SERVICE AGREEMENT

This Agreement is entered into, by, and between the San Mateo Health Commission, Health Plan of San Mateo ("HPSM") and the County of San Mateo by and through San Mateo County Health, Family Health Services Division (FHS), as of January 1, 2019 ("Effective Date") and through December 31, 2020.

RECITALS

A. WHEREAS, HPSM is a County Organized Health System formed pursuant to Welfare and Institutions Code section 14087.51 and Sections 2.68.010, 2.68.030 of the San Mateo County Ordinance Code;

B. WHEREAS, HPSM contracts directly with the California Department of Health Care Services (DHCS) to provide health care services to eligible enrollees of California Children's Services (CCS);

C. WHEREAS, FHS has developed expertise in arranging for and managing delivery of services provided to eligible enrollees of CCS and FHS has operated the CCS Program for HPSM beneficiaries for over 25 years;

D. WHEREAS, FHS has been delegated by HPSM to arrange for and manage health care services to CCS-eligible enrollees, specifically to manage authorizations and care coordination;

E. WHEREAS, the parties hereto desire to enter into this Agreement to identify their respective rights and responsibilities in connection with the provision of CCS benefits to eligible enrollees by a CCS PROVIDER during the term hereof;

F. NOW THEREFORE, in consideration of the mutual promises and agreement hereinafter contained, HPSM and FHS hereby agree as follows:

ARTICLE I

DEFINITIONS

A. **Care Coordination** means the assessment, linkage, and/or review of provided and needed medical treatment and ancillary services.

B. **California Children Services (CCS) Eligible Conditions** means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR) Section 41800.

C. **California Children Services (CCS) Program** means the public health program that assures delivery of specialized diagnosis, treatment and therapy services to financially and medically eligible children under the age of twenty-one (21) years of age who have CCS eligible conditions.

D. **California Children Services (CCS) Provider** means any of the following Providers, when used to treat Members for a CCS condition:

1. A medical provider that is paneled by the CCS program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.
2. A licensed acute care hospital approved by the CCS program.
3. A special care center approved by the CCS program

E. **Complex Case Management** means the systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

F. **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.

G. **Contracting Providers** means a Physician, Nurse, technician, hospital, home health agency, nursing home, or any other individual or institution that contracts with HPSM to provide medical services to Members.

H. **County Organized Health System (COHS)** means a health plan that contracts with the State Department of Health Care Services to arrange and pay for comprehensive health care to all eligible CCS beneficiaries and other eligible beneficiaries residing in the county, and that is operated directly by a public entity established by a county government pursuant to Welfare and Institutions (W&I) Code, Section 14087.51 or 14087.54, or H&S Code, Chapter 3 (commencing with Section 101675) of Part 4 of Division 101.

I. **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

J. **Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Federal Medicaid (referred to Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP) Child Health and Disability Prevention Program (CHDP) and other health related programs.

K. **Department of Managed Health Care (DMHC)** means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

L. **Eligible Beneficiary** means any CCS beneficiary who has a county code in HPSM's Service Area.

M. **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in HPSM during the date of service. It includes, but is not limited to, all services for which HPSM incurred any financial liability.

N. **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of HPSM.

O. **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (Title 42 CFR 455.2; W&I Code 14043.1(i).

P. **Grievance** means an oral or written expression of dissatisfaction made by a Member or Provider about any matter other than a Notice of Action. Examples of grievances are complaints related to quality of care, access problems, or provider interactions.

Q. **Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administered by the DMHC (H&S Code 1340).

R. **Member** means any Eligible Beneficiary who is enrolled with HPSM. For the purposes of this Agreement, "Enrollee" shall have the same meaning as "Member".

S. **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner, certified nurse midwife, or a physician assistant authorized to provide Primary Care under Physician supervision.

T. **Notice of Action** means a formal letter informing a Member's family of any action taken to deny, defer, or modify authorization of a requested medical service by a Provider.

U. **Nurse (or a "Participant")** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

V. **Person-Centered Planning** means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of Basic and Complex Case Management and discharge planning.

W. **Physician** means a person duly licensed as a Physician by the Medical Board of California.

X. **Primary Care Physician** means a person duly licensed as a Physician by the Medical Board of California and contracted to provide primary care services.

Y. **Specialist** means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

Z. **Specialized Durable Medical Equipment** means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to Physician's description and orders; is made to order or adapted to meet the specific needs of the beneficiary; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

AA. **Specialty Care Center** means a center that is accredited or designated by the State or federal government, or by a voluntary national health organization, as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

BB. **Timely Access** means compliance with the California regulations that establish specific, time-elapse standards regarding the maximum time period a patient has to wait to receive health care services, in accordance with 28 CCR 1300.67.2.

CC. **Urgent Care** means an episodic physical or mental condition perceived by a managed care beneficiary as a serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

DD. **Vaccines for Children (VFC) Program** means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age eighteen (18) or younger and distributes immunization updates and related information to participating providers. Providers contracting with HPSM are eligible to participate in this program.

EE. **Whole Child Model (WCM) Program** means a program that incorporates California Children's Services (CCS) program covered services into Medi-Cal managed care for CCS-eligible members to provide improved care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

ARTICLE II

DUTIES OF FAMILY HEALTH SERVICES

HPSM and FHS shall collaborate to fulfill the requirements of HPSM's agreement with DHCS to be a Contractor under the WCM program.
Responsibilities specifically belonging to FHS shall include:

A. **Family Centered Care** – FHS shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between Providers and family members. Consideration must be given to factors such as promoting continuity of Providers and allowing adequate time at visits to encourage Provider-family dialogue and the management of care coordination issues. FHS may not prohibit, or otherwise restrict, Health Care Practitioners acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient. FHS shall ensure that the list of core elements of family-centered care is integrated into Provider practices:
   1. Respect and dignity: HCPs listen to and honor patient and family perspectives and choices.
   2. Information sharing: HCPs communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
   3. Participation: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
   4. Collaboration: HCPs collaborate with patients and families at all levels of health care, including: Care of an individual child; program development, implementation and evaluation; and policy formation.

B. **Referrals** – FHS will implement policies and procedures to accept and evaluate referrals from HPSM for patients who may be potential CCS enrollees.

C. **Scope of Services**
   1. The services covered by this agreement include **all** medically necessary covered services for enrollees in the WCM. This includes medically necessary covered services both related to the CCS condition, and not related to the CCS condition. Covered services are those services set forth in 22 CCR, Chapter 3, Article 4, beginning with Section 51301, and 17 CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS Contract with HPSM.
   2. These services must include all medically necessary primary and preventive health care services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to the care coordination and case management that are necessary for the appropriate treatment of the CCS-eligible condition.

   3. For CCS-eligible Members, FHS shall coordinate all Medically Necessary Covered Services, including EPSDT services, when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, FHS shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition and coordinate EPSDT services as follows:

      i. EPSDT services shall include case management services.

      ii. If necessary, FHS shall assist in coordinating appointments and arranging transportation and maintenance, in accordance with HPSM's CCS Policy and Procedure Manual, CCS-04.

iii. FHS shall make every effort to ensure that appropriate EPSDT services are initiated in a timely manner, as soon as possible but no later than 60 calendar days following either a preventative screening or other visit that identifies a need for follow-up.

iv. FHS shall determine the Medical Necessity of EPSDT services using the criteria established in Section 1396(d)(r) of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code and the California Welfare and Institutions Code Section 14132(v).

