnering with ECM and Community Supports Providers.
- 1.14 **“Overpayments”** shall mean the amount of money Provider has received in excess of the amount due and payable under any federal, state, contractual, or other health care program requirements.
- 1.15 **“Participating Provider(s)”** shall mean a Physician or provider of health care services, DHCS approved Community Supports who have entered into an Agreement with HPSM to provide Covered Services to

Members. The terms Participating and Contracting may be used interchangeably. Community Supports Providers are entities with experience and/or training providing one or more of the Community Supports approved by DHCS.

- 1.16 **“Physician(s)”** shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law.
- 1.17 **“Physician Advisory Group”** shall mean the committee of Physicians practicing in San Mateo County who serve on the advisory group appointed by HPSM to provide input on the HPSM’s Quality Program.
- 1.18 **“Preventive Care”** shall mean health care provided for prevention and early detection of disease, illness, injury or other health condition.
- 1.19 **“Primary Care Provider” or “PCP”** shall mean a Participating Provider or Physician duly licensed in California and who has executed a contract with HPSM to provide the services of a Primary Care Provider.
- 1.20 **“Primary Care Services”** shall mean those services provided to Members by a Primary Care Provider.
- 1.21 **“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.
- 1.22 **“Prior Authorization Request Form”** shall mean the forms completed by Participating Providers to request a service/treatment that requires prior authorization by the HPSM.
- 1.23 **“Provider Manual”** shall mean the Manual that contains HPSM’s policies and procedures necessary for the proper operation of Participating Providers, as it relates to Members and all benefit plans.
- 1.24 **“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.
- 1.25 **“Referral”** shall mean the process by which PCPs direct a Member to seek or obtain Covered Services from a Participating Provider or other health professional in accordance with HPSM’s referral and authorization procedures.
- 1.26 **“Referral Authorization Form” (RAF)** shall mean forms generated by the Primary Care Provider identifying needs based on Member’s clinical status. RAFs are used by the PCP to authorize referral to a provider who is not contracted with HPSM.
- 1.27 **“Referral Provider”** means any qualified Participating Provider to whom the PCP may refer any Member for consultation or treatment.
- 1.28 **“Referral Services”** shall mean any services which are not Primary Care Services and which are provided by Referral Provider on referral from the Member’s PCP.

- 1.29 **“Regulatory Agency”** means the federal, State, County, and local government agencies and entities with regulatory or other authority over HPSM, Provider, and/or this Agreement. Regulatory Agencies include, but are not limited to, DHCS, DMHC, State Auditor, United States Department of Health and Human Services (“DHHS”) and its agents (the “Secretary”), DHHS Inspector General, CMS, U.S. Department of Justice (“DOJ”), California Attorney General - Division of Medi-Cal Fraud and Elder Abuse (“DMFEA”), and Comptroller General of the United States.
- 1.30 **“Surcharge”** means an additional fee that is charged to a Member for a Community Supports or Covered Service that is not authorized by the State or contained in the Evidence of Coverage.
- 1.31 **“Telehealth”** shall mean the mode of delivering Covered Services or Community Supports via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member’s health care, including the real time interactive communication between the Member and the Provider, while the Member is at a separate site from Provider.
- 1.32 **“Urgent Care”** shall mean health care for a condition that requires prompt attention.
- 1.33 **“Utilization Management (UM)”** shall mean those review processes and procedures which are designed to determine whether services are Covered Services and/or Medically Necessary.

## SECTION 2 QUALIFICATIONS

### 2.1 **Professional Licensure and Certification**

Provider warrants that it shall, at all times during the term of the Agreement, hold any necessary licenses, certifications, or accreditations necessary to perform the services under this Agreement, with no restrictions or other limitations, and shall ensure that personnel employed by or under contract with Provider hold any necessary licenses, certifications, or accreditations necessary to perform the services under this Agreement, with no restrictions or other limitations. Provider further represents and warrants that any and all equipment utilized for the performance of services under this Agreement shall be licensed or registered as required by law. Upon request, Provider shall provide HPSM with a copy of such licenses, certifications, accreditations, registrations, and any renewals thereof.

Each provider of Community Supports Services employed, contracted, and/or affiliated with Provider, currently and for the duration of this Agreement, shall meet the following qualifications:

- 2.1.1 Shall have the capacity to provide Community Supports in a culturally and linguistically competent manner; as demonstrated by a successful history of providing such services, training or other factors identified by HPSM;
- 2.1.2 Shall have experience and/or training in the provision of the Community Support(s) being offered;
- 2.1.3 Has been appropriately credentialed or vetted, as applicable, by HPSM;
- 2.1.4 Shall enroll in Medi-Cal, if a State-level enrollment pathway exists for Provider;

- 2.1.5 Practicing within San Mateo County or has been specifically exempted from this requirement by HPSM's Peer Review Committee;
- 2.1.6 Has never had his/her license to practice revoked or suspended by any State licensing board nor been subject to any State or Federal sanction activity;
- 2.1.7 Has never been convicted of a felony or misdemeanor relating to the practice of his or her profession, or that in the opinion of HPSM would adversely affect the integrity of HPSM or the ability of the practitioner to participate with HPSM. Such offenses may include but are not limited to: fraud, third-party reimbursement, controlled substance violations, child/adult abuse charges, or any other matter; and
- 2.1.8 Meets the capabilities and standards required to be a Community Supports Provider.

