MEDICAL SERVICES AGREEMENT
BETWEEN
SAN MATEO HEALTH COMMISSION
AND
COUNTY OF SAN MATEO

This Medical Services Agreement ("Agreement") is entered into this 1st day of **July** 2023 (**the "Effective Date"**) by and between County of San Mateo, a provider of Covered health services who is duly licensed to practice in the State of California and validly enrolled and certified to provide services under the Medi-Cal and/or Medicare Programs (hereinafter referred to as "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 (hereinafter referred to as "HPSM" or "PLAN" or "Commission"). HPSM and Provider are sometimes individually referred to as "Party" and collectively referred to as "Parties". The Parties agree as follows:

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

Medical Services Agreement
Attachment A Scope of Services Enhanced Care Management
Attachment B Reimbursement
Attachment C Claims Submission and Reporting
Attachment D Medical Records Information

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

Lines of Business	Contract Status
Medi-Cal	☒ Yes ☐ No

Provider

Executed by:

Signature

Lizelle Lirio de Luna

Print Name

2000 Alameda de las Pulgas, Suite 230

San Mateo, CA 94403

Address

Date

Commission

Executed by:

Authorized Signature for Health Plan of San Mateo

801 Gateway Blvd., Suite 100

South San Francisco, CA 94080

Address

June 14, 2023

Date

TIN#	94-6000532
NPI#	1760541585

HEALTH PLAN OF SAN MATEO

ADDENDUM TO MEDICAL SERVICES AGREEMENT

(FOR GROUPS ONLY)

The undersigned representative represents the Provider of the healthcare group, is the authorized representative thereof signing this Agreement, and certifies by their signature that:

(a) The Provider is a duly organized single business entity organized for the express purpose of providing health care services to the public at large; and

(b) All providers of the Provider group have entered into separate agreements with the Provider group whereby they agree that each individual provider is the provider for purposes of delivering health care services, determining fees, billing patients and setting office practices and procedures. The individual providers have further agreed to accept as compensation a salary, a share of the Provider group's net profits or other compensations in lieu of the actual fee income from the patients they treat; and

(c) Upon reasonable request by HPSM, the Provider group agrees to provide certified copies of documents, including, but not limited to, articles of incorporation, partnership agreements or member provider agreements, which will verify its legal and organizational status and operation as described above; and

(d) Each individual provider participating in the Provider group Agreement must complete an individual Credentialing Application, Provider Training (pursuant to Section 2.7 of the Agreement), and approved by Health Plan of San Mateo prior to providing services to an HPSM member; and

(e) Provider group is responsible for notifying HPSM for each individual provider participating in the Provider group agreement of any provider termination or addition through roster submission; and

(f) The signatory is authorized to enter into this Agreement and Addendum to Medical Services Agreement on behalf of the Provider group.

County of San Mateo
GROUP

Signature: _____

Date: _____

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MEDICAL SERVICES AGREEMENT

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TERMS AND CONDITIONS

Recitals:

A. San Mateo Health Commission dba Health Plan of San Mateo 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 has entered, or intends to enter into agreements with various government agencies under which HPSM agrees to provide or arrange healthcare services to Members. HPSM has entered into an agreement with the California Department of Health Care Services ("DHCS"), the Centers for Medicare and Medicaid Services ("CMS"), and with the San Mateo County Public Authority.

C. Provider shall participate in providing Covered Services to Members and shall receive payment from Commission for the rendering of those Covered 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 "**Advanced Access"** shall mean the provision, by an individual provider, provider group or the medical group to which a Member is assigned, of appointments with a provider, or other qualified health care professional such as a nurse physician or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

1.2 "**Appointment Waiting Time**" shall mean the time from the initial request for health care services by a Member or the Member's provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from HPSM or completing any other condition or requirement of HPSM.

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

1.4 **"Capitation"** shall mean the average budgeted expenditures per Member per month for the provision of a defined scope of services.

1.5 **"Case Managed Members"** shall mean those Members who select or are assigned to a Provider and are identified on the Provider's Case Management list. The Provider is responsible for delivering or arranging for delivery of all health services required by these Members under the conditions set forth in this Agreement.

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

1.7 **"Child Health and Disability Prevention (CHDP) Program"** shall mean a preventative program that provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

1.8 **"CMO"** shall mean HPSM's Chief Medical Officer or his/her designee.

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

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

1.11 **"Co-payment"** shall mean the fee prescribed by State statute and paid by most Members for certain Covered Services, if applicable based on Member's benefit plan.

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

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

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

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

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

1.17 **"Engaged Member"** shall mean a Member who is actively receiving ECM services in a given month as

evidenced by the submission of a claim with the appropriate CPT codes. See Attachment A for details.

1.17 **Enhanced Care Management" (ECM)** shall mean a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

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

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

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

1.21 **"Excluded Services"** shall mean those services for which HPSM is not responsible and for which it does not receive a capitation payment, and not required by the Knox-Keene Act, and shall mean specific conditions or circumstances listed in this Agreement or each program's Evidence of Coverage, for which the PLAN will not provide benefit payments.

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

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

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

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

1.26 **"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.

1.26 "**Lead Care Manager"** shall mean the designated care manager responsible for coordinating all aspects of Members' ECM.

1.27 **"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.

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

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

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

1.31 **"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. For individuals under 21 years of age, a service is "medically necessary" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

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

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

1.34 **"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.

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

1.36 **"Participating Provider(s)"** shall mean a Physician or provider of health care services, including but not limited to those individual providers listed in the Addendum of this Agreement, who has entered into an Agreement with HPSM to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

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

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

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

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

1.41 **"Primary Care Services"** shall mean those services provided to Members by a Primary Care Physician.