4. Factor replacement therapy products are excluded from the covered services provided by HPSM's CCS WCM program and under this Agreement. HPSM shall notify FHS if there is a change to the list of excluded services.

5. "Medically necessary" services are all covered services that are reasonable and necessary to protect life, prevent significant illness or disability, and alleviate severe pain through the diagnosis or treatment of disease, illness or injury, (22 CCR 51303(a)) or are services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a HCP operating within the scope of their practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, Physician or another Provider of services (22 CCR 51340(e)(3)(A)).

D. **Medical Home**

1. FHS will provide support to the medical home by providing care coordination services, chronic care management and disease management services that support the PP and the enrollee and family. Care coordination activities will include providing assistance to families needing social services and coordination with other program supports such as the MTP. Referral and active coordination with disease management programs appropriate to an enrollee's condition(s) will be provided with a "whole child" focus.
2. Each enrollee in the WCM will be assigned to a PP, who with support provided by HPSM and FHS, will function as the enrollee's medical home. Physicians that may serve as an enrollee's PP include General Pediatricians, Family Physicians, and Internists for enrollees over fourteen (14) years of age, specialty Physicians, or qualified sub-specialty Physicians appropriate to the enrollee's condition.
3. The medical home is responsible, working with the FHS CCs and the family, for the development of an individual plan of care that will serve as the basis for ensuring enhanced access to timely and appropriate services across the entire continuum of care and providing family-centered care coordination services. FHS shall support HPSM to ensure that the individual plan of care is completed and updated on a regular basis. The FHS CCs will incorporate the individual plan of care into the individualized family-centered care plan in collaboration with the family and the medical home PP. It is the responsibility of the medical home to stay apprised of all condition-related services and assure appropriate coordination of those services.
4. The medical home is responsible for ensuring that the enrollee receives needed services timely and in an appropriate setting. FHS shall support HPSM to ensure that the medical home fulfills this role.
5. FHS will assist member in finding/changing a Primary Care Physician as requested by member.

6. FHS shall assist the CCS-eligible member, or the member's parents, custodial parents, legal guardians, or other authorized representative, to request a specialist or a clinic as a Primary Care Physician.

E. **Care Coordination**

1. FHS shall provide authorization, case management, and care coordination for CCS by an employee or subcontractor with adequate knowledge or training on the CCS program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions. Once a member's eligibility for the CCS program is established, FHS shall complete the following for risk stratification, assessment, and coordination of care in accordance with the most stringent standard among APL 18-011 and HPSM's CCS Policies and Procedures Manuals, including but not limited to CCS-01:

2. For CCS-eligible Members, FHS shall utilize a DHCS-approved risk stratification mechanism or algorithm to identify CCS-eligible Members as high or low risk. FHS must assess the risk level of Members who are newly CCS-eligible members or WCM transition members within 45 days of enrollment or start date of transition. The risk stratification will assess the Member's risk level by:

    i. Reviewing medical utilization and claims processing data, including data received from the county and DHCS;

    ii. Utilization of existing member assessment or survey data; and

    iii. Telephonic or in-person communication, if available at time of stratification process.

3. If there is no medical eligibility data, utilization data, claims processing data history or other assessment and/or survey information available, the CCS-eligible Member will be automatically classified as high risk until further information is available to make a determination

4. Based on the results of the health risk stratification, CCS-eligible Members' risk levels and needs must be further assessed by telephonic and/or in-person communication with the Member or Member's parents, legal guardians, or other authorized representatives, or a risk assessment survey. Any risk assessment survey created by FHS for the purposes of WCM is subject to review and approval by DHCS.

5. The risk assessment process must be tailored to each CCS-eligible member's age group. At FHS's discretion, additional assessment questions may be added to assess the need for or impact of future health care services. The risk assessment process must address:

    i. General health status and recent health care utilization;
    ii. Health history;
    iii. Specialty Provider Referral Needs;
    iv. Prescription Medication Utilization;
    v. Specialized or Customized Durable Medical Equipment Needs;
    vi. Need for Specialized Therapies (if applicable);

vii. Limitations of Activities of Daily Living or Daily Functioning (if applicable);
viii. Demographics and Social History.

6. The HRA shall include parent-validated questions about medical and psychosocial needs.

7. Regardless of the risk level of the member, all communications, whether by phone or mail, must inform the member and/or member's designated caregiver that the assessment will be provided in a culturally and linguistically appropriate manner and identify the method by which the provider will arrange for an in-person assessment.

8. FHS shall create an individual care plan (ICP) for CCS-eligible Members who have completed the health risk assessment. FHS shall establish an ICP for CCS-eligible Members within 90 days of a completed risk assessment survey or other assessment by telephonic or in-person communication.

9. The ICP will be developed by the FHS's care management team and must be completed in collaboration with the CCS-eligible member, member's family, and/or their designated caregiver.

10. The ICP will, at a minimum, incorporate the CCS-eligible member's goals and preferences, and provide measurable objectives and timetables to meet the needs for:
    i. Medical (primary care and CCS specialty) services;
    ii. Mild to moderate or county specialty mental health services;
    iii. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
    iv. County substance use disorder (SUD) or Drug Medi-Cal services;
    v. Home health services;
    vi. Regional center services; and
    vii. Other medically necessary services provided within the FHS's network or, when necessary, by an out-of-network provider.

11. The ICP should also include the following information, as appropriate, and only if the information has not already been provided as part of another process:

    i. Access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an interdisciplinary team is, and what the community resources are (including local family resource and family empowerment centers).

    ii. A primary or specialty care physician who is the primary clinician for the CCS-eligible member and who provides core clinical management functions.

    iii. Care management and care coordination for the CCS-eligible member across the health care system, including transitions among levels of care and interdisciplinary care teams.

iv. Provision of information about qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of HPSM.

12. FHS shall re-evaluate and update the ICP at least annually or upon a significant change to the member's condition, this includes reassessing the member's risk level and needs.

13. FHS will make every effort to ensure that contracted providers provide basic comprehensive medical case management to each Member eligible for CCS and facilitate the communication between the Member's health care providers, personal care providers such as In-Home Supportive Services (IHSS) and behavioral health providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

14. FHS shall provide Person-Centered Planning to CCS-eligible Members and in collaboration with CCS-eligible Member's parents, custodial parents, legal guardians, or other authorized representatives when appropriate.

15. FHS shall provide case management and coordination of care to Members eligible for CCS and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

16. FHS shall monitor coordination of care provided to Members, including but not limited to all Medically Necessary services delivered both within and outside of the HPSM's provider network.

17. FHS shall refer to Specialty Mental Health and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through FHS's assessment. To coordinate services with a regional center, FHS shall coordinate with CCS-eligible Members and their parents, custodial parents, legal guardians, or other authorized representatives, and operate as a central point of contact for questions regarding access, care, and problem resolution.

18. FHS shall coordinate and authorize High Risk Infant Follow-Up (HRIF) services for CCS-eligible Members and ensure HRIF case management services.

19. FHS shall work in partnership with the Member's Primary Care Physician and other applicable entities, including but not limited to: specialty providers, hospitals, CCS Medical Therapy Program (MTP), mental health providers, agencies serving members with developmental disabilities, agencies providing early intervention services, local education agency services, dental services, targeted case management (TCM) services, and local school districts.

