ENHANCED CARE MANAGEMENT PROVIDER SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

And

Sonoma County Department of Health Services

This Enhanced Care Management Provider Services Agreement (the "Agreement") is entered into this 1st day of January, 2022, by Partnership HealthPlan of California, a public entity referred to as ("**PARTNERSHIP**" or "**PLAN**") and between Sonoma County Department of Health Services by and on behalf of its providers either employed and/or contracted (collectively, "**Provider**" or "**Provider Group**"). PARTNERSHIP and Provider are collectively referred to as the "Parties" and individually as a "Party."

PROVIDER GROUPS

If the undersigned Provider is a member of a Provider Group and is the authorized representative of this Provider Group, the signature affixed to this Agreement on behalf of the Provider Group certifies the following by his or her signature:

(a) All members of the Provider Group have granted the authority to the undersigned Provider for the purpose of signing this Agreement on their behalf.

(b) Each member of the Provider Group will be aware of and comply with the terms of the Agreement.

Upon reasonable request by PARTNERSHIP, the Provider Group agrees to provide certified copies of documents, including, but not limited to, Articles of Incorporation, Partnership Agreements or Member Provider Agreements, which will verify its legal and organizational status and operation as described above.

IN WITNESS WHEREOF, the subsequent Agreement between PARTNERSHIP and Provider is entered into by and between the Parties.

PROVIDER
Sonoma County Department of Health Services

Signature:________________________________

Printed Name:_____________________________

Title:____________________________________

Date:____________________________________

PLAN
Partnership HealthPlan of California

Signature:_________________________

Printed Name: Elizabeth Gibboney____

Title: Chief Executive Officer________

Date:_____________________________

Individuals in Group *(if needed use additional sheet of paper)*:

PROVIDER Address for Notices:

____

____

____

Attn:_________________________________

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
ENHANCED CARE MANAGEMENT PROVIDER SERVICES AGREEMENT

Table of Contents

RECITALS 4

SECTION 1 – DEFINITIONS...4

SECTION 2 – QUALIFICATIONS, OBLIGATIONS AND COVENANTS 9

SECTION 3 – SCOPE OF SERVICES TO BE PROVIDED...17

SECTION 4 – REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES...25

SECTION 5 – MEDICAL RECORDS 29

SECTION 6 – INSURANCE AND INDEMNIFICATION 32

SECTION 7 – GRIEVANCES AND APPEALS 33

SECTION 8 – TERM, TERMINATION, AND AMENDMENT 36

SECTION 9 – GENERAL PROVISIONS 40

SECTION 10 – RELATIONSHIP OF PARTIES...44

ATTACHMENT A- INFORMATION REGARDING OFFICERS, OWNERS, AND STOCKHOLDERS…………………………………………………………………...46

ATTACHMENT B – ECM SITE LOCATION(S)…………………………………...…47

ATTACHMENT C- ECM FEE SCHEDULE…………………………………..................48

ATTACHMENT X- NETWORK PROVIDER MEDI-CAL REQUIREMENTS……………...49

EXHIBIT 1 – PHYSICIAN OR PHYSICIAN GROUP DELEGATION AGREEMENT……..51

RECITALS

A. Whereas PARTNERSHIP has entered into and will maintain contracts (the "Medi-Cal Contract(s)") with the State of California, Department of Health Care Services ("DHCS") in accordance with Title 10, CCR, Section 1300 et. seq.; W&I Code, Section 14200 et. seq.; Title 22, CCR, Section 53250; and applicable federal and State laws and regulations, under which PARTNERSHIP provides services to Medi-Cal beneficiaries.

B. Whereas PARTNERSHIP will now offer Enhanced Care Management ("ECM"), as defined below, to Members pursuant to the Medi-Cal Contract provisions addressing ECM ("ECM Provisions").

C. Whereas Provider is a community-based entity with experience and expertise providing intensive, in-person care management services to individuals in one (1) or more of the Populations of Focus, as defined below, for ECM.

D. Whereas Provider desires to provide ECM Services within Provider's area of practice as appropriate for such Medi-Cal Members.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the Parties set forth in this Agreement agree and covenant as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

1.1 Accreditation Organization – means any organization including without limitation, the National Committee for Quality Assurance (NCQA), or other entities engaged in accrediting, certifying and/or approving PARTNERSHIP, Provider, and/or their respective programs, centers or services.

1.2 Agreement - This Agreement and all of the Attachments attached hereto and incorporated herein by reference.

1.3 Assigned Member or Member – A PARTNERSHIP Medi-Cal member who has been assigned or who chose Provider for their ECM Services.