1.42 **"Prior Authorization"** shall mean the process by which an authorization must be obtained from HPSM prior to rendering the requested service to ensure reimbursement, subject to the Member's eligibility and covered benefits at the time of service.

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

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

1.45 **"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.

1.46 **"Referral"** shall mean the process by which Participating Primary Care Physicians direct a Member to seek or obtain Covered Services from a health professional, hospital or any other provider of Covered Services in accordance with the PLAN's referral and authorization procedures.

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

1.48 **"Referral Provider"** shall mean any qualified Physician, duly licensed in California and certified and enrolled by the Medi-Cal Program and who has executed an Agreement with the PLAN and is professionally qualified to practice his/her designated specialty and, to whom the Primary Care Physician may refer any Member for consultation or treatment.

1.49 **"Referral Services"** shall mean any services which are not Primary Care Services, and which are provided by Physicians on referral from the Member's Primary Care Physician.

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

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

1.52 "**Special Members**" shall include all beneficiaries determined by PLAN to be inappropriate for inclusion in the regular case management system. Special Members are those beneficiaries: (a) who are case-managed (either on a temporary or permanent basis) by the PLAN or a non-capitated Primary Care Physician and (b) eligible only for retroactive coverage of services.

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

1.54 **"Telehealth"** shall mean the mode of delivering Covered Services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care from a site where the Member is located at the time healthcare services are provided or the site where the Member's medical information is transmitted from without the presence of the Member to a site where the Provider is located while providing these services, including the real time interactive communication between the Member and the Provider.

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

1.56 "**Triage" or "Screening**" shall mean the assessment of a Member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

1.57 "**Triage or Screening Waiting Time**" shall mean the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a Member who may need care.

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

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

SECTION 2
QUALIFICATIONS

2.1 Professional Licensure and Certification

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

2.1.1 Licensed and in good standing to provide healthcare services in the State of California;

2.1.2 Is validly enrolled, certified, and in good standing to provide services under the Medi-Cal Program, including those requirements contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations;

2.1.3 Is validly enrolled, certified, and in good standing to provider services under the Medicare Program, if applicable;

2.1.4 Is professionally qualified to practice his/her designated specialty, including maintaining board certifications if applicable and required;

2.1.5 Shall have the capacity to provide culturally appropriate and timely in-person care management functions for the provision of ECM.

2.1.6 Shall be able to communicate in culturally and linguistically appropriate and accessible ways.

2.1.7 Maintains active medical staff privileges and in good standing at one of the HPSM's Contracted Hospitals, or has been specifically excepted from this requirement by HPSM's Peer Review Committee, or this requirement is determined by HPSM to be inapplicable based on the type of services provided by provider or type of licensure maintained by provider. Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate for each Member;

2.1.8 Has been appropriately credentialed by HPSM;

2.1.9 Practicing within San Mateo County or has been specifically exempted from this requirement by HPSM's Peer Review Committee

2.1.10 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;

2.1.11 Has never been convicted of a felony or misdemeanor relating to the practice of his or her profession, or that in the opinion of PLAN would adversely affect the integrity of PLAN or the ability of the practitioner to participate with PLAN. 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

2.1.12 Committed to making every effort to comply with PLAN's drug formularies.

2.1.13 The Provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rending provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group, if applicable.

2.1.14 The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements, if applicable, and must be located in California or a border community.

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 Continuing Education

During the entire term of this Agreement, each provider of healthcare services employed and/or affiliated with Provider shall maintain his/her professional competence and skills as well as Continuing Education units in accordance with professional standards and as required by federal, state and municipal laws.

2.4 Assistants

Provider shall employ such assistants and employees as Provider deems necessary to perform Covered Services for Members in Provider's office. HPSM may not control, direct or supervise Provider's assistants and employees in the performance of those Covered 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.

2.5 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.

At all times, Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned Member consistent with Agreement and any other related DHCS guidance.

2.6 Provider Training

HPSM shall ensure that a designated contact at the Provider practice site receives training materials on 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.

Providers shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by the PLAN, including in-person sessions, webinars, and/or calls, as necessary.

SECTION 3
ACCESS TO CARE AND CARE COORDINATION

3.1 Provider Directory

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

- 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 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, Provider shall provide to HPSM monthly rosters of information and data pertaining to each individual provider in Provider's group practice, including but not limited to any changes in provider information and data. Information and data required shall be determined by HPSM, including without limitation the above listed fields.

3.1.3 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 Provider Responsibility

Provider is responsible for coordinating the care of the Member among multiple physicians, including the Member's Primary Care Physician. In addition, it is expected that, to the extent possible, any services provided to HPSM members are rendered according to evidence-based guidelines and professionally recognized standards of care. Provider may freely communicate with Members who are patients about their treatment, regardless of benefit coverage and limitations. The Provider shall abide by PLAN's case management policies and procedures, including but not limited to those program requirements outlined in PLAN's Provider Manual.

Provider may identify Members who would benefit from ECM and send a request to the PLAN, to determine if the Member is eligible for ECM, consistent with the PLAN's process for such request.

In addition, there are specific items or services that require HPSM prior authorization (e.g. durable medical equipment, certain medications, specific procedures, etc.) before rendering the service in order for the service to be reimbursed.

Provider to whom the Primary Care Physician has delegated the authority to proceed with treatment shall be responsible for all health care advice and services performed or prescribed by him/her for the Member. The Primary Care Physician is responsible for oversight of the quality of care the Member receives. Member's Primary Care Physician may raise any concerns regarding quality of care to Provider and/or the PLAN CMO or designee.