20. FHS shall have experience working with members with special health care needs. Care coordination for members with special health care needs shall include both face-to-face and telephone communication.

21. FHS shall be responsible for the following key functions:

i. Assessment of a Member's medical, behavioral, psychosocial and functional needs;
ii. Assessment of the family's functional needs;
iii. Development and implementation of an individualized family-centered care plan in collaboration with the family and medical home Provider;
iv. Facilitation of meetings and/or team conferences with family, enrollee and relevant and appropriate Providers of services;
v. On-going monitoring and evaluation of the care plan, including re-assessments upon a change in condition or status;
vi. Coordination of care among systems and Providers;
vii. Member education and advocacy, including research of and linkage to resources, services and support for the family;
viii. Referral into disease and chronic care management programs, ongoing monitoring of the Member's status in these programs and coordination and linkage with or to other appropriate Providers or resources;
ix. Making referrals and ensuring authorization of services;
x. Transition planning;
xi. Coordination with the evaluation activities to obtain Member and family feedback regarding their experiences of health care; and
xii. Informing Members that EPSDT services are available for Members under twenty-one (21) years of age.

22. While FHS may not be financially responsible for a range of special services, such as those provided through regional centers, HCBS waiver, behavioral health, medical therapy through the MTP, residential and institutional care services and dental services, FHS will be responsible for ensuring coordination of all the care the Member receives.

23. Out-of-Plan Case Management and Coordination of Care

    i. FHS shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services.

    ii. FHS shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

24. FHS shall coordinate or assist HPSM in coordinating with the local CCS Medical Therapy Unity (MTU) to ensure appropriate access to MTU services.

F. **Care Transition**

FHS shall ensure that all Members, with a medical condition expected to last beyond the 21st birthday, receive the services necessary to make a seamless transition to adult health care. FHS shall work with members and their families to prepare them for how their future health care needs will be met once eligibility for the CCS program ceases at the member's 21st birthday.

FHS shall ensure that Members will have a transition plan completed on an annual basis beginning at 16 years of age, prepared in conjunction with Members and their family.

FHS will work with Members' families to ensure that families have considered applying for conservatorship for Members prior to their 18th birthday, when appropriate.

FHS must identify and track CCS-eligible Members for the duration of their participation in the CCS WCM program until age 21. All CCS eligible HPSM members will be transitioned to the HPSM Care Coordination Unit by their 21st birthday. The HPSM Care Coordination Unit will continue to follow and provide care coordination services as long as they are HPSM members, for at least 3 years after they age out of the CCS WCM program. FHS must establish and maintain a process for preparing Members approaching WCM age limitations, including but not limited to, identification of primary care and specialty care providers appropriate to the Members' CCS qualifying condition(s) to the extent feasible.

FHS must provide care coordination and transition to an adult provider when CCS-eligible Member no longer requires the service of a pediatric provider.

G. **Utilization Management and Review** – FHS shall implement HPSM's UM program that ensures appropriate processes are used to review and approve the provision of all medically necessary covered services, including CCS and non-CCS conditions. FHS is responsible to ensure that the UM program includes:

1. Utilization Management
    i. HPSM is responsible for the UM program. FHS shall provide qualified staff to support the UM program.
    ii. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.
    iii. Established criteria for approving, modifying, deferring, or denying all requested services – inpatient, outpatient, and other services. The established criteria include HPSM's Utilization Management guidelines as well as the CCS Utilization Management guidelines. FHS shall utilize these evaluation criteria and standards to approve, modify, defer, or deny services.
    iv. FHS shall help communicate to HCP the procedures and services that require prior authorization and ensure that all contracting HCPs are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
    v. FHS shall support HPSM's specialty referral system to track and monitor referrals requiring prior authorizations. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting Providers.
    vi. FHS's policies, procedures and written guidelines, and criteria for utilization review shall include CCS guidelines and CCS Numbered Letters and will be based on standards of clinical practice for members with CCS-eligible medical conditions. Such policies, procedures, written guidelines, and criteria shall be consistently applied, regularly reviewed, and updated. In cases where the CCS prior authorization guidelines conflict with FHS's prior authorization guidelines, FHS shall use the standard that provides the most generous benefit to the CCS-eligible member.
    vii. FHS shall conduct Neonatal Intensive Care Unit acuity assessments and neonatal authorizations in accordance with W&I Code section 14094.65 with pertinent CCS program guidelines and numbered letters.

viii. FHS shall use all current and applicable CCS program guidelines, including CCS program regulations, CCS program information notices, and CCS numbered letters in developing criteria for use by FHS's UM and Care Management staff to manage utilization of CCS services. When applicable CCS clinical guidelines do not exist, FHS shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-eligible condition.

2. Pre-Authorizations and Review Procedures – FHS shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:
   i. Decisions to deny or authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.
   ii. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified Physician or HPSM's Pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the plan Medical Director, in collaboration with the plan Pharmacy and Therapeutics committee or its equivalent.
   iii. There is a set of written criteria or guidelines for utilization review that is based on standards of clinical practice for enrollees with CCS-eligible medical conditions, and is consistently applied, regularly reviewed, and updated.
   iv. Reasons for decisions are clearly documented.
   v. Notification to Members regarding denied, deferred or modified referrals is made. Enrollees and their families and Providers shall be advised of the appeals procedures.
   vi. Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
   vii. Prior authorization requirements shall not be applied to emergency services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.
   viii. Records, including any Notice of Action (NOA), shall meet the retention requirements.
   ix. FHS must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be orally or in writing.

3. Timeframes for Medical Authorization
   i. Emergency care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
   ii. Concurrent review of authorization for treatment regimen already in place: Within twenty-four (24) hours of the decision, consistent with urgency of the Member's medical condition and in accordance with H&S Code, Section 1367.01(h)(3).
   iii. Retrospective review: Within thirty (30) calendar days in accordance with H&S Code, Section 1367.01(h) (1).
   iv. Pharmaceuticals: Twenty-four (24) hours on all drugs that requires prior authorization in accordance with W&I Code, Section 14185(a) (1).

v. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with H&S Code, Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Member or the Member's Provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

vi. Expedited authorizations: For requests in which a Provider indicates, or the Contractor determines that, the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.

vii. Post-stabilization: Upon receipt of an authorization request from an emergency services Provider, the Contractor shall render a decision within thirty (30) minutes or the request is deemed approved, in accordance to 28 CCR 1300.71.4.

viii. Non-urgent care following an exam in the emergency room: Response to request within thirty (30) minutes or deemed approved.

ix. Therapeutic enteral formula for medical conditions in infants and children: Timeframes for medical authorization of medically necessary therapeutic enteral formulas for infants and children and the equipment and supplies necessary for delivery of these special foods are set forth in Numbered Letter 22-0805, Enteral Nutrition Products as a CCS Benefit, W&I Code, Section 14103.6 and H&S Code, Section 1367.01.

x. Hospice inpatient care: Twenty-four (24) hour response.

4. Review of Utilization Data
   i. FHS shall work with HPSM to develop mechanisms to detect both under and over-utilization of health care services within the UM program. The Contractor shall include internal reporting mechanisms used to detect enrollees' utilization patterns. Reports shall be submitted to DHCS upon request.
5. Second Opinion
   i. FHS shall work with HPSM to ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.