1.4 California Children's Services ("CCS") - A public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800.

1.5 Care Plan - The comprehensive, individualized, person-centered care plan created by Provider that identifies Member's needs, strengths, risks, goals, and preferences, and includes strategies and recommendations to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorder ("SUD"), long-term services and support ("LTSS"), oral health, palliative care, necessary community-based and social services, and housing.

1.6 Child Health and Disability Prevention Services (CHDP) - Those health care preventive services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et. seq., and Title 17, CCR, Sections 6842 through 6852.

1.7 Clean Claim - A claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of ECM Services provided.

1.8 Contract Year - Twelve (12) month period following the effective date of this Agreement between Provider and PARTNERSHIP and each subsequent twelve (12) month period following the anniversary of the Agreement.

1.9 County Organized Health System (COHS) - A plan serving either a single or multiple county area formed pursuant to California Welfare and Institutions Code Section 14087.54.

1.10 DHCS - The State of California Department of Health Care Services.

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

1.12 ECM Provider - A provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one (1) or more of the Populations of Focus for ECM. ECM Providers may include, but are not limited to, the following entities: (i) counties; (ii) county behavioral health providers; (iii) Primary Care Physician, Specialist, or physician groups; (iv) Federally Qualified Health Centers; (v) Community Health Centers; (vi) Community-based organizations; (vii) hospitals or hospital-based physician groups or clinics (including public hospitals and district and/or municipal public hospitals); (viii) Rural Health Clinics and/or Indian Health Services Programs; (ix) local health departments; (x) behavioral health entities; (xi) community mental health centers; (xii) substance use disorder treatment providers; (xiii) organizations serving individuals experiencing homelessness; (xiv) organizations serving justice involved individuals; (xv) CCS providers; and (xvi) other qualified providers or entities not listed above, as approved by DHCS.

1.13 ECM Services or Services - The services which include, but are not limited to: (i) Outreach

and Engagement of Members into ECM; (ii) Comprehensive Assessment and Care Management Plan; (iii) Enhanced Coordination of Care; (iv) Health Promotion; (v) Comprehensive Transitional Care; (vi) Member and Family Supports; and (vii) Coordination of and Referral to Community and Social Support Services, as described in Section 3 below.

1.14 ECM Populations of Focus or Populations of Focus - Members belonging to the following populations: (i) Adult Populations of Focus: (a) Experiencing Homelessness, (b) High Utilizers, (c) Serious Mental Illness ("SMI") or SUD, (d) Transitioning from Incarceration, (e) Individuals At Risk for Institutionalization who are Eligible for Long-Term Care Services, and (f) Nursing Facility Residents Transitioning to the Community; and (ii) Children/Youth (up to Age 21) Populations of Focus: (a) Experiencing Homelessness, (b) High Utilizers, (c) Serious Emotional Disturbance (SED) or Identified to be At Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis, (d) Enrolled in CCS/CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Qualifying Condition; (e) Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26), and (f) Transitioning from Incarceration.

1.15 Encounter Form - Form submitted electronically to PARTNERSHIP in a HIPAA compliant 837 format to report the ECM Services provided to Medi-Cal Members.

1.16 Enrollment - The process by which a Medi-Cal Beneficiary selects or is assigned to PARTNERSHIP by DHCS.

1.17 Fee-For-Service Payment (FFS) - (1) the maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by PARTNERSHIP and Provider. All Services that are Non Capitated Services or authorized by PARTNERSHIP pursuant to this Agreement will be compensated by PARTNERSHIP at the lowest allowable Fee-For-Service rate unless otherwise identified in Section 4 of this Agreement.

1.18 Fiscal Year of Partnership HealthPlan of California - The twelve (12) month period starting each July 1.

1.19 Governmental Agencies - The Department of Managed Health Care ("DMHC"), Department of Health Care Services ("DHCS"), United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General and any other agency which has jurisdiction over PARTNERSHIP or Medi-Cal (Medicaid).

1.20 Hospital - Any acute, general care or psychiatric hospital licensed by the DHCS and contracted with PARTNERSHIP.

1.21 Identification Card - The card that is prepared by PARTNERSHIP which bears the name and symbol of PARTNERSHIP and contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with PARTNERSHIP or proof of Medi-Cal eligibility.

1.22 In Lieu of Services ("ILOS") - The services or settings that are offered, pursuant to 42 CFR 438.3(e)(2), in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. ILOS are optional for both PARTNERSHIP and the Member and must be approved by DHCS.

1.23 ILOS Provider - A contracted provider of DHCS-approved ILOS. ILOS Providers are community-based entities with experience and/or training providing one (1) or more of the ILOS approved by DHCS.