3.4 Direct Contact and Coverage Plan

PLAN shall communicate new Member assignments to provider as soon as possible, but in an any event no later than ten business days after ECM authorization.

Provider shall accept all Members assigned by PLAN for ECM within five (5) business days, with the exception that an ECM shall be permitted to decline a Member assignment if Provider is at its pre-determined capacity. Provider shall immediately alert PLAN if it does not have the capacity to accept a Member assignment.

Upon initiation of ECM, Provider shall ensure that each Member assigned has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address Social Determinants of Health (SDOH) needs, regardless of setting. Provider shall advise the Member on the process for changing Provider, which is permitted at any time. Provider shall notify PLAN if the Member wishes to change Providers. PLAN must implement any requested Provider change within thirty (30) days.

Provider shall make suitable arrangements for personal contact with the Member, or for services by appropriate personnel in accordance with customary professional practice and with law, and shall provide for the Member, or order for the Member on his or her behalf, all Covered Services which are consistent with the Member's presenting conditions and health care needs, and with the objectives of the PLAN's locally administered program, as made explicit in the Recitals to this Agreement. These arrangements shall be made in a timely fashion suitable to meet the health care needs of the Member's condition/request.

Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with the PLAN's Policies and Procedures. Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.

Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences:

a. Mail
b. Email
c. Texts
d. Telephone calls
e. Telehealth

Provider shall be responsible for organizing a pattern of supportive health care resources, so that Members may be appropriately served by health care advice and supervision seven (7) days each week and twenty-four (24) hours per day. This includes arranging for: 1) appropriate cross-coverage when not available during regular business hours (e.g. for vacation, illness, etc), of forty (40) hours per week and 2) a coverage plan for Members if the Provider is not available/cannot be contacted for urgent issues on evenings and weekends.

If Provider is unable from time to time to provide Covered Services when needed, he/she shall secure the services of a qualified covering provider who shall render the Covered Services required of Provider; provided, however, that the covering provider must be approved by HPSM to provide Covered Services to Members and must comply with the representations set forth in Section 2 of this Agreement. Provider shall be solely responsible for securing the services of the covering provider. Provider shall ensure that the covering provider: (1) looks solely to HPSM for payment of Covered Services; (2) will accept HPSM's peer review procedures; (3) will not directly bill Members for Covered Services under any circumstances; (4) will comply with HPSM's utilization review/quality assurance program; and (5) will comply with the terms of this Agreement.

Provider shall meet the after hours requirements set forth in the Provider Manual including but not limited to, standards for maintaining certain practices, policies, and procedures for after hours healthcare services.

PLAN shall ensure that Members are able to decline or end ECM upon initial outreach and engagement, or at any other time. Provider shall notify the PLAN to discontinue ECM under the following circumstances:

i. The Member has met their care plan goals for ECM;
ii. The Member is ready to transition to a lower level of care;
iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
iv. Provider has not had any contact with the Member despite multiple attempts.

When ECM is discontinued, or will be discontinued for the Member, PLAN is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA, refer to Section 10.1. Provider shall communicate to the Member other benefits or programs that may be available to Member, as applicable (e.g. Complex Care Management, Basic Care Management, etc.).

3.5 Eligibility Verification

Provider shall verify the eligibility of Members who present themselves at the time of service. At all times, Provider shall verify the eligibility of Members for HPSM's plan benefits. Provider may make such verification by using the verification options as described in the Provider Manual.

3.6 Timely Access to Care

3.6.1 Pursuant to Department of Managed Health Care regulation (Title 28, Section 1300.67.2.2), HPSM is obligated to ensure Provider shall provide covered health care services in a timely manner appropriate for the nature of a Member's condition consistent with good professional practice and offer Members appointments that meet the following timeframes:

a) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (g);

b) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (g);

c) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (g) and (h);

d) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (g) and (h)

e) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (g) and (h);

f) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (g) and (h);

g) The applicable waiting time for a particular appointment must be extended if the referring or treating licensed health care physician, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member;

h) Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the Provider acting within the scope of his or her practice.

3.6.2 Triage

3.6.2.1 Provider shall provide or arrange for the provision, 24 hours per day, 7 days per week, of Triage or Screening services by telephone.

3.6.2.2 Provider shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the Member's condition, and that the triage or screening waiting time does not exceed 30 minutes.

3.6.2.3 Provider shall maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, which will inform the caller:

i. Regarding the length of wait for a return call from the Provider; and

ii. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

3.6.2.4 Provider understands that unlicensed staff may only take information for the Provider and may not attempt to assess, evaluate, advise or make any decision regarding the condition of a Member or determine when a Member needs to be seen by a licensed health care professional.

3.6.3 Other provisions

3.6.3.1 Provider is aware that HPSM has the responsibility under the Timely Access Regulations (28 CCR 1300.67.2.2) to provide or arrange for the provision of access to health care services in a timely manner and to measure and monitor how Participating Providers provide Members with timely access to covered health care services.

3.6.3.2 When it is necessary for Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs, and ensures continuity of care consistent with good professional practice, and the requirements of the Timely Access regulations.

3.6.3.3 When required, Provider shall participate in an annual provider survey to solicit from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the Timely Access standards.

3.6.3.4 Provider may upon request provide information to enable HPSM verify that Provider's services are in compliance with the Timely Access regulations as set forth in 28 CCR 1300.67.2.2. Where compliance monitoring reveals deficiencies, Provider shall cooperate with HPSM to identify the causes underlying identified deficiencies and take steps to bring his/her appointments scheduling into compliance with the regulations.