## 2.2 **Participation Requirements**

Provider understands that HPSM is prohibited by CMS and DHCS 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.

## 2.3 **Assistants**

Provider shall employ such assistants and employees as Provider deems necessary to perform Community Supports Services for Members. HPSM may not control, direct or supervise Provider's assistants and employees in the performance of those Community Supports Services. Provider warrants that all such assistants and employees shall be properly licensed, certified and/or registered, and shall comply with all applicable federal, state and municipal laws.

## 2.4 **Personnel and Facilities**

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

## 2.5 Provider Training

HPSM shall ensure that a designated contact at the Provider practice site receives training materials on Community Supports and the Medi-Cal Managed Care program, including training on Medi-Cal Managed Care services, policies, procedures, and Member rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. The designated contact at the practice site shall ensure that all healthcare providers rendering to the Provider practice receive this training no later than 10 (ten) working days after a newly rendering healthcare provider is placed on active status, and that training shall be completed by the newly rendering healthcare provider within 30 calendar days of being placed on active status.

HPSM shall share notification of material updates to services, policies or procedures in accordance with this Agreement. The designated contact will receive and disseminate HPSM updates to services, policies or procedures and shall ensure that ongoing training is conducted when deemed necessary by either the designated contact of the Provider practice or HPSM.

On an ongoing basis, HPSM shall make available training and/or information to the designated contact regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instructions for seniors and persons with disabilities. This shall include information posted to HPSM's website as well as sent via other methods of provider outreach. The designated contact at the Provider practice shall disseminate this information to rendering healthcare providers and/or staff as deemed appropriate.

## **SECTION 3 ACCESS TO CARE AND CARE COORDINATION**

### 3.1 Provider Directory

HPSM will enter the information of each Participating Provider onto a list of HPSM Participating Providers from which Members may seek Covered Services or Community Supports, pursuant to Health and Safety Section 1367.27. Such a list shall contain the following information of Provider and Participating Providers, as applicable:

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

3.1.1 Provider shall update HPSM when any of the above information and data pertaining to Provider and/or each individual Participating Provider in Provider's group practice, including, without limitation, the information listed in the above fields, in Provider's listing

changes, or upon HPSM's request for updated information. HPSM shall update its online provider directory periodically to include an updated list of all Participating Providers.

3.1.2 As applicable to group practices, in addition to above, Provider shall provide to HPSM monthly rosters of information and data pertaining to each individual provider in Provider's group practice.

3.1.3 To the extent applicable, Provider shall inform HPSM within five (5) business days when either of the following occurs:

3.1.3.1 The Provider is not accepting new patients, or

3.1.3.2 If the Provider had previously not accepted new patients, the Provider is currently accepting new patients.

### 3.2 **Notice of Directory Inaccuracy**

If Provider is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Provider shall direct the Member or potential Member to both HPSM for additional assistance in finding a provider and to the State Department of Managed Health Care to report any inaccuracy with HPSM's directory or directories.

### 3.3 **Direct Contact and Coverage Plan**

Provider shall deliver contracted Community Supports in accordance with DHCS service definitions and requirements, and in accordance with all applicable DHCS All Plan Letters, (APLS), the DHCS Community Supports Policy Guide, HPSM's CS Model of Care, and other HPSM requirements.

Provider shall accept and act upon Member referrals from HPSM for authorized Community Supports, unless the Provider is at pre-determined capacity. Provider shall conduct outreach to the referred Member for authorized Community Supports as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable.

Provider shall respond to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week.

If a Community Supports is discontinued for any reason, the Provider shall support transition planning for the Member into other programs or services that meet their needs.

### 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 using the verification options as described in the Provider Manual.

### 3.5 **Timely Access to Care**

Provider shall provide Community Supports to Members in a timely manner, in accordance with HPSM policies

and procedures.

### 3.6 **Discrimination Prohibited**

Provider shall not differentiate or discriminate in the treatment of Members, nor shall he/she discriminate on the basis of sex, gender, gender identity, gender expression, race, creed, color, ancestry, religious creed, national origin, ethnic group identification, marital status, sexual , sexual preference, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental or developmental disability, age, medical condition or mental status, genetic information, pregnancy, childbirth, veteran's status, income, source of payment, identification with any other persons or groups defined in Penal Code 422.56, or any other protected 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.

### 3.7 **Member Non-Compliance with Community Supports**

A Member, for personal reasons, may refuse to follow or undergo one or more Community Support Services recommended by Provider.

## **SECTION 4 SERVICES TO BE PROVIDED AND UTILIZATION MANAGEMENT**

### 4.1 **Consultation with the CMO**

Provider or any other Participating Provider may at any time seek consultation with HPSM's CMO or his/her designee, on any matter concerning the treatment of the Member.

### 4.2 **Community Supports Services**

Provider shall provide Community Supports Services to each Member when they are appropriate for the care of that Member.

### 4.3 **Prior Authorization**

Certain Community Supports Services require prior authorization from HPSM prior to rendering the Community Supports Service to ensure reimbursement. Provider shall provide HPSM, along with a request for prior authorization, access to records to the extent necessary for HPSM to make the appropriate decision regarding authorization.