H. **EPSDT Private Duty Nursing Authorization Requests** - FHS shall receive all CCS EPSDT Private Duty Nursing requests. The CCS PHN will:

1. Ensure that the request is medically necessary according to clinical guidelines

2. Collect all required documents, such as but not limited to:
    i. Treatment Authorization Request (TAR)
    ii. Signed prescription
    iii. All pertinent documents needed to evaluate requests

3. All initial and increase in PDN hours also need review and approval by the HPSM Medical Director

I. **CCS Orientation** – FHS shall provide orientation of CCS policy and process changes to Providers and staff.

J. **Quality Improvement Projects** – FHS agrees to participate and cooperate in HPSM's quality improvement system. FHS will provide data and resources for quality improvement projects through the CCS nurses and administrative staff, and through the CCS Medical Director and the CCS Administrator. These quality improvement projects will be identified by HPSM's Quality Improvement Department in conjunction with the CCS Medical Director and HPSM's Pediatric Health Manager.

FHS shall report data on identified performance measures in the form and manner specified by DHCS's pediatric plan performance standards and measurements.

FHS shall report data on identified performance measures in the form and manner specified by DHCS.

K. **Information Technology (IT)** - FHS will provide IT services to support its staff, including, but not necessarily limited to, facilitating a secure data connection between HPSM and FHS, enabling secure email and file sharing. Additionally, FHS agrees that FHS staff will work with HPSM staff to utilize to HPSM utilization management and care management systems.

L. **Family Advisory Committee and Clinical Advisory Committee**– FHS will participate in the meetings of the Family Advisory Committee consisting of community stakeholders and parents of CCS enrollees or CCS consumers for the purposes of quality improvement, education, and guidance related to the development of family-centered care processes.

FHS shall identify and recruit members in the CCS WCM program for the Family Advisory Committee and shall participate in the committee. FHS shall provide necessary resources, including without limitation, sharing data, recruiting CCS-eligible members and their families, and recruiting Participating Providers to the Clinical Advisory Committee and Family Advisory Committees.

M. **Whole Child Model Staff** –

1. FHS Medical Director will determine eligibility for the CCS program and will collaborate with the HPSM Medical Director to ensure quality care and be responsible for clinical oversight of the CCS Medical Therapy Units.
2. FHS will also provide a CCS Administrator, at least 50% of whose time will be dedicated to the CCS program, and who will supervise the Care Management Team and any FHS administrative staff. FHS will retain staffing that properly addresses the language needs of the population served.
3. FHS will provide qualified staff with experience working with enrollees with special health care needs at a level that is sufficient to conduct the care management, utilization management, and other services for the Whole Child Model, as described in this contract.

4. FHS will confer with HPSM about the hiring of any Whole Child Model staff.

N. **Staff Training:** FHS will ensure that CCS staff completes training related to ethics, HIPAA, and other mandatory State and Federal training, and that staff licenses are in good standing.

O. **Abuse Reporting** – FHS staff with direct client contact acknowledge their status as mandated reporters and will therefore adhere to all State of California abuse reporting requirements.

P. **Continuity of Care for CCS-Eligible Members**

FHS shall ensure the continuity of care to CCS-eligible Members transitioning to the WCM Program in accordance with the most stringent standard among the Welfare and Institutions Code ("W&I Code") Sections 14094.13, Health and Safety Code ("H&S Code"), Section 1373.96, APL 18-011, and HPSM's CCS Policies and Procedures Manuals, including but not limited to CCS-03, and as follows:

1. In accordance with W&I Code, Section 14094.13(a)-(d), FHS shall ensure continuity of care between Members eligible for CCS and CCS Providers, and Providers of Specialized Durable Medical Equipment ("SDME"), with whom there is an existing relationship for up to 12 months after the transition.

2. For out-of-Network CCS Providers and Providers of SDME, FHS shall ensure the continuity of care under the following conditions:
    i. The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months previous to Member's transition to the Whole Child Model program.
    ii. The Member has previously received SDME from the SDME Provider.
    iii. The CCS Provider or Provider of SDME accepts HPSM's rate for the service, unless the CCS Provider enters into an alternative payment mutually agreed upon by HPSM and the CCS Provider.
    iv. FHS confirms that the CCS Provider meets applicable CCS standards.
    v. The CCS Provider makes treatment information available to FHS, to the extent authorized by the State and federal patient privacy provisions.
    vi. The Provider of SDME makes information available as requested by FHS, to the extent authorized by the State and federal patient privacy provisions.
    vii. At its discretion, FHS may assist with extending the continuity of care period beyond the 12 months specified in Paragraph C(1)(i) above.

3. FHS will inform members of the HPSM G&A process as needed.

Q. **Required Documentation for the CCS WCM Program**

1. FHS shall maintain and periodically update policies and procedures, which will be maintained in addition to FHS's obligations to maintain policies and procedures established in the Agreement, addressing the following:

i. Providing information on how to access local family resource centers or family empowerment centers;

ii. continuity of care for CCS-eligible members with their CCS Providers, SDME Provider, and prescription drugs;

iii. arranging for timely provision of services for a CCS-eligible Member with CCS Providers in accordance with 28 CCR Sections 1300.67.2 and 1300.67.2.2 to the extent possible;

iv. administering health risk stratification and assessment of CCS-eligible members, including other health information used for risk stratification, the risk stratification mechanism or algorithm designed for the purpose of identifying CCS-eligible members as high or low risk, and risk assessment tools used to comprehensively assess CCS-eligible Member's current health risk;

v. development of individualized care plans for CCS-eligible members based on risk assessments, including basic and Complex Case Management and Person-Centered Planning in accordance with WCM program requirements for CCS-eligible members;

vi. provision, and administering and monitoring the provision of, Complex Case Management services to CCS-eligible members, including procedures to identify Members who may benefit from Complex Case Management;

vii. ensuring the provision of Person-Centered Planning for CCS-eligible members as part of case management and coordination of care;

viii. CCS-eligible Member selection of a Primary Care Physician or non-physician medical practitioner. Include the mechanism used for allowed CCS-eligible Members to request a Specialist or clinic to serve as their Primary Care Physician or non-physician medical practitioner.

2. FHS shall provide copies of policies and procedures, data, and any reports when requested by HPSM. FHS's obligations to maintain and update policies and procedures required by this Section U does not remove or limit FHS's obligations to maintain, update and provide to HPSM policies and procedures set forth in the Agreement, and as required to be maintained by state and federal laws, regulations, and sub-regulatory guidance.

3. FHS shall provide policies and procedures, reports, and any and all data required to be submitted by this Second Amendment in the manner and frequency as required by state and/or federal law, DHCS Medi-Cal Contract, applicable sub-regulatory guidance, or as mutually agreed upon between the parties.

R. **WCM Program Evaluations**

DHCS may utilize an evaluation method to assess the effects of the WCMs as they relate to key public health research questions. An independent evaluation team may be selected to conduct the

program evaluation. HPSM may perform a separate program evaluation conducted by either HPSM staff members or a subcontractor. FHS shall cooperate with the independent evaluation team, DHCS, HPSM or any entity designated by DHCS or HPSM for this purpose, as necessary, to ensure successful implementation of the program evaluation protocol and methodologies and provide the required information related to WCM patients.