1.24 Lead Care Manager - A Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with PARTNERSHIP). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any ILOS. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1.29 Medical Director - The Medical Director of PARTNERSHIP, or his/her designee, a physician licensed to practice medicine in the State of California employed by PARTNERSHIP to monitor the quality assurance and implement Quality Improvement Activities of PARTNERSHIP.

1.30 Medi-Cal Managed Care Program - The program that PARTNERSHIP operates under its Medi-Cal Contract with the DHCS.

1.31 Medi-Cal Provider Manual - The Medical Services Provider Manual issued by DHCS,.

1.32 Medically Necessary - Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Member who is under the age of twenty-one (21), "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare & Institutions Code Section 14132(v). These services will be in accordance with accepted standards of medical practice and not primarily for the convenience of the Member or the participating provider.

1.33 Medicare – The federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.34 Member Handbook - The PARTNERSHIP Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Medi-Cal Member is entitled under the Medi-Cal Managed Care Program, the limitations and exclusions to which the Medi-Cal Member is subject and terms of the relationship and agreement between PARTNERSHIP and the Medi-Cal Member.

1.35 Model of Care ("MOC") – The PARTNERSHIP framework for providing ECM, including its Policies and Procedures for partnering with ECM Providers and ILOS Providers, as approved by DHCS.

1.36 Participating Provider - Any health professional or institution contracted with PARTNERSHIP that meets all applicable the Standards for Participation in the State Medi-Cal Program to render services to Medi-Cal Members.

1.37 Per Enrollee Per Month (PEPM) – A Fee-for-Service rate paid to Provider for Members who are in ECM Populations of Focus and authorized for ECM Services.

1.38 Provider Group – A group of Participating Providers, that are a duly organized business entity who have entered into an Agreement with PARTNERSHIP.

1.39 Providers Advisory Group - The committee of physicians chosen each year from among contracting physicians by PARTNERSHIP for the purpose of advising PARTNERSHIP. The physicians must be Board Certified.

1.40 PLAN – refers to Partnership HealthPlan of California.

1.41 Primary Care Physician ("PCP") - A physician or physicians who have executed an Agreement with PARTNERSHIP to provide Primary Care services. The physician must be duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. Primary care physicians include general and family practitioners, internists, Obstetrician-Gynecologists and pediatricians. A resident or intern will not be a Primary Care Physician.

1.42 Provider Manual - The Manual of Operational Policies and Procedures for PARTNERSHIP Medi-Cal Managed Care Program.

1.43 Quality Improvement Plan (QIP) - Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Medi-Cal Contract with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.

1.47 Subcontract – A contract entered into by Provider with a Subcontractor that agrees to furnish items and/or services to PARTNERSHIP Members, or administrative functions or services related to Provider fulfilling its obligations to PARTNERSHIP under the terms of this Agreement if, and to extent, permitted under this Agreement and consistent with applicable federal and state law.

1.48 Subcontractor – A provider or any organization or person who has entered into a Subcontract with Provider for the purpose of providing or facilitating the provision of items and/or services under this Agreement.

1.49 Treatment Authorization Request ("TAR") - The Treatment Authorization Request form approved by PLAN for the provision of Non-Emergency Services. Those Non-Emergency Services that require a Treatment Authorization Request form approved by PLAN are set forth in the Provider Manual.

1.50 Utilization Management Program - The program(s) approved by PARTNERSHIP, which are designed to review and monitor the utilization of Services. Such program(s) are set forth in PARTNERSHIP's Provider Manual.

SECTION 2
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

2.1 Provider is responsible for:

2.1.1 Standards of Care – Provider shall provide ECM Services for PARTNERSHIP Members that are within Provider's professional competence,with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.

2.1.2 Medi-Cal Enrollment - If a State-level enrollment pathway exists, Provider shall be enrolled in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If APL 19-004 does not apply to Provider, Provider must comply with the PLAN's process for vetting Provider, which may extend to individuals employed by or delivering services on behalf of Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

a. Provider will notify PARTNERSHIP immediately if Provider is referred for suspension or termination, or actually identified as suspended, excluded, or terminated from participation in the Medicare or Medi-Cal/Medicaid programs.

2.1.3 Participation Requirements

a. Provider shall be experienced in serving the ECM Population(s) of Focus Provider will serve.

b. Provider shall have experience and expertise with the ECM Services Provider will provide.

c. Provider shall comply with all state and federal laws and regulations, and all ECM program requirements in the ECM Provisions and associated guidance.

d. Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13: Ethnic and Cultural Composition, of the Medi-Cal Contract, including accompanying Members to critical appointments when necessary.

e. Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways, in accordance with Exhibit A, Attachment 9, Provision 14: Cultural and Linguistic Program, of the Medi-Cal Contract.

f. Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, such as ILOS Providers, to coordinate care as appropriate to each Member.