### 4.4 **Place of Service**

All services are to be provided at a place which the Provider determines is appropriate for the proper rendition thereof, within the constraints of the Medi-Cal and/or Medicare Program regulations. In accordance

with Medi-Cal regulations, please keep in mind, that whatever the lowest cost service or item that is necessary to meet a member's needs, is the item that should be ordered. This allows HPSM to use resources efficiently to the benefit of all members.

#### **4.5 Services for Members with Disabilities**

4.5.1 Any HPSM Member with a physical or intellectual disability needs to be accommodated by Provider 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.

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

#### **4.6 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.

#### **4.7 Linguistic Services**

4.7.1 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 Participating Providers' 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.

##### **4.7.2 Interpreter Services for Limited English Proficient (LEP) Members**

Provider shall ensure equal access to Community Support 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.

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

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

4.7.2.3 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.

4.7.2.4 Provider shall not rely on adult or minor child accompanying a limited LEP Member as an interpreter or to facilitate communication, except under the following circumstances:

- If the LEP Member specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances; or
- In the case of an emergency, if a qualified interpreter is not immediately available.

Prior to using a family member, friend or, in an emergency only, a minor child as an interpreter for an LEP individual, Provider must first inform the Member that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the LEP Member's confidentiality. Provider must also ensure that the LEP Member's refusal of free interpreter services and their request to use family members, friends, or a minor child as an interpreter is documented in the medical record.

#### 4.7.3 Language Assistance

Provider shall comply with the HPSM language assistance standards developed pursuant to California Health and Safety Code Section 1367.04 and 28 CCR 1300.67.04 and shall cooperate with HPSM by providing any information necessary to assess Provider's compliance with California Health and Safety Code Section 1367.04 and 28 CCR 1300.67.04. HPSM shall provide cultural competency, sensitivity, and diversity training, as needed.

### 4.8 Medi-Cal Restrictions

4.8.1 Services provided shall be subject to HPSM's most current Medi-Cal Agreement.

4.8.2 Services provided shall be subject to the limitations, policies, and procedures of the Medi-Cal program.

### 4.9 Utilization Data

To the extent that Provider is responsible for the coordination of care for Members, HPSM shall share with Provider requested utilization data that DHCS has provided to HPSM that is relevant to the care of the Members seen by Provider and to the extent necessary for care coordination. HPSM 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 HPSM and use it as the Provider is able for the purpose of Member care coordination. Any utilization data exchange between HPSM 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 HPSM policies regarding privacy and confidentiality.

As part of the referral process, HPSM will ensure Provider has access to:

- i. Demographic and administrative information confirming the referred Member's eligibility for the requested service;
- ii. Appropriate administrative, clinical, and social service information the Provider might need in order to effectively provide the requested service; and
- iii. Billing information necessary to support the Provider's ability to submit invoices to HPSM.

## **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, agents, or subcontractors 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, agents, subcontractors, or related entities 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 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 or obligation, or specify other remedies, if Provider fails to meet HPSM's or any regulatory agency's 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.

Provider acknowledges that HPSM will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both HPSM and the Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

Provider shall maintain the confidentiality of member records, including medical records, protected health information (PHI), and any mental health records contained therein, in compliance with applicable rules and regulations, including those outlined in 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), the "Confidentiality of Medical Information Act", Cal. Civ. Code § 56 et seq., this Agreement, HPSM's policies and procedures, and HPSM's Provider Manual. 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 to comply with all applicable laws, including, but not limited to, the Knox-Keene Act, Confidentiality of Medical Information Act (Civil Code §56 et seq.), 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, the False Claims Act (31 U.S.C. §3729 et. seq.) and the Anti-Kickback statute (section 1128B(b) of the Social Security 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 Regulatory Agencies 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 the Regulatory Agencies, the U.S. General Accounting Office, the Comptroller General, any Peer Review Organization, Quality Improvement Organization, 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, subcontractors or related entities for a minimum of ten (10) years from the final date of the contract period or the date of completion of the last audit, whichever is later unless further extended for the reasons specified in Title 42, Code of Federal Regulations ("42 CFR"), §422.504(e)(4). Provider shall comply with all monitoring provisions of HPSM's contracts, including but not limited to HPSM'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 HPSM. Provider shall comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. HPSM shall inform Provider of prospective requirements added by DHCS to HPSM'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 and to the extent possible.

## **5.2 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 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 and any of his/her/its subcontractors and agents, shall provide all information and records requested by HPSM for HPSM's quality improvement, grievance and appeals, risk adjustment, and utilization review activities at no charge to HPSM, HPSM-authorized subcontractors and designees, appropriate regulatory agencies, and Members.

Provider agrees to comply with HPSM's quality improvement program. 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, Provider's staff, and any subcontractors engaged by Provider shall comply with HPSM's policies related to case management, care coordination, and utilization management. 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.

## **SECTION 6 PAYMENTS**

### **6.1 Conditions for Payment**

HPSM will reimburse Provider for Community Supports 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 Community Supports Service according to regulations in effect at the time of services; and

6.1.3 Authorization was obtained from HPSM.

## 6.2 **Billing Procedures**

Provider shall submit initial claims within three hundred sixty five (365) days following the date of service.

## 6.3 **Form**

Provider shall bill using the guidelines set forth in the Provider Manual and Attachment C. 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 applicable state and federal regulations and guidelines. HPSM shall pay Provider at the rates set forth in Attachment B for all properly documented and authorized Community Supports Services provided to eligible Members.