FHS shall evaluate WCM patient and family experiences with FHS's care coordination services through an annual survey. HPSM may provide the survey or HPSM and FHS shall work together to develop a survey.

S. **Failure to Meet Plan's Performance Requirements–** In the event that HPSM determines that FHS is not meeting its obligations under this Agreement, including but not limited to managing authorizations, and managing and arranging care coordination for CCS- eligible Members, HPSM reserves the right to redirect the funds allocated to the CCS program to HPSM's internal health services fund, to the extent necessary for HPSM to use such funds to manage authorizations and manage and arrange care coordination for CCS-eligible Members. Prior to redirecting any funds, HPSM shall give FHS written notice of intent to redirect funds and shall outline expectations that FHS must meet within 90 days in order to continue the terms of the existing Agreement. If after 60 days of written notice HPSM reasonably determines that FHS cannot realistically meet the expectations within the 90 day period, HPSM reserves the right to terminate this Agreement in accordance with Article VII, Termination for Material Breach. If after 90 days, HPSM determines that FHS is still not meeting the expectations under the contract, HPSM will allow an additional 30 days for FHS to wind down operations and transition duties prior to re-directing funds to HPSM's internal health services fund.

ARTICLE III

ENSURING PATIENT ACCESS

A. **Linguistic and Cultural Access** – HPSM and FHS shall work together to ensure that communication and/or cultural barriers will not inhibit enrollees and their families from obtaining services from the health care system.
    1. Linguistic Access and Communication
        i. Communication Impairments
            1. HPSM and FHS shall establish methods for communicating effectively with enrollees and their families who have a range of communication-affecting conditions, including cognitive, vision or hearing impairments, to ensure that enrollees and their families can make informed decisions.
            2. Standard informational and/or education materials shall be made available to enrollees and their families in alternative formats, (e.g., written, Braille, audio/video tape, etc.). Sign language interpretation for English speaking hearing impaired individuals shall also be available upon request.
        ii. Non-English Speaking Enrollees and Families
            1. Interpreter services shall be made available for planned encounters with enrollees or families with limited proficiency in comprehending English to ensure that enrollees and their families are afforded full access to WCM services and benefits. In addition, interpretation services shall be made available on an ad hoc basis for unplanned or emergency contacts.
            2. These services shall include the ability to orally translate commonly used medical terminology from English to languages used by enrollees and their

families and from the enrollee's or family's language to the English language. FHS shall work with HPSM to provide oral interpreters, signers, or bilingual Providers and Provider staff at all key points of contact.

3. Written materials, including commonly used forms and informational materials, shall be available in languages appropriate to the enrolled population. Sign language interpretation for non-English speaking hearing impaired individuals shall be made available upon request.

2. Access to Culturally Appropriate Care
    i. HPSM and FHS shall provide a mechanism to ensure that health care services provided through the WCM are designed and delivered in a manner which is sensitive and responsive to the varying cultural needs of the enrollees and their families.
    ii. This mechanism shall, at a minimum, address:
        1. Staffing that reflects the racial and ethnic makeup of the population served and is familiar with the cultural backgrounds of enrollees.
        2. Written polices stating the importance of culturally competent care and acknowledging differing cultural definitions of "family" and respecting differing views of medical care.
        3. Provision for asking each family who should attend conferences, what kind of translation services are needed, what are the family's concerns and what added assistance is needed to gain access to care.
        4. Provision for working with family and Providers when the enrollee's and/or family's view of the illness and treatment differs substantially from the Physician's.
        5. Protocols for defining and removing practices which are found to be barriers to care for enrollees.

B. **Access for Disabled Members**
All of HPSM and FHS's facilities shall comply with the requirements of Title III of the Access for Disabled Clients Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

C. **Civil Rights Act of 1964**
HPSM and FHS shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any implementing regulations (42 USC 2000d and 45 CFR Part 80) that prohibit recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

D. **Federal Nondiscrimination Requirements**
HPSM and FHS shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC 794) Nondiscrimination under federal grants and programs; 45 CFR 84 Nondiscrimination on the basis of handicap in programs or activities receiving federal financial assistance; 28 CFR 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1972 (regarding education programs and activities); 45 CFR 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

E. **Transportation**

FHS shall ensure that the CCS-eligible member or member's family receives CCS Maintenance and Transportation (M&T) benefit in accordance with program guidelines, CCS' Policy and Procedure Manual CCS-04, and must comply with all requirements listed in CCS Numbered Letter 03-0810. These services include, but are not limited to, M&T for out of county and out of state services.

FHS must also comply with all requirements listed in DHCS's APL 17-010 for all HPSM Members to obtain non-emergency medical transportation (NEMT) and non-medical transportation (NMT) to a medical service or if the member requires standard transportation that does not require CCS M&T.

ARTICLE IV
PAYMENTS AND CLAIMS PROCESSING

In consideration of the services provided by FHS in accordance with all terms, conditions, and specifications set forth in this Agreement, HPSM shall make payment to FHS based on the rates and in the manner specified as follows:

HPSM shall reimburse FHS for actual costs for providing all services as described above. The following process will be followed:

i. FHS shall invoice DHCS for CCS Administration costs within 60 days after the end of each quarter. Within five business days of sending the invoice to DHCS, FHS shall provide HPSM a copy of the invoice and related back-up in order for HPSM to accrue expected costs.
ii. FHS will invoice HPSM for HPSM's share within 10 business days of receipt of payment from DHCS. Invoicing dates may vary since FHS receives the payment from DHCS at various times.
iii. The amount that HPSM pays FHS shall be the amount remaining following DHCS reimbursement, which shall be approximately 70% of claimed costs. FHS shall be reimbursed 100% of claimed CCS Administration costs by DHCS and HPSM.
iv. HPSM will provide payment within 30 days of receiving FHS's invoice.

In no event shall HPSM total fiscal obligation under this Agreement exceed seven million, two hundred and fifty thousand dollars ($7,250,000). In the event that HPSM makes any advance payments, FHS agrees to refund any amounts in excess of the amount owed by HPSM at the time of contract termination or expiration.

ARTICLE V

RECORDS AND REPORTS

A. **Maintenance of Records** - FHS shall maintain, and require any of its Downstream Entities, contractors, or subcontractors to maintain, documentation of all activity conducted under this Agreement, including Claims processed, for a minimum of ten (10) years from the final date of the contract period between HPSM and FHS, from the date of completion of any audit, or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations. Such documentation, including books and records, shall be in a format and media deemed appropriate by FHS and HPSM, and sufficient to accommodate periodic auditing of records to evaluate the quality, appropriateness, and timeliness of services performed by FHS under this Agreement. This

shall include maintenance of encounter data for a period of at least ten (10) years.

Records pertaining to goods or services furnished under this agreement shall be accessible to HPSM upon thirty (30) days prior written notice for annual audits, or sooner if required by the circumstances or state or local oversight agencies.