3.6.3.5 Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

3.7 **Discrimination Prohibited**

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

3.8 **Treatment Plan and Reports of Services Rendered**

Provider agrees to use best efforts to submit a written report to the Member's PCP and PLAN outlining the plan of treatment proposed by Provider, including any proposed hospitalization or surgery, prior to rendering any treatment proposed by Provider within 15 days after contact with Member. Provider, the Member's PCP, and the PLAN shall agree on the plan of treatment proposed by Provider prior to treating a Member. Provider shall provide a complete report to a Member's Primary Care Physician of all services rendered.

Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g. discharges from a hospital, long-term care facility, housing status).

3.9 **Member Non-Compliance with Medical Treatment**

A Member, for personal reasons, may refuse to follow or undergo one or more procedures or courses of treatment recommended by Provider. In cases where Provider determines that no professionally acceptable alternatives to such recommended procedures or courses of treatment exist which are consistent with the objectives set forth in the Recitals of this Agreement, Provider shall consult with the Member's Primary Care Physician at the earliest convenient time.

3.10 **Provider to Member Ratio**

Provider shall serve a minimum of 30 Members per provider full-time equivalent (FTE) CM/CHW unless otherwise negotiated with the PLAN.

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 **Covered Services**

Provider shall provide Covered Services to each Member when they are Medically Necessary and appropriate for the care of that Member, subject to the Exclusions listed in Section 4.10 of this Agreement.

4.3 Prior Authorization

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

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

4.4 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 Medically 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 Imposition of Controls if Necessary

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

4.6 Services for Members with Disabilities

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

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

4.7 Patient Rights and Linguistic Services

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.

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

4.7.2 Interpreter Services for Limited English Proficient (LEP) Members

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

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. NOTE: The use of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and is only to be used if a Member insists on this after provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

- HPSM contracts with a qualified telephonic interpreter service to assist providers in complying with this Section. Providers are 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 patient's preferred language, the request/type of interpreter services provided or refusal of language interpreter services by a Limited English Proficient (LEP) Member in the medical record.

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.

4.7.3 Additional Linguistic Services for Threshold Language Members

Threshold languages in each county are designated by the Department of Health Care Services.

These are primary languages spoken by the LEP population groups meeting a specific numeric threshold or concentration standard. The threshold language(s) for San Mateo County is(/are) published annually.

In addition to interpreter services for LEP Members, as stated in Section 4.7.2, the Provider shall provide the following for Members whose language proficiency is in a threshold language:

4.7.3.1 Translated signage
4.7.3.2 Translated written materials
4.7.3.3 Referrals to culturally and linguistically appropriate community service programs
4.7.3.4 Information on how to file a grievance and the ability to file a grievance in a non-English language.

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

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

4.8 Medi-Cal, Medicare, and HealthWorx Restrictions, as Applicable

4.8.1 Services provided shall be subject to HPSM's most current Medi-Cal and Medicare Agreements, as applicable.

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

4.9 Formulary

If applicable, prescriptions payable by HPSM shall be subject to the restrictions on the State's Medi-Cal Formulary, except where Formulary changes are authorized by HPSM in accordance with its contract Services which in the judgment of the Primary Care Physician (for services requiring referral) with the State of California. Provider is expected to use HPSM's formulary medications and generic medications preferentially, when clinically appropriate.

4.10 **Exclusions.** Excluded services from the Medi-Cal, Medicare, or HealthWorx programs and/or the scope of services under this Medical Services Agreement include but are not limited to:

4.10.1 Services which in the judgment of the Primary Care Physician (for services requiring referral) and/or HPSM's CMO (for services requiring prior authorization) or his/her designee, are not Medically Necessary or appropriate for the control and prevention of health related illness, disease, or disability.

4.10.2 Services reimbursed by long term in-home waivered services, Multi-Senior Services, Community-Based Adult Services, Adult Day Health Services, Medi-Cal specialty mental health

services/Short-Doyle Medi-Cal services and Drug Medi-Cal substance use treatment services (except for outpatient pharmaceuticals and laboratory services prescribed by a non-psychiatrist Provider).

4.10.3 Services that are not covered under the Medi-Cal, Medicare, or HealthWorx programs.

4.10.4 Other services as may be determined by HPSM, and as noticed to the Participating Providers.

4.11 Utilization Data

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

PLAN shall provide to Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the Provider;
ii. Encounter and/or claims data;
iii. Physical, behavioral, administrative and SDOH data for all assigned Members;
iv. Reports of performance on quality measures and/or metrics as requested.

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 shall comply with all applicable State and Federal laws pursuant to the Telehealth Advance Act of 2011.

PROVIDER shall provide reports, information, and documentation for PLAN to comply with any applicable state and federal regulatory reporting requirements including but not limited to those requirements outlined in 42 CFR §422.516, 42 CFR §438.602, 42 CFR §455.436, and the requirements in 42 CFR §422.310 for submitting data to CMS for the purposes of reporting costs, utilization, quality, enrollee health status, and fiscal soundness to CMS, as well as of enabling CMS to characterize the context and purpose of each item and service provided to a Member under this Agreement for accurate application of CMS's risk adjustment payment model. PROVIDER also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data. Provider shall submit to PLAN complete, accurate, reasonable, and timely provider data needed by PLAN in order to meet its provider data and encounter data reporting requirements to DHCS. Data provided shall include, without limitation, health care services delivery encounter data and claims data in the format and timeline required by PLAN and DHCS.