## 6.5 **Member Liability**

Other than applicable copayments, Provider shall look only to HPSM for compensation for Community Supports Services to Members. Provider shall not bill, charge, charge co-payments or coinsurance, surcharge, collect a deposit or other sum; 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 Community Supports Services payable by HPSM. Provider shall report to HPSM in writing all surcharges 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 Community Supports 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.

## 6.6 **Member Hold Harmless**

The Provider agrees to hold harmless the Member and DHCS in the event that HPSM cannot or will not pay for services performed by the Provider pursuant to the terms of the Agreement for which HPSM is financially liable.

## 6.7 **Overpayments**

Provider shall furnish and be paid for Community Supports 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 day 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 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.

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.

## 6.8 **Payment Withhold for Failure to Update Listing**

If Provider fails to respond to HPSM's attempts to verify the Provider's or Provider group's information as requested by HPSM in accordance with Section 3.1, HPSM may delay payment or reimbursement owed to Provider. HPSM shall not delay payment unless it has attempted to verify Provider's information in writing, electronically, and by telephone to confirm whether Provider's information is correct or requires updates. HPSM shall notify Provider 10 business days before it delays payment or reimbursement pursuant to this paragraph. If Provider receives compensation on a capitated or prepaid basis, HPSM shall delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.

6.8.1 For any claims payments made to Provider, HPSM shall delay the claims payment for up to one calendar month beginning on the first day of the following month.

6.8.2 HPSM shall reimburse the full amount of any payment or reimbursement subject to delay to Provider according to either of the following timelines, as applicable:

- i. No later than three business days following the date on which the HPSM receives the information required to be submitted by Provider pursuant to Section 3.1. At the end of one calendar-month delay, if Provider fails to provide the information required to be submitted to the HPSM pursuant to Section 3.1.

## **SECTION 7 TERM, TERMINATION, AND AMENDMENT**

### 7.1 **Term**

This Agreement shall be for a term of one (1) year from the Effective Date(s) 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 ninety (90) days advance written notice of intent to terminate, transmitted by the Provider to HPSM email, fax, or mail, addressed to the office of HPSM, as provided in Section 12.2, made to the attention of HPSM's Provider Services Department.

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 sixty (60) days written notice via mail, fax, or email.

### 7.2.3 Conditions for Immediate Termination by HPSM

- a) 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; 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 effective immediately 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 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.

7.2.4 This Agreement shall terminate automatically on the date of termination of HPSM's Medi-Cal 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 so that the Member may choose a new provider as soon as practicable.

### 7.4 Assignment

Neither HPSM nor Provider shall assign this Agreement without the prior written consent of the other party and applicable Regulatory Agencies.

### 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 this Agreement and any necessary Regulatory Agency approvals. 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. HPSM shall not change a material term of the Agreement unless the change has first been negotiated and agreed to by Provider and HPSM or the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. HPSM shall provide at least 45 business days' notice of its intent to change a material term of the Agreement as well as any manual, policy, or procedure document referenced in the Agreement, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance. If HPSM and Provider cannot agree to the change, Provider has the right to terminate the Agreement prior to the implementation of the change. If the Parties mutually agree, the 45-business day notice requirement may be waived. 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, all of which were provided to Provider at least fifteen (15) business days in advance of the execution of this Agreement, 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 Community Supports 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 Community Supports Services to any Member who is receiving Community Supports Services from Provider on the effective termination date of this Agreement until the Community Supports Services being rendered to the Member by Provider are completed, consistent with existing requirements for providing continuity of care, or HPSM makes reasonable and medically appropriate provisions for the assumption of such Community Supports Services by another Participating Provider.

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

## SECTION 8 MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

### 8.1 Inspection Rights and Audits

8.1.1 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 HPSM or a Regulatory Agency upon reasonable notice and at all reasonable times at Provider's place of business or at such other mutually agreeable location in California for a period of at least five (5) years, or as required by law, whichever is longer.

8.1.2 The inspections or reviews described in this Section 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.

### 8.2 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 and regulations governing protection of patient information, 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 Provider; 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.

When federal law requires authorization for data sharing, Provider shall obtain and document such authorization from each assigned Member, including sharing of Protected Health Information (PHI), and shall confirm it has obtained such authorization to HPSM.

Member authorization for Community Supports related data sharing is not required for the Provider to initiate delivery of Community Supports unless such authorization is required by federal law.

Provider will be reimbursed only for services that are authorized by HPSM. In the event of a Member requesting services not yet authorized by HPSM, Provider shall send prior authorization request(s) to HPSM, unless a different agreement is in place (e.g., if HPSM has given the Provider authority to authorize Community Supports directly).

### 8.3 **Subcontracts**

Provider shall maintain and make available to HPSM, and Regulatory Agencies, upon written request, copies of all subcontracts for the performance of any of Provider's obligations under this Agreement. Provider shall further ensure that all subcontracts are in writing and require that the subcontractor to comply with the obligations set forth in this Agreement that are applicable to functions performed by the subcontractor, including, but not limited to, requirements pertaining to records, inspections, nondiscrimination, and reporting.