B. **Use of Information** - FHS and HPSM may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

C. **Right to Audit Records**

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

2. FHS may inspect and audit, or cause to be inspected and audited, once annually, the books and records of HPSM directly relating to this Agreement, including the existence and number of Members. HPSM and FHS shall fully cooperate with and assist and provide information to representatives of each other, independent accountants hired by either party, and representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that HPSM and/or FHS have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, HPSM and FHS will cooperate with the requirements of the auditing agency to the extent possible. If a completed audit, conducted by HPSM, FHS, or their respective designees, reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings. When a regulatory or accreditation agency imposes demands that do not meet the above standards for resolving

discrepancies and paying owed amounts, HPSM and FHS shall follow the requirements of the auditing agency.

3. FHS understands and agrees that DHCS, DMHC, CMS, the U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, and the California Department of Justice, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, computer or other electronic systems, including medical records and documentation of the FHS or of the FHS's subcontractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under HPSM's contract with DHCS. FHS will make available, for the purposes of an audit, evaluation or inspection, as defined above, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to Medi-Cal enrollees. This right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later, as required by 42 CFR §422.504(i)(2) and §438.230(c)(3)(iii). If the State, CMS, DMHC or DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or DHHS Inspector General may inspect, evaluate and audit FHS at any time.

4. In addition, FHS agrees to provide to HPSM, to any Federal or State department having monitoring or review authority, to HPSM's authorized representatives, and/or their appropriate audit agencies, access to and the right to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules and regulations, NCQA standards, and this Agreement, and to evaluate the quality, appropriateness and timeliness of services performed.

D. **Records Related to Recovery for Litigation** - Upon request by DHCS, HPSM and FHS shall gather in a timely manner, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in HPSM or FHS' possession, relating to threatened or pending litigation by or against DHCS. HPSM or FHS retain and may assert that requested documents are privileged, by identifying such documents and stating the privilege that supports withholding them.

E. **Reporting** - Family Health Services will provide data and amend processes to support HPSM's compliance with State and federal regulatory agencies or private accreditation requirements, such as NCQA. Specific reports or information, which may not be set forth in this Agreement, may be required of HPSM by State or federal regulatory agencies or private accreditation organizations from time to time. FHS shall make such changes and provide data or reports to HPSM in a mutually agreeable time and manner that enables HPSM to meet its obligations.

The Office of Inspector General (OIG) publishes compliance program guidance for health plans available at http://oig.hhs.gov/fraud/complianceguidance.asp. FHS shall require its employees and its subcontractors and their employees to, comply with the HPSM's compliance requirements, and HPSM's compliance training requirements. FHS shall report to HPSM any suspected fraud, waste, or abuse or criminal acts by HPSM employees, as well as FHS respective employees or subcontractors. Reports may be made anonymously through HPSM's Compliance Hotline at 1-800-826-6762 or compliance issues can be reported to HPSM's Compliance Officer during business hours at 1-650-616-0050.

ARTICLE VI

Grievances and Appeals Process

FHS shall utilize HPSM's Grievance and Appeals system when a HPSM member or provider is dissatisfied with his/her experience accessing or utilizing the CCS WCM. HPSM will accept Grievances and Appeals in writing, by phone, or through email or other electronic means. FHS shall participate in the grievance process by 1) resolving grievances and notifying HPSM of the grievance details and resolution; and/or 2) by referring members to HPSM to file a grievance, or by forwarding grievance details to HPSM on behalf of the member.

FHS shall forward to HPSM all Appeals or Grievances received through CCS or through other avenues within FHS related to the CCS program within five (5) business days.

ARTICLE VII

TERM AND TERMINATION

Term - The term of this Agreement shall commence on January 1, 2019, and shall continue in full force and effect, subject to the following provisions for termination:

Termination for Material Breach – Except as provided in Article II(S), either party shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party if the party to whom such notice is given is in material default under this Agreement. The party claiming the right to terminate hereunder shall set forth in the notice of intended termination required hereby the effective date of such termination and the facts underlying its claim that the other party is in breach of this Agreement. If FHS or HPSM remedies such alleged breach within twenty (20) days of the receipt of such notice, the Agreement shall remain in effect for the remaining term and such termination notice shall no longer be in effect. Notwithstanding the other provisions of this paragraph, the HPSM may immediately suspend this Agreement pending completion of applicable termination procedures, if the HPSM makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

Both parties shall notify the State of California, in writing, thirty (30) days prior to termination of this Agreement.

Effect of Termination

1. As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect, and each of the parties shall be relieved and discharged from performance, except as specified in Paragraph 2 of this Section.

2. HPSM shall remain liable for payment of all CCS services rendered to HPSM's Member up to the termination of this Agreement.

3. FHS agrees to assist HPSM in the transfer of care in the event of the termination of this agreement for any reason.

4. FHS agrees to notify DHCS in the event the agreement with HPSM is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

5. Contract Materials: At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by FHS under this Agreement shall become the property of HPSM and shall be promptly delivered to HPSM. Upon termination, FHS may make and retain a copy of such contract materials if permitted by law.

ARTICLE VIII

INSURANCE

A. **General Requirements** – HPSM and FHS shall not commence work or be required to commence work under this Agreement unless and until all insurance required under this Section has been obtained and such insurance has been approved by County's Risk Management, and HPSM and FHS shall use diligence to obtain such insurance and to obtain such approval. HPSM and FHS shall furnish to each other certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending HPSM and FHS's coverage to include the contractual liability assumed by HPSM and FHS pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to HPSM and FHS of any pending change in the limits of liability or of any cancellation or modification of the policy.

B. **Workers' Compensation and Employer's Liability Insurance** – HPSM and FHS shall have in effect during the entire term of this Agreement workers' compensation and employer's liability insurance providing full statutory coverage. In signing this Agreement, HPSM and FHS certifies, as required by Section 1861 of the California Labor Code, that (a) it is aware of the provisions of Section 3700 of the California Labor Code, which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and (b) it will comply with such provisions before commencing the performance of work under this Agreement.

C. **Liability Insurance** - HPSM and FHS shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which HPSM and FHS engages pursuant to this Agreement, commercial general liability insurance of not less than $1,000,000 per occurrence for bodily injury and property damage liability combined. The commercial general liability insurance policy shall include coverage for liabilities arising out of premises, operations, independent contractors, products, completed operations, personal and advertising injury, and liability assumed under the insured agreement.

ARTICLE IX

INDEMNITY

A. **FHS Indemnification**

1. HPSM - FHS agrees to indemnify, defend and hold harmless HPSM, its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with any negligence in connection with FHS' operations or its services hereunder including the

operations and services of FHS' affiliates, Subcontractors/Vendors and their respective employees and agents. This provision is not intended to, nor shall it be construed to, require FHS to indemnify HPSM for any HPSM liability independent of that of FHS, nor to cause FHS to be subject to any liability to any third party (either directly or as an indemnitor of HPSM or its agents, officers and employees) in any case where FHS liability would not otherwise exist. Rather, the purpose of this provision is to assure that HPSM and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against HPSM or such agents, officers, or employees resulting from the actions or other omissions of FHS, its affiliates, Subcontractors/Vendors and their respective employees and agents in connection with their operations and services relating to this Agreement

2. State and Members - FHS agrees to hold harmless both the State and Members in the event HPSM cannot or will not pay for services performed by FHS pursuant to this agreement.