PROVIDER understands and agrees that HPSM is responsible for the monitoring and oversight of all duties of PROVIDER under this Agreement, and that HPSM has the authority and responsibility to: (i) implement, maintain and enforce HPSM's policies governing PROVIDER's duties under this Agreement; (ii) conduct audits, inspections and/or investigations in order to oversee PROVIDER's performance of duties described in this Agreement; (iii) require PROVIDER to take corrective action if HPSM, any applicable federal or state regulator, or applicable accreditation organization determines that corrective action is needed with regard to any duty under this Agreement; and/or (iv) revoke the delegation of any duty 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 PLAN will conduct oversight of its participation in ECM to ensure that quality of ECM and ongoing compliance with the program requirements, which may include audits/and or corrective actions. Provider shall respond to all MCP requests for information and documentation to permit ongoing monitoring of ECM.

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

PROVIDER agrees to permit the California Department of Managed Health Care ("DMHC"), CMS and the U.S. Department of Health and Human Services ("HHS") to conduct on-site evaluations of PROVIDER periodically in accordance with the current state and federal laws and regulations and to comply with the agency's recommendations, if any. PROVIDER shall give CMS, DMHC, HHS, the U.S. General Accounting Office ("GAO"), the Comptroller General, any Peer Review Organization ("PRO"), Quality Improvement Organization ("QIO"), or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of PLANs, 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 PLAN. Provider shall comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. PLAN shall inform Provider of prospective requirements added by DHCS to PLAN's contract with DHCS before the requirement's effective date. Provider shall comply with the new contractual requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

5.3 **Compliance with Governing Board Standards**

PROVIDER shall at all times during the term of this Agreement comply with, and have any of its Downstream Entities, including agents and subcontractors, comply with all applicable federal, state and municipal laws, and all applicable standards, rules, and regulations of the appropriate California governing boards for

healthcare services, including but not limited to the Medical Board of California, the California Board of Osteopathic Examiners, the American Medical Association, and the California Medical Association.

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

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

PROVIDER understands that HPSM has certain obligations including the credentialing of Providers, and that HPSM will have the right to oversee and review the quality of care and services provided to Members by PROVIDER. PROVIDER agrees to be accountable to cooperate and comply with HPSM whenever HPSM imposes such obligations on PROVIDER. Obligations may include, but may not be limited to: on- site review, member transfer from or to referring facilities, cooperation with Healthcare Effectiveness Data Information Sets ("HEDIS") measurements and other internal and external quality review and improvement programs, and risk adjustment programs. Provider 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, encounter data validation, 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. HPSM's quality improvement program shall be developed in consultation with its Participating Providers to ensure that practice guidelines of quality improvement and quality management pursuant to CMS regulations and instructions are met. The program may include audits, reviews and surveys performed from time to time upon the request of HPSM.

PROVIDER and its Downstream Entities, including agents and subcontractors, shall fully cooperate with and participate in HPSM's quality improvement program and procedures as described in the Provider Manual. PROVIDER shall immediately notify HPSM of those Members and cases which fall within the catastrophic and targeted case management guidelines set forth in the Provider Manual and shall cooperate with HPSM's case management program for catastrophic and targeted cases. PROVIDER and Participating Providers 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.

Although HPSM's quality improvement activities are not delegated to PROVIDER, HPSM may delegate, in whole or in part, such quality improvement activities to PROVIDER, through an amendment in accordance with this Agreement

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SECTION 6
PAYMENTS

6.1 Conditions for Payment

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

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

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

6.1.3 The Provider must determine that the Covered Services being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s), associated with the Covered Service as well as any other requirements described in the Medi-Cal Provider Manual, available on DHCS's website.

6.1.4 Prior authorization was obtained from HPSM, if required.

6.2 Billing Procedures

Provider shall submit initial claims within three hundred sixty five (365) days following the date of discharge (for Inpatients) or date of services (for Outpatients). Claims received after one hundred and eighty (180) days from the date Covered Services are rendered are subject to the Medi-Cal reduced reimbursement structure as set forth in the Provider Manual unless the claim meets Medi-Cal's timely filing exceptions

6.3 Form

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

6.4 Payment

HPSM shall process claims in accordance with 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 Covered Services provided to eligible Members.

6.5 Correct Coding Initiative (CCI) Edits

HPSM will utilize current CCI edits unless superseded by existing Medi-Cal and Medicare payment methodologies, as applicable.

6.6 Member Liability

Provider shall look only to HPSM for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services, including but not limited to, nonpayment by HPSM, the HPSM's insolvency, dissolution, bankruptcy or breach of the Agreement. The Provider shall not bill, charge, charge co-payments or coinsurance, surcharge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against any Member for any debts owed by HPSM under this Agreement for Covered Services payable by HPSM. In addition, Provider shall not invoice or balance bill a Member for the difference between Provider's billed charges and the reimbursement paid by the PLAN for Covered Services. The Provider shall report to HPSM in writing all surcharges and co-payments paid by Members to the Provider. If HPSM receives notice of any surcharges upon any Member, it shall be empowered to take appropriate action. This provision shall not prohibit billing and collecting from Members for services which are not Covered Services, provided that prior to rendering of a non-covered service, Provider supplies to the Member a written notice informing them of financial responsibility for said services and Member must formally accept financial responsibility in writing, prior to rendering of a non-covered service.

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

6.7 Hold Harmless

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

6.8 Other Health Insurance Coverage and Coordination of Benefits (COB) Obligations

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

6.9 Third Party Liability (TPL) and Liens

Provider shall report to HPSM, when Provider discovers that Covered Services rendered either directly

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

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

6.10 **Overpayments**

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

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

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

HPSM 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.