### 8.4 **Reporting Fraud, Waste, and Abuse (FWA)**

Provider shall report to HPSM all cases of suspected fraud, waste and/or abuse (FWA), as such activity is defined in 42 CFR §455.2, and as it relates to the rendering of Community Supports 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 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 records to HPSM within fifteen (15) working days of HPSM's written request for records. If HPSM does not receive the requested records within fifteen (15) working days, HPSM will make two (2) additional attempts at requesting records from Provider in writing. If Provider fails to deliver the records to HPSM within five (5) working days of HPSM's third and final written request, the failure to supply records will be presented to HPSM's FWA Committee for further action on the matter.

### 8.5 **Member Access to Records**

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

## **SECTION 9 INSURANCE AND INDEMNIFICATION**

### 9.1 **Liability Insurance**

Each individual provider covered by this Agreement shall carry at his/her sole expense 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 each provider, his/her members and employees, and HPSM Members.

9.2 **Other Insurance Coverage**

Provider shall carry at its sole expense at least THREE HUNDRED THOUSAND DOLLARS (\$300,000) per person per occurrence of the following insurance for the protection of the interest and property of the Provider, its members and employees, HPSM Members, HPSM and third parties; namely, personal injury on or about the premises of the Provider, general liability, employer's liability and Workers' Compensation to the extent said Workers' Compensation is required by law.

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 **Provider Indemnification of HPSM**

Provider shall indemnify and hold harmless HPSM and its officers, agents, employees, and servants from all claims, sanctions, penalties, damages, suits, or actions of every name, kind, and description, including attorney fees, resulting from this Agreement, the performance of any work or services required of Provider under this Agreement, or payments or expenses made pursuant to this Agreement brought for, or on account of, any action or failure of action, including, but not limited to, the failure to comply with HIPAA standards, by Provider.

9.6 **Liability**

Notwithstanding the above, Provider agrees Provider and HPSM are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others.

## **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 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 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, 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.

### 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 and shall provide HPSM's grievance forms promptly upon request. 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**

- 11.1 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 or the process described in Section 10 above as well as the Provider Manual, 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 this informal dispute resolution process outlined in this Section 11, 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 Dispute Procedure stated in Section 10, Provider shall be subject to and required to comply with the provisions of the Government Claims Act (Government Code Section 900, et seq.).
- 11.2 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 In the event any part of this Agreement is found to be unlawful or Legislation modifies the entitlement of Members or other provision hereunder, the Agreement shall automatically and without prior notice, be modified to reflect that which is lawful and all other provisions shall remain in full force and effect.
- 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 the Provider at the address which appears on the signature page of the Medical Services Agreement.

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 neutral and feminine, and the neutral 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 as set forth in this Agreement.
- 12.10 The recitals, exhibits, and attachments are hereby incorporated into this Agreement by reference. All applicable DHCS APLs, the Community Supports Policy Guide, HPSM's Model of Care, and all HPSM policies and procedures 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 12.10, 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 ninety (90) 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(s) 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(s) 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 and DHCS.
- 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.
- 12.19 Provider shall be entitled to all protections afforded them under the Health Care Providers' Bill of Rights pursuant to Health and Safety Code Section 1375.7.

## **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.
- 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.

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## ATTACHMENT A SCOPE OF SERVICES

Provider may elect to offer the following DHCS-authorized Community Supports to Members (check as applicable):

- ii.  Housing Transition Navigation Services – Exhibit A
- iii.  Housing Deposits – Exhibit B
- iv.  Housing Tenancy and Sustaining Services – Exhibit C
- v.  Respite Services - Exhibit D
- vi.  Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF) – Exhibit E
- vii.  Community Transition Services/Nursing Facility Transition to a Home – Exhibit F
- viii.  Personal Care and Homemaker Services - Exhibit G
- ix.  Environmental Accessibility Adaptations (Home Modifications) – Exhibit H
- x.  Medically Supportive Food/Meals/Medically Tailored Meals – Exhibit I
- xi.  Transitional Rent – Exhibit J

Exhibits A through Exhibit I provide a description and overview of Community Supports Services. These Exhibits are hereby incorporated by reference into this Agreement.

## ATTACHMENT B REIMBURSEMENT

**Medi-Cal:**

HPSM shall pay Provider for the provision of Community Supports in accordance with DHCS guidelines. Provider shall not receive payment from HPSM for the provision of any Community Supports not authorized by HPSM. Provider must have a system in place to accept payment from HPSM for Community Supports rendered.

HCPCS Level II Code	HCPCS Description	Modifier(s)	Modifier Description	Rate
<b>Housing Tenancy and Sustaining Services</b>				
S5151	Unskilled respite care, not hospice; per diem	U6	Used by Managed Care with HCPCS code S5151 to indicate Community Supports Respite Services.	\$40 per hour

HPSM shall pay 90 percent of all clean claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt. HPSM will provide expedited payments for urgent Community Support services (e.g. recuperative care services for an individual who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

Payment under Medi-Cal shall be subject to applicable state and federally-mandated payment reductions and pricing rules, when applicable.