B. **HPSM Indemnification** – HPSM agrees to indemnify, defend and hold harmless FHS, Its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with any negligence in connection with HPSM's operations or its services hereunder including the operations and services of HPSM's affiliates, Subcontractors/Vendors and their respective agents. This provision is not intended to, nor shall it be construed to, require HPSM to indemnify FHS for any FHS liability independent of that of HPSM, nor to cause HPSM to be subject to any liability to any third party (either directly or as an indemnitor of FHS or its agents, officers employees) in any case where HPSM liability would not otherwise exist. Rather, the purpose of this provision is to assure that FHS and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against FHS or such agents, officers, or employees resulting from the actions or other omission of HPSM, its affiliates, subcontractors/vendors and their respective employees and agents in connection with their operations and services relating to this Agreement.

C. **Third Party Liability** – In the event that FHS renders services to Members for injuries or other conditions resulting from the acts of other parties, the HPSM will have the right to recover from any settlement, award or recovery from any responsible third party the value of all services which have been rendered by FHS pursuant to the terms of this Agreement.

ARTICLE X

MISCELLANEOUS

A. **Entire Agreement** – This Agreement (together with all Exhibits 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 FHS and the HPSM that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the Effective Date hereunder.

B. **Amendments** – This Agreement and any Exhibits hereto may be amended only by an instrument in writing, duly executed by both parties in accordance with applicable provisions of State and Federal law and regulations.

C. **Approval of Agreement/Amendments By DHCS** – This Agreement or Amendments entered into by HPSM shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Agreement and has failed to approve or disapprove the proposed Agreement within sixty (60) calendar days of receipt. Amendments shall be submitted to DHCS for prior approval at least (30) days before the effective date of any proposal governing compensation, services or term.

D. **Notices**

1. Notices to HPSM and FHS: Any notice required to be given pursuant to the terms and provisions of this Agreement, unless otherwise indicated in this Agreement, shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or courier service (Federal Express, UPS, etc.) or other means which can provide written proof of delivery, to HPSM at:

   Maya Altman, Chief Executive Officer
   Health Plan of San Mateo
   701 Gateway Blvd, Suite 400
   South San Francisco, CA 94080

   and FHS at:

   Louise F. Rogers, Chief
   San Mateo County Health
   225 37th Avenue
   San Mateo, CA 94403

2. Notice to DHCS: FHS agrees to notify DHCS in the event the Agreement with HPSM is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

E. **Waiver of Obligations** – No obligation under this Agreement or an Exhibit hereto may be waived by any party except by an instrument in writing, duly executed by the party waiving such obligations. All waivers shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the extension of the waiver to any other provisions of this Agreement unless so specified in writing.

F. **Counterparts** – This Agreement may be executed in counterparts, each of which shall be considered to be an original; however, all such counterparts shall constitute but one and the same Agreement. This Agreement may be executed by facsimile or PDF signature, all of which taken together constitute a single agreement between the parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and PDF), will be considered as legally effective as an original signature.

G. **Headings** – 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.

H. **Governing Law** – This Agreement will be governed by and construed in accordance with the laws of the State of California, without regard to any conflict of law principles applied therein. Any suit or proceeding relating to this Agreement shall be brought only in the state or federal courts located in California, and all Parties hereby submit to the personal jurisdiction and venue of such courts will be the County of San Mateo.

This Agreement shall be governed by and construed in accordance with all laws and applicable regulations governing the HPSM contract with DHCS, Agreement Number 11-88291.

I. **Confidentiality** - For the purposes of this Agreement, "Confidential Information" means any software, data, business, financial, operational, customer, or other information disclosed by one party to the other and not generally known by or disclosed to the public. Confidential Information shall include any and all Personal Information, defined as any information that is or includes personally identifiable information. Personal Information includes, but is not limited to, name, address and any unique personal identification number. Notwithstanding anything herein to the contrary, Confidential Information shall not include information that is: (a) already known to or otherwise in the possession of a party at the time of receipt from the other party, provided such knowledge or possession was not the result of a violation of any obligation of confidentiality; (b) publicly available or otherwise in the public domain prior to disclosure by a party; (c) rightfully obtained by a party from any third party having a right to disclose such information without breach of any confidentiality obligation by such third party; or (d) developed by a party independent of any disclosure hereunder, as evidenced by written records. Each party shall maintain all of the other party's Confidential Information in strict confidence and will protect such information with the same degree of care that such party exercises with its own Confidential Information, but in no event less than a reasonable degree of care. If a party suffers any unauthorized disclosure, loss of, or inability to account for the Confidential Information of the other party, then the party to whom such Confidential Information was disclosed shall promptly notify and cooperate with the disclosing party and take such actions as may be necessary or reasonably requested by the disclosing party to minimize the damage that may result therefrom. Except as provided in this Agreement, a party shall not use or disclose (or allow the use or disclosure of) any Confidential Information of the other party without the express prior written consent of such party. If a party is legally required to disclose the Confidential Information of the other party, the party required to disclose will, as soon as reasonably practicable, provide the other party with written notice of the applicable order or subpoena creating the obligation to disclose so that such other party may seek a protective order or other appropriate remedy. In any event, the party subject to such disclosure obligation will only disclose that Confidential Information which the party is advised by counsel as legally required to be disclosed. In addition, such party will exercise reasonable efforts to obtain assurance that confidential treatment will be accorded to such Confidential Information. Access to and use of any Confidential Information shall be restricted to those employees and persons within a party's organization who have a need to use the information to perform such party's obligations under this Agreement or, in the case of HPSM, to make use of the services, and are subject to a contractual or other obligation to keep such information confidential. A party's consultants and subcontractors may be included within the meaning of "persons within a party's organization," provided that such consultants and subcontractors have executed confidentiality agreements with provisions no less stringent than those contained in this section. Such signed agreements shall be made available to the other party upon its request. Additionally, HPSM, may, in response to a request, disclose FHS

Confidential Information to a regulator or other governmental entity with oversight authority over HPSM, provided HPSM (i) first informs FHS of the request, and (ii) requests the recipient to keep such information confidential. All of a party's Confidential Information disclosed to the other party, and all copies thereof, are and shall remain the property of the disclosing party. All such Confidential Information and any and all copies and reproductions thereof shall, upon request of the disclosing party or the expiration or termination of this Agreement, be promptly returned to the disclosing party or destroyed (and removed from the party's computer systems and electronic media) at the disclosing party's direction, except that to the extent any Confidential Information is contained in a party's backup media, databases and email systems, then such party shall continue to maintain the confidentiality of such information and shall destroy it as soon as practicable and, in any event, no later than required by such party's record retention policy. In the event of any destruction hereunder, the party who destroyed such Confidential Information shall provide to the other party written certification of compliance therewith within fifteen (15) days after destruction.

J. **Conflicts of Interest** – FHS shall ensure that its personnel do not have any conflicts of interest with respect to HPSM's "Conflict of Interest" policy including activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to HPSM or any Member or CCS Applicant, or the person's objectivity in performing the contract work is or might be otherwise impaired, or a person has an unfair competitive advantage.

K. **Inurement** - This Agreement shall be binding upon all assignees, heirs and successors-in-interest of either party.

L. **Assignment** – Neither HPSM nor FHS shall assign this Agreement without the written consent of the other party,and will be void unless prior written approval is obtained by DHCS.