6.11 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.

6.11.1 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.

6.11.2 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 plan 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 plan pursuant to Section 3.1.

6.12 Coverage for Emergency Services

PLAN is responsible for coverage and payment of emergency services and post stabilization care services and must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the PLAN. PLAN may not deny payment for treatment obtained

when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical condition. Further, PLAN may not deny payment for treatment obtained when a representative of the PLAN instructs the enrollee to seek Emergency Services.
PLAN may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room Physician, Hospital, or fiscal agent not notifying the Member's Primary Care Physician or the PLAN of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

PLAN is financially responsible for post- stabilization services obtained within or outside PLAN's network that are pre-approved by a PLAN provider or other entity representative.
PLAN is also financially responsible for post-stabilization care services obtained within or outside PLAN's network that are not pre-approved by a PLAN provider or other entity representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if PLAN does not respond to a request for pre-approval within 30 minutes; PLAN cannot be contacted; or PLAN's representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation.

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

SECTION 7
TERM, TERMINATION, AND AMENDMENT

7.1 Term

This Agreement shall be for a term of one (1) year from the Effective Date(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 ninety (90) days written notice via mail, fax, or email.

7.2.3 Conditions for Immediate Termination by HPSM

a) HPSM shall terminate this Agreement effective immediately in the following situations: change in licensure status resulting in restricted licensure or loss; loss of Medi-Cal and/or Medicare Provider certification; medical staff privileges at a Participating Hospital are denied or reduced; professional liability insurance coverage or any other insurance required under this Agreement is reduced or no longer in effect; change in licensure status to prescribe controlled substances resulting in restricted licensure or loss; any sanctions imposed against Provider under Medi-Cal or Medicare programs; any other professional disciplinary action or criminal action of any kind against Provider that is initiated, in progress, or completed during the term of this Agreement

b) HPSM may terminate this Agreement 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 or Commission decisions; failure to comply with Corrective Action Plan requirements; failure to provide adequate level of service to Members as demonstrated by inadequate hours of operation; failure to provide minimum scope of services in care delivery; or repeated (two or more) grievances filed by Members that are not adequately addressed in spite of HPSM offers of assistance.

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 the PLAN nor Provider shall assign this Agreement without the prior written consent of the other party and DHCS.

7.5 **Amendment**

7.5.1 Amendment by Mutual Agreement

This Agreement may be amended at any time by mutual agreement of the Parties and subject to the requirements of Section 12.17 of this Agreement. Any such amendment must be in writing, dated and signed by the Parties and attached to this Agreement.

7.5.2 Knox-Keene Amendments

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

7.6 **Transfer of Care**

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

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

Provider.

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

7.7 Provider Rights Upon Termination

Issues raised about a Provider's performance shall be considered initially by HPSM's CMO, who shall have the broad discretion to determine how to proceed as delegated by the Commission. His/her options shall include but not be limited to maintaining a record of the matter without further investigation or action; referring the matter to HPSM's Peer Review Committee (PRC) or any other quality oversight body for investigation and the preparation of a report to the Chief Executive Officer (CEO) and/or the Commission.
Effective immediately upon notice to the Provider, pending reconsideration and action by the PRC or any other quality oversight body, the Chair of the PRC, or the CMO or CEO may summarily reduce or suspend the Provider's privilege to provide patient care services, in instances where there may be immediate danger to the health of any individual. The Committees may perpetuate the reduction or suspension pending action by the Commission.

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

7.8 Notice of Termination and Amendments to DHCS

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

SECTION 8
MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 Medical Record

The Provider shall maintain for each Member who has received services, a legible medical record, kept in detail and accuracy consistent with appropriate medical and professional practice, which permits effective internal professional review and external medical audit process and which facilitates an adequate system for follow-up treatment and maintained in a manner as required by state and federal law and regulations, including but not limited to, Sections 70747- 70751 of Title 22 of the California Code of Regulation and Section 51476 of Title 22 of the California Administrative Code. The Provider shall maintain such records for at least ten (10) years from the final date of a particular

contract period between HPSM and Provider, from the date of completion of any audit, or from the date the service was rendered, whichever is later. Provider will ensure that unauthorized individuals are unable to gain access to or alter physical or electronic patient records. The negligent disposal or destruction of medical records is prohibited.

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

If an individual provider from Provider's group practice terminates his/her relationship with Provider's group practice, medical records of such individual provider for each Member who has received services, shall be retained and maintained by Provider group practice in accordance with this Section 8 and shall include documentation showing the individual provider's date of termination.

8.2 **Inspection Rights**

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

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

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

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

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

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

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

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

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

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

8.3 **Confidential Information**

For the purpose of this Agreement, all information, records, payment information, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by the Provider and his/her staff from unauthorized disclosure as required by Medi-Cal and all applicable state and federal law and regulations governing protection of patient information, including but not limited to "Confidentiality of Medical Information Act", Cal. Civ. Code § 56 et seq., 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.

Provider shall obtain, document, and manage Member authorization the sharing of Personally Identifiable Information between the PLAN and ECM, Community Supports, and other Providers involved in the provision of Member care to extend required by federal law.

Member authorization for ECM-related data sharing is not required for the Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, Provider shall communicate that it has obtained Member authorization for such data sharing back

to the PLAN.