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**ATTACHMENT C  
LOCATIONS**

**Practice Location(s):**

<b>Group Name</b>	<b>Phone Number</b>	<b>Address</b>	<b>NPI</b>	<b>TIN</b>	<b>Effective Date</b>
County of San Mateo	(650) 573-2501	2000 Alameda De Las Pulgas, Ste 230, San Mateo, CA 94403	1164105698	94-6000532	05/20/2026

**Mailing Address:**

Same as Practice Address

**Billing Address:**

Same as Practice Address

## **ATTACHMENT D CLAIMS SUBMISSION**

Provider shall record, generate, and send a claim or invoice to HPSM for Community Supports services rendered. If Provider submits claims, Provider shall submit claims to HPSM using specifications based on national standards, terminologies, and codes sets to be defined by DHCS. When possible, claims shall include data necessary for DHCS to stratify services by age, sex, race, ethnicity and language spoken to inform health equity initiative and efforts to mitigate health disparities undertaken by DHCS. If a Community Support is provided through Telehealth, the additional GQ modifier must be used. All Telehealth services must be provided in accordance with DHCS policy.

In the event Provider is unable to submit claims to HPSM for Community Supports using specifications based on national standards or DHCS-defined standard specifications and code sets, Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the Community Supports rendered, and Community Supports Providers' information to support appropriate reimbursement by HPSM, that will allow HPSM to convert Community Supports invoice information into DHCS-defined standard specifications and codes sets for submission to DHCS.

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## ATTACHMENT E COMMUNITY SUPPORTS PROVISIONS

### 1. Reporting

Provider shall provide HPSM with data for the purposes of regulatory reporting in a frequency and format mutually agreed upon by the Parties. The reporting requirements are subject to change depending on DHCS guidelines and updates for Community Supports Providers.

### 2. Data System Requirements and Data Sharing

2.1 HPSM shall support Provider access to systems and processes allowing Provider to do the following, at a minimum:

2.1.1 Obtain and document Member information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and

2.1.2 HPSM shall must also support Provider notification to HPSM and Enhanced Care Management (ECM) Providers and Member's Primary Care Provider (PCP), as applicable, when a referral has been fulfilled, as described in the Medi-Cal Agreement, Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*).

2.2 As part of the referral process, HPSM shall ensure Provider has access to:

2.2.1 Demographic and administrative information confirming the referred Member's eligibility for the requested service;

2.2.2 Appropriate administrative, clinical, and social service information the Community Supports Provider might need in order to effectively provide the requested service; and

2.2.3 Billing information necessary to support the Community Supports Provider's ability to submit invoices to MCP.

### 3. Coordination

Provider shall coordinate with other providers in the Member's care team, including ECM providers, other Community Supports providers and HPSM.

### 4. Identification of Additional Community Supports

Provider is encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to HPSM for authorization.

To the extent that Provider identifies Members for Community Supports, Provider shall do so in a manner that is equitable and does not exacerbate or contribute to existing racial and ethnic disparities.

**5. CS Policies and Procedures**

5.1 Provider shall deliver Community Supports in accordance with HPSM’s Community Supports policies and procedures, including:

- 5.1.1 Ensuring that the Member agrees to receiving Community Supports;
- 5.1.2 Where required by law, ensuring that Member s authorize information sharing with HPSM and all others involved in the Member’s care as needed to support the Member and maximize the benefits of Community Supports, in accordance with all applicable DHCS APLs;
- 5.1.3 Provide HPSM with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with HPSM; and
- 5.1.4 Obtain Member authorization to communicate electronically with the Member, Member’s family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if HPSM intends to do so.

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## **EXHIBIT D RESPITE SERVICES**

### **Description/Overview**

Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the Member in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

For guidance regarding Eligibility (Population Subset), Restrictions and Limitations and State Plan Service(s) To Be Avoided for Community Supports services, please refer to the Community Supports Policy Guide located on DHCS's website.

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## **ATTACHMENT F DHCS SUBCONTRACTOR REQUIREMENTS**

This Attachment sets forth the applicable requirements that are mandated required by the DHCS Medi-Cal Contract with HPSM (“DHCS Contract”). State and Federal laws and regulations, and applicable All Plan Letters to be included in this Agreement and any other provisions necessary to reflect compliance with law. Any citations in this Exhibit are to the applicable sections of the Medi-Cal DHCS Contract, APLs, or applicable law. This Attachment will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this Attachment and any other provision of the Agreement, this Attachment will control with respect to Medi-Cal. Any capitalized term utilized in this Attachment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this Attachment. If a capitalized term used in this Attachment is not defined in the Agreement or this Attachment, it will have the same meaning ascribed to it in the DHCS Contract.

1. The parties acknowledge and agree that this Agreement specifies HPSM’s obligations and functions undertaken by Provider. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.1.)
2. The parties acknowledge and agree that the term of the Agreement, including the beginning and end dates as well as methods of extension, renegotiation, phaseout, and termination, are included in this Agreement. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.2.)
3. The parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by Provider from HPSM. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.3.)
4. The parties acknowledge that this Agreement and any amendments thereof shall become effective only upon approval by DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.2.B and Section 3.1.5.B.4.)
5. Provider agrees that assignment or delegation of this Agreement and any related subcontract will be void unless prior written approval is obtained from DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.5)–6.)
6. This Agreement will be governed by and construed in accordance with all applicable laws and regulations governing the DHCS Contract, including, but not limited to, 42 CFR section 438.230, the Knox-Keene Health Care Services Plan Act of 1975 as codified in Health and Safety Code Section 1340 et seq. (unless expressly excluded under the DHCS Contract); 28 CCR Section 1300.43 et seq.; W&I Code Sections 14000 et seq.; 22 CCR Sections 53800 et seq.; and 22 CCR Sections 53900 et seq. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.7.)
7. Provider shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program pertaining to the obligations and functions undertaken by Provider, including, but not limited to, all applicable Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, All Plan Letters, and the provisions of the DHCS Contract. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.8.)
8. If applicable, Provider shall submit to HPSM, either directly or through an HPSM subcontractor, as applicable, complete, accurate, reasonable, and timely reports and data as needed by HPSM, in order for

HPSM to meet its reporting requirements to DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.10); DHCS APL 23-006.)