M. **Compliance with Laws** – All services to be performed by FHS pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, ordinances, regulations, reporting requirements, NCQA standards and requirements, and federal instructions, and with PLAN's policies and procedures and contractual obligations with the Centers for Medicare and Medicaid Services (CMS), the California Department of Managed Care (DMHC), and the California Department of Health Care Services (DHCS). Applicable laws include, but are not limited to, Title VI of the Civil Rights Act of 1984, the False Claims Act (31 U.S.C. §3729 et.seq.), the Anti-Kickback statute (section 1128B(b) of the Act), and the Americans with Disabilities Act of 1990, as amended. They also include the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Federal Regulations promulgated thereunder, as amended.

FHS understands that HPSM is accountable to the Centers for Medicare and Medicaid Services (CMS) for any functions or responsibilities that are described in the laws or regulations applicable to Medicare Plans, and that HPSM may be held accountable by CMS if FHS and/or its Downstream Entity violates the provisions of such law or regulations or HPSM's policies in the performance of this Agreement. In furtherance of the foregoing, FHS shall comply with and ensure any of its Downstream Entities or related entities providing services under this Agreement also comply with applicable Medicare and Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, reporting requirements, and CMS instructions, and will cooperate, assist, and provide information, as requested.

FHS agrees that services shall also be performed in accordance with all applicable ordinances and regulations, including, but not limited to, appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. In the event of a conflict between the terms of this Agreement and State, Federal, County, or municipal law or regulations, the requirements of the applicable law will take precedence over the requirements set forth in this Agreement.

FHS will timely and accurately complete, sign, and submit all necessary documentation of compliance reasonably requested by HPSM in connection with the foregoing.

FHS shall comply with HPSM's written policies and procedures related to detecting, preventing, and monitoring fraud, waste, and abuse pursuant to 42 CFR §438.608(a).

N. Non-Discrimination and Other Requirements

1. General Non-discrimination - No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information.

2. Equal Employment Opportunity – HPSM and FHS shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. HPSM and FHS's equal employment policies shall be made available to either party upon request.

3. Section 504 of the Rehabilitation Act of 1973 – HPSM and FHS shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to entities who are providing services to members of the public under this Agreement.

4. Compliance with County's Equal Benefits Ordinance - With respect to the provision of benefits to its employees, HPSM and FHS shall comply with Chapter 2.84 of the County Ordinance Code, which prohibits Contractors from discriminating in the provision of employee benefits between an employee with a domestic partner and an employee with a spouse. In order to meet the requirements of Chapter 2.84, HPSM and FHS must certify which of the following statements is/are accurate:
    i. ☒ Entity complies with Chapter 2.84 by offering the same benefits to its employees with spouses and its employees with domestic partners.
    ii. ☐ Entity complies with Chapter 2.84 by offering, in the case where the same benefits are not offered to its employees with spouses and its employees with domestic partners, a cash payment to an employee with a domestic partner that is equal to Contractor's cost of providing the benefit to an employee with a spouse.

iii. ☐ Entity is exempt from having to comply with Chapter 2.84 because it has no employees or does not provide benefits to employees' spouses.
iv. ☐ Entity does not comply with Chapter 2.84, and a waiver must be sought.

5. Discrimination Against Individuals with Disabilities - The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60–741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

6. History of Discrimination – HPSM and FHS must check one of the two following options, and by executing this Agreement, HPSM and FHS certifies that the option selected is accurate:
   i. ☒ No finding of discrimination has been issued in the past 365 days against HPSM or FHS by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or any other investigative entity.
   ii. ☐ Finding(s) of discrimination have been issued against HPSM or FHS within the past 365 days by the Equal Employment Opportunity Commission, Fair Employment and Housing Commission, or other investigative entity. If this box is checked, HPSM and FHS shall provide to the other party a written explanation of the outcome(s) or remedy for the discrimination.

7. Reporting; Violation of Non-discrimination Provisions – HPSM and FHS shall report to the County Manager the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or Section 12, above. Such duty shall include reporting of the filing of any and all charges with the Equal Employment Opportunity Commission, the Fair Employment and Housing Commission, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

   Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject HPSM or FHS to penalties, to be determined by the County Manager, including but not limited to the following:
   i. termination of this Agreement;
   ii. disqualification of HPSM from being considered for or being awarded a County contract for a period of up to 3 years;
   iii. liquidated damages of $2,500 per violation; and/or
   iv. imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

   To effectuate the provisions of this Section, the County Manager shall have the authority to offset all or any portion of the amount described in this Section against

amounts due to HPSM or FHS under this Agreement or any other agreement between HPSM and FHS.

O. **Compliance with County Employee Jury Service Ordinance** – HPSM and FHS shall comply with Chapter 2.85 of the County's Ordinance Code, which states that HPSM and FHS shall have and adhere to a written policy providing that its employees, to the extent they are full-time employees and live in San Mateo County, shall receive from HPSM and FHS, on an annual basis, no fewer than five days of regular pay for jury service in San Mateo County, with jury pay being provided only for each day of actual jury service. The policy may provide that such employees deposit any fees received for such jury service with HPSM or FHS, or that HPSM or FHS may deduct from an employee's regular pay the fees received for jury service in San Mateo County. By signing this Agreement, HPSM and FHS certifies that it has and adheres to a policy consistent with Chapter 2.85. For purposes of this Section, if HPSM and FHS has no employees in San Mateo County, it is sufficient for HPSM and FHS to provide the following written statement to County: "For purposes of San Mateo County's jury service ordinance, Contractor certifies that it has no full-time employees who live in San Mateo County. To the extent that it hires any such employees during the term of its Agreement with San Mateo County, Contractor shall adopt a policy that complies with Chapter 2.85 of the County's Ordinance Code." The requirements of Chapter 2.85 do not apply if this Agreement's total value listed Section 3, above, is less than one-hundred thousand dollars ($100,000), but HPSM and FHS acknowledges that Chapter 2.85's requirements will apply if this Agreement is amended such that its total value meets or exceeds that threshold amount.

P. **Independent Contractor** - The relationship between HPSM and FHS is an independent contractor relationship. Neither FHS nor its employee(s) and/or agent(s) shall be considered to be an employee(s) and/or agent(s) of HPSM, and neither HPSM nor any employee(s) and/or agent(s) of HPSM shall be considered to be an employee(s) and/or agent(s) of FHS. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

Q. **Invalidity and Severability** - In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

R. **Electronic Signature**
If both HPSM and FHS wish to permit this Agreement and future documents relating to this Agreement to be digitally signed in accordance with California law and San Mateo County Health's Electronic Signature Administrative Memo, both boxes below must be checked. Any party that agrees to allow digital signature of this Agreement may revoke such agreement at any time in relation to all future documents by providing notice pursuant to this Agreement.

For HPSM: ☒ If this box is checked by HPSM, HPSM consents to the use of electronic signatures in relation to this Agreement.

For FHS: ☐ If this box is checked by FHS, FHS consents to the use of electronic signatures in relation to this Agreement.

Signatures on Following Page

By signing below, I affirm that I am the duly authorized representative of the signing party and have authority to execute and bind the party for which I affix my signature.

Health Plan of San Mateo

Signature Name Title

Dated: _____

San Mateo County Health, Family Health Services

DocuSigned by:
Maya Altman
1E120A1BD07C41A...

Maya Altman CEO

Signature Name Title

Dated: 2/13/2019 | 4:42 PM PST