8.4 Subcontracts

Provider shall maintain and make available to the PLAN, DHCS, CMS, DHHS Inspector General, the Comptroller General, the DOJ, and DMHC, all applicable state and federal agencies, self-regulatory agencies, applicable accrediting organization, or their designees, upon written request, copies of all subcontracts for the performance of any of Provider's obligations under this Agreement. If the Provider subcontracts with other entities to administer its functions of ECM, the Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set here and that its subcontractors comply with all requirements in this Agreement and any other related DHCS guidance. Provider shall further assure that all subcontracts entered into from the Effective Date(s) of this Agreement are in writing and shall require that the subcontractor:

8.4.1 Make all premises, facilities, equipment, applicable books, records, contracts, computers, or other electronic systems related to the subcontracting agreements, available at all reasonable times for audit, inspection, examination, or copying by the PLAN, DHCS, CMS, DHHS Inspector General, the Comptroller General, the DOJ, and DMHC, all applicable state and federal agencies, self-regulatory agencies, applicable accrediting organization, or their designees.

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

8.5 Reporting Fraud, Waste, and Abuse (FWA)

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

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

8.6 Member Access to Records

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

8.7 **Records Related to Recovery for Litigation**

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

SECTION 9
INSURANCE AND INDEMNIFICATION

9.1 **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 save harmless HPSM and its officers, agents, employees, and servants from all claims, suits, or actions of every name, kind, and description 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 of the following (including but not limited to attorneys' fees):

(A) injuries to or death of any person, including Provider or its employees/officers/agents;

(B) damage to any property of any kind whatsoever and to whomsoever belonging;

(C) any sanctions, penalties, or claims of damages resulting from Provider's failure to comply, if applicable, with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended; or

(D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of HPSM and/or its officers, agents, employees, or servants. However, Provider's duty to indemnify and save harmless under this Section shall not apply to injuries or damage for which HPSM has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of Provider to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code. This Section shall survive termination or expiration of this Agreement.

SECTION 10
PROVIDER DISPUTES AND MEMBER COMPLAINTS

10.1 Grievances, Appeals and Provider Disputes

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

10.2 Dispute Procedure

10.2.1 Responsibility

HPSM's Chief Executive Officer has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance, Appeals and Provider

Disputes review systems. The Chief Executive Officer shall be assisted by HPSM'S Chief Compliance Officer, Director of Customer Support, Claims Director, Director of Provider Services, the Chief Medical Officer), or their designees.

10.2.2 Disputes Relating to Claims Payment

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

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.

10.2.3 Member Complaints

Provider shall provide contact information to Members informing them how to contact HPSM in the event of a question, concern, or complaint. Provider shall display in a prominent place at their place of service, notice informing Members how to contact HPSM and file a complaint. Provider may file an appeal of a denial of an authorization request for services on behalf of a Member and shall submit the appeal in accordance with the Member Complaints Section of the Provider Manual. However, Provider shall not bill, charge, collect a deposit, or seek payment from the member for filing an appeal on their behalf. If a Member files an appeal of a denial of an authorization request for services, Provider shall assist in the appeals process, including but not limited to, forwarding relevant medical records to help the HPSM make a decision on an appeal. Members have the right to submit a grievance expressing dissatisfaction with any aspect of Provider's operations, activities, behaviors, including quality of care concerns. Provider shall participate when requested by HPSM in the resolution of the grievance, in accordance with the Member Complaints Section of the Provider Manual. Participation by Provider shall include, without limitation, providing timely responses to concerns raised by Members and relevant medical records.

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

SECTION 11

DISPUTES ARISING FROM OR RELATING TO THIS AGREEMENT

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. In the event of any dispute arising out of this Agreement that cannot be resolved through HPSM's PDR process or the process described in Section 10.2 above, 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 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 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.

12.2 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:

12.2.1 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

12.2.2 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.

12.3 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.

12.4 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.

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

12.6 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.

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

12.8 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.

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

12.10 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.

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

12.12 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.

12.13 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.

12.14 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.

12.15 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.

12.16 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.

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

12.18 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.

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

12.20 Provider shall comply with non-discrimination requirements set forth in State and Federal law and any other related DHCS guidance.

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 – ECM

Provider shall ensure ECM is a whole-person, interdisciplinary approach to care than addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

Provider shall:

i. Ensure each Member receiving ECM has a Lead Care Manager;
ii. Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;
iii. Alert PLAN to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources; and
iv. Follow PLAN instruction and participate in efforts to ensure ECM and other care management services are not duplicative.
v. Members enrolled in the following programs are excluded from ECM and/or from the scope of services under this Medical Services Agreement:

    i. 1915 (c) waivers:
        a. Multipurpose Senior Services Program (MSSP);
        b. Assisted Living Waiver
        c. Home and Community-Based Alternatives (HCBA) Waiver;
        d. HIV/AIDS Waiver;
        e. HCBS Waiver for Individuals with Developmental Disabilities (DD); and
        f. Self-Determination Programs for Individuals with I/DD.
    ii. Fully integrated programs for Members dually eligible for Medicare and Medicaid;
        a. Cal MediConnect
        b. Fully Integrated Dual Eligible Specials Needs Plans (FIDE_SNPs); and
        c. Program for All-Inclusive Care for the Elderly (PACE).
    iii. Family Mosaic Project
    iv. California Community Transitions (CCT) Money Follows the Person (MFTP)
    v. Basic or Complex Case Management

Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as ILOS Providers, as appropriate, to coordinate Member care.