9. Provider will comply with all monitoring provisions in the DHCS Contract and any monitoring requests by DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.11.)
10. Provider shall maintain and make available to DHCS, upon request, copies of all contracts it enters related to the performance of the obligations and functions it undertakes pursuant to the Agreement, and to ensure that such contracts are in writing. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.12.)
11. Provider shall make all of its premises, facilities, equipment, books, records, contracts, computer, and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Agreement, available for the purpose of an audit, inspection, evaluation, examination, or copying pursuant to the Access Requirements and State's Right to Monitor, as set forth in DHCS Contract, Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities), as follows: (a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), Department of Managed Health Care (DMHC), or their designees; and (b) At all reasonable times at Provider's place of business or at such other mutually agreeable location in California. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.13.)
12. Provider shall maintain all of its books and records, including Encounter Data, as applicable, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.14.)
13. Provider shall timely gather, preserve and provide to DHCS, CMS, Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Provider's possession, in accordance with the DHCS Contract, Exhibit E, Section 1.27 (Litigation Support). (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.15.)
14. To the extent applicable, Provider and its subcontractors must assist HPSM in the transfer of the Member's care as needed, and in accordance with the DHCS Contract, Exhibit E, Section 1.17 (Phaseout Requirements), in the event of termination of this Agreement, or the Medi-Cal Contract termination for any reason. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.16.)
15. Provider shall notify DHCS in the event this Agreement is amended or terminated for any reason. Notice is considered given when properly sent via the United States Postal Service as first-class registered mail to the address listed below, or when sent via email to DHCS at the email address designated by DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.17.)

Department of Health Care Services  
Managed Care Operations Division  
MS 4407  
P.O. Box 997413  
Sacramento, CA 95899-7413  
Attention: DHCS Contract Manager

16. Provider must hold harmless both the State and Members in the event HPSM, or another HPSM

subcontractor if applicable, cannot or will not pay for obligations and functions undertaken pursuant to this Agreement. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.18).)

17. Provider and its subcontractors must participate and cooperate in HPSM's Quality Improvement System as applicable. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.19).)
18. If Provider and its subcontractors takes on Quality Improvement activities, the Agreement and/or the relevant subcontracts must include those provisions stipulated in DHCS Contract, Exhibit A, Attachment III, Subsection 2.2.5 (Subcontractor and Downstream Subcontractor QI Activities). (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.20).)
19. To the extent Provider undertakes coordination of care obligations and functions for Members, HPSM shall share with Provider any utilization data that DHCS has provided to HPSM and Provider agrees to receive the utilization data and use it solely for the purpose of Member care coordination. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.21).)
20. HPSM must inform Provider of prospective requirements added by State or federal law or DHCS related to the DHCS Contract that impact obligations and functions undertaken through the Agreement before the requirement would be effective, and Provider must comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.22).)
21. Provider must inform its subcontractors taking on delegated HPSM functions of prospective requirements added by State or federal law or DHCS related to the DHCS Contract that impact obligations and functions undertaken through the subcontract before the requirement would be effective, and the subcontractors must comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.23).)
22. To the extent applicable, Provider must ensure that cultural competency, sensitivity, Health Equity, and diversity training is provided for Provider's staff at key points of contact with Members. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.24).)
23. To the extent that Provider communicates with Members, Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to Health and Safety Code section 1367.04. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.25).)
24. Provider will notify HPSM within ten (10) working days of any suspected fraud, waste, or abuse. Provider agrees that HPSM may share such information with DHCS in accordance with DHCS Contract, Exhibit A, Attachment III, Section 1.3.2.D (Contractor's Reporting Obligations) and Section 1.3.2.D.6 (Confidentiality). (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.26).)
25. Provider shall (i) report to HPSM, or to an HPSM subcontractor as applicable, when Provider has received an overpayment, (ii) return the overpayment to HPSM within sixty (60) calendar days after the date on which the overpayment was identified, and (iii) notify HPSM in writing of the reason for the overpayment. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.27).)
26. Provider must perform the obligations and functions undertaken pursuant to this Agreement, including, but not limited to, reporting responsibilities, in compliance with HPSM's obligations under the DHCS Contract in accordance with 42 CFR section 438.230(c)(1)(ii). (DHCS Contract, Exhibit A, Attachment III, Section

3.1.5.B.28).)