Provider shall provide all core service components of ECM to each assigned Member, in compliance with PLAN's Policies and Procedures, as follows:

i. Outreach and Engagement of PLAN Members into ECM.
ii. Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:
    a. Engaging with each Member authorized to receive ECM primarily through in-person contact;
        i. When in-person communication is unavailable or does not meet the needs of the Member, the Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
    b. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess

Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.

c. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
d. Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.
e. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and
f. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.

iii. Enhanced Coordination of Care, which shall include, but is not limited to:
   a. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;
   b. Maintaining regular contact with all Providers, that are identified as being part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;
   c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
   d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
   e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
   f. Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

iv. Health Promotion, which shall adhere to the federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:
   a. Working with Members to identify and build on successes and potential family and/or support networks.
   b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Member's ability to successfully monitor and manage their health; and
   c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

v. Comprehensive Transitional Care, which shall include, but is not limited to:
   a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
   b. For Members who are experiencing, or who are likely to experience a care transition;
      i. Developing and regularly updating a transition of care plan for the Member;
      ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
iv. Coordinating medication review/reconciliation; and
v. Providing adherence support and referral to appropriate services.

vi. Member and Family Supports, which shall include, but are not limited to:
   a. Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and PLAN as applicable;
   b. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;
   c. Ensuring the Member's Provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);
   d. Identifying supports needed for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;
   e. Providing for appropriate education of the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and
   f. Ensuring that the Member has a copy of their Care Plan and information about how to request updates.

vii. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
   a. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by PLAN as Community Supports; and
   b. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "closed loop referrals").

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Attachment B
Reimbursement

Medi-Cal:

PLAN shall pay Provider for the provision of ECM services in accordance with DHCS guidelines.
Payment under Medi-Cal shall be subject to applicable state and federally-mandated payment reductions and pricing rules

CalAIM Rates:

In consideration of the services provided in Attachment A, PLAN shall pay Provider a monthly case rate of $ 472.00 Per Engaged Member Per Month (PEMPM) enrolled in ECM.

PLAN shall pay Provider for ECM related services as outlined below:

HCPCS Level II Code	HCPCS Description	Modifier(s)	Modifier Description	Rate
ECM00	Monthly case rate- not dependent on submission of ECM encounter data.	N/A	N/A	$472.00 Per Engaged Member Per Month (PEMPM) – Maximum of once per calendar month
G9008	Enhanced Care Management ECM In-Person: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services	U1	Used by Managed Care with HCPCS Code G9008 to indicate Enhanced Care Management services. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services provided must be in accordance with DHCS policy.	$0 on ECM encounter data submissions.
	ECM Phone/Telehealth: Provided by Clinical Staff. Coordinated care fee, physician coordinated care oversight services.	U1 and GQ		
G9012	ECM In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified	U2	Used by Managed Care with HCPCS code G9012 to indicate Enhanced Care Management services. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services provided must be in accordance with DHCS policy.	
	ECM Phone/Telehealth: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified	U2 and GQ		

HCPCS Level II Code	HCPCS Description	Modifier(s)	Modifier Description	Rate
G9008	ECM Outreach In- Person: Provided by Clinical Staff. Other specified case management service not elsewhere classified	U8	Used by Managed Care with HCPCS code G9008 to indicate a single in-person Enhanced Care Management outreach attempt for an individual Member, for the purpose of initiation into Enhanced Care Management If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services provided must be in accordance with DHCS policy. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g. mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.	$50 per month per Member, once per month, no more than 3 times in 12 rolling months. ECM Outreach will be reimbursed in addition to the monthly case rate.
	ECM Outreach Telephonic/Electronic: Provided by Clinical Staff. Other specified case management service not elsewhere classified	U8 and GQ		
G9012	ECM Outreach In-Person: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified.	U8	Used by Managed Care with HCPCS code G9012 to indicate a single in-person Enhanced Care Management outreach attempt for an individual Member, for the purpose of initiation into Enhanced Care Management. If an ECM service is provided through telehealth, an additional modifier GQ must be used. All telehealth services provided must be in accordance with DHCS policy. Telephonic/electronic methods can include text messaging or secure email individualized to the Member. However, mass communications (e.g. mass mailings, distribution emails, and text messages) do not count as outreach and should not be included.	
	ECM Outreach Telephonic/Electronic: Provided by Non-Clinical Staff. Other specified case management service not elsewhere classified	U8 and GQ		

For all other services provided by the ECM Provider, HPSM will pay $0 unless the Provider is eligible to bill Community Support services. Community Support services will be paid in addition to ECM.

PLAN shall pay 90 percent of all clean claims from practitioners who are individual or group practices or who practice in shared health facilities within 30 days of date of receipt and 99 percent of all clean claims within 90 days for the

provision of ECM services to Members. The date of receipt shall be the date PLAN receives the claim, as its date stamp on the claim and the date of payment shall be the date on the check or other form of payment.

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Attachment C
Claims Submission and Reporting

Provider shall submit claims for the provision of ECM-related services to PLAN using the national standard specifications and code sets to be defined 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 PLAN for ECM-related services using the national standard specifications and DHCS-defined code sets, Provider shall submit an invoice to the PLAN with a minimum set of data elements (to be defined by DHCS) necessary for the PLAN to convert the invoice to an encounter for submission to DHCS.

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Attachment D
Medical Records Information

San Mateo IT, is the custodian of records ("Custodian of Records") for County of San Mateo. The records will be stored at 225 W. 37th Avenue, San Mateo, CA 94403 , using the following storage mechanism(s) (e.g., office-based, off-site, combination): EHS, and in the following format(s) (e.g., paper charts, EHR and type, combination): MedHOK.

Contact information for Custodian of Records:

Phone:	N/A
Fax:	N/A
Mailing Address:	225 W. 37th Avenue, San Mateo, CA 94403
Email:	msheehan@smcgov.org

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

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