27. Provider agrees and acknowledges that DHCS is a direct beneficiary of the Agreement with respect to all obligations and functions undertaken pursuant to this Agreement and that DHCS may directly enforce any and all provisions of the Agreement. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.29).)
28. Provider agrees to provide HPSM with written disclosures on ownership and control as required under 42 CFR 455.104 and 22 CCR 51000.35, prior to commencing services under this Agreement. This Agreement and all information received from Provider in accordance with the subcontract requirements under the DHCS Contract shall become public record on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of Provider, stockholders owning more than 5 percent of the stock issued by Provider, and major creditors holding more than 5 percent of the debt of Provider will be attached to the Agreement at the time the Agreement is presented to DHCS. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.12; DHCS APL 23-006.)
29. Provider, and Provider's employees, officers, and directors, shall comply with the conflict of interest requirements set forth in Exhibit H of the DHCS Contract. (DHCS Contract, Exhibit H, Section A.)
30. Provider agrees that in the event Provider delegates its duties under this Agreement to a third party, the third party will be a Downstream Subcontractor. Provider must enter into a written agreement with the Downstream Subcontractor and ensure the written agreement contains the provisions set forth in this Exhibit and all other requirements under the Agreement and the DHCS Contract that are applicable to the specific obligations and functions that Provider delegates to the Downstream Subcontractor. (DHCS Contract, Exhibit A, Attachment III, Section 3.1.5.B.)
31. Provider agrees to all remedies specified by the Agreement and the DHCS Contract, including, but not limited to, revocation of delegated functions, imposition of corrective actions, and imposition of financial sanctions, in instances where DHCS or HPSM determine Provider has not performed satisfactorily. Provider acknowledges that HPSM must, upon discovery of Provider's noncompliance with the terms of the Agreement or any Medi-Cal requirements, report any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to the obligations under the DHCS Contract to DHCS within three Working Days of the discovery or imposition. (DHCS APL 23-006.)

## ATTACHMENT G DMHC ADMINISTRATIVE SERVICES REQUIREMENTS

This Attachment sets forth provisions that are required to be included in certain agreements pursuant HPSM's license with the Department of Managed Health Care ("DMHC"), and other provisions necessary to reflect compliance with law. Any citations in this Attachment are to the applicable sections of the Knox-Keene Health Care Service Plan Act of 1975 as contained in Health and Safety Code Section 1340 et seq. ("Section(s)"), and the regulations promulgated thereunder as set forth in Title 28 of the California Code of Regulations ("Rule(s)") (collectively, "Knox-Keene Requirements"). In the event of a conflict between this Attachment and any other provision of the Agreement, this Attachment will control with respect to Knox-Keene Requirements that are applicable to the Services provided by Provider hereunder. Any capitalized term utilized in this Attachment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this Attachment. If a capitalized term used in this Attachment is not defined in the Agreement or this Attachment, it will have the same meaning ascribed to it in the Knox-Keene Requirements.

1. Books and Records. To the extent required by the Knox-Keene Requirements or other applicable laws (a) Provider shall maintain and make available to HPSM, DMHC, and any other state or federal agency ("Regulatory Agency") having an interest in the subject of this Agreement, accurate books and records relative to all of Provider's activities under this Agreement for a period of at least five (5) years; and (b) a paper or electronic copy of such books and records must be available in California in order to permit HPSM, DMHC, and Regulatory Agency to audit, examine, copy, review, and inspect all invoices, materials, records, or other data related to matters covered by this Agreement. (Sections 1381, 1382(a), and 1385; Rules 1300.81, 1300.85, and 1300.85.1.)
2. Confidentiality of Medical Information Act. To the extent applicable, Provider shall comply with the provisions of the Confidentiality of Medical Information Act, Civil Code §56 et seq. (Section 1348.5.)
3. Liability. Provider agrees that Provider and HPSM are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending others. (Section 1371.25.)
4. Proper Licensure/Certification of Contracted Personnel & Equipment. To the extent applicable, Provider represents and warrants that it shall, at all times during the term of the Agreement, hold any necessary licenses, certifications, or accreditations that, to its knowledge, are necessary to perform its obligations under this Agreement, with no restrictions or other limitations that would prevent it from performing its obligations under this Agreement, and shall ensure that personnel employed by or under contract with Provider and who are performing any obligations under this Agreement hold any necessary licenses, certifications, or accreditations that, to Provider's knowledge, are necessary for such personnel to perform such obligations under this Agreement, with no restrictions or other limitations that would prevent such personnel from performing such obligations under this Agreement. To the extent applicable, Provider further represents and warrants that any and all equipment utilized for the performance of Services or obligations under this Agreement shall be licensed or registered as required by law. To the extent required by the Knox-Keene Requirements or other applicable laws, upon request, Provider shall provide HPSM with a copy of such licenses, certifications, accreditations, registrations, and any renewals thereof. (Section 1367(b)-(c).)
5. Administrative Capacity. Provider shall maintain the organizational and administrative capacity to perform its obligations under this Agreement. (Section 1367(g); Rule 1300.67.3.)

6. Audits & Inspections. To the extent required by the Knox-Keene Requirements or other applicable laws, Provider shall cooperate with and allow access to HPSM, DMHC, and applicable Regulatory Agency for the purposes of audits, inspections, examination, and any other reviews necessary to ensure proper performance of the terms of the Agreement and as required by law. (Sections 1381 and 1382(a); Rules 1300.82 and 1300.82.1.)
7. Corrective Actions. To the extent required by the Knox-Keene Requirements or other applicable laws, Provider agrees to promptly implement any corrective actions dictated by HPSM in the event there is a failure of performance on behalf of Provider. (Rule 1300.51(d)(N)(2).)
8. Compliance. Provider represents and warrants that it shall perform, and shall ensure any approved subcontractor performs, its obligations under this Agreement in compliance with all applicable Knox-Keene Requirements. (Section 1367(j).)

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