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

h. Provider shall comply with PARTNERSHIP's ECM Model of Care, incorporated by reference herein.

2.1.4 ECM Services - Provider shall provide those ECM Services, as set forth in Attachment [X], which are within Provider's service specialty, to Members in accordance with the terms and conditions of this Agreement and in accordance with DHCS service definitions and requirements.

2.1.5 Identification of Members for ECM – Provider is responsible for identifying Members who would benefit from ECM Services and sending requests to PLAN, to determine if the Member is eligible for ECM, consistent with PLAN's process for such requests. In so identifying, Provider must consider Members' health care utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health; and LTSS needs.

2.1.6 Member Assignment

a. Provider shall immediately accept all Members assigned by PLAN for ECM, with the exception that Provider shall be permitted to decline a Member assignment if Provider is at its pre-determined capacity, as agreed upon between the Parties. Provider shall immediately notify PARTNERSHIP if it does not have the capacity to accept a Member assignment.

b. Upon initiation of ECM, Provider shall ensure each Member assigned has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports, Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any ILOS, and other services that address social determinants of health ("SDOH") needs, regardless of setting.

c. Provider shall advise the Member on the process for changing ECM Providers, which is permitted at any time.

   i. Provider shall advise the Member on the process for switching ECM Providers, if requested.

   ii. Provider shall notify PARTNERSHIP if the Member wishes to change ECM Providers.

   iii. PARTNERSHIP must implement any requested ECM Provider change within thirty (30) days.

d. Provider acknowledges that PLAN shall have the right to immediately withdraw Members from assignment to Provider or any of its Subcontractors in the event the health or safety of Members is jeopardized by the actions of Provider or such Subcontractor or by reason of Provider's or such Subcontractor's failure to provide Services in accordance with PLAN's Quality Improvement and Utilization Management Programs ("QI/UM") Program.

2.1.7 Provider Outreach and Member Engagment - Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with PLAN's policies and procedures.

a. Provider shall prioritize outreach to those Members with the highest level of risk and need for ECM.

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

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

i. Mail
ii. Email
iii. Texts
iv. Telephone calls
v. Telehealth

d. Provider shall comply with nondiscrimination requirements set forth in state and federal law, the Medi-Cal Contract, and this Agreement

2.1.8 Accessibility and Hours of Service – Provider shall provide ECM Services to Medi-Cal Members on a readily available and accessible basis in accordance with PARTNERSHIP policies and procedures as set forth in PARTNERSHIP's Provider Manual during normal business hours at Provider's usual place of business.

2.1.9 Initiating Delivery of ECM - Provider shall obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between PARTNERSHIP and ECM Providers, ILOS Providers, and other providers involved in the provision of Member care to the extent required by federal law.

(a) Member authorization for ECM-related data sharing is not required for Provider to initiate delivery of ECM unless such authorization is required by federal law.

(b) When federal law require Member authorization for data sharing, Provider shall communicate that Provider has obtained Member authorization for such data sharing back to PARTNERSHIP.

2.1.10 Disclosure Statement – Provider agrees to provide PARTNERSHIP with the disclosure statement set forth in 22 CCR 51000.35, included in Attachment A, prior to commencing services under this Agreement. Provider shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Contract. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Provider shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by the Medi-Cal Contract. Such Debarment Certification and its instructions are set forth in the Provider Manual.

2.1.11 Quality and Oversight – Provider acknowledges PARTNERSHIP will conduct oversight of its delivery of ECM to ensure the quality of ECM rendered and ongoing compliance with all legal and contractual obligations both PARTNERSHIP and Provider have, including, but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

(a) Provider shall respond to all PARTNERSHIP requests for information and documentation to permit ongoing monitoring of ECM.

(b) Provider shall be responsible for the same reporting requirements as those PARTNERSHIP must report to DHCS, including Encounter Data and other supplemental reporting, as applicable.

(c) Failure of Provider to follow PARTNERSHIP's Policies and Procedures, reporting requirements, subcontractual requirements, or ECM program requirements, may result, at PARTNERSHIP's option, in a corrective action plan or any sanctions incorporated in the PARTNERSHIP Provider Manual.

2.1.12 Credentialing – If applicable to Provider's provider type, Provider agrees to provide PARTNERSHIP with a completed credentialing form, will use best efforts to notify PARTNERSHIP in advance of any change in such information, and will successfully complete a facility site review, if deemed necessary by PARTNERSHIP in accordance with the Medi-Cal Contract.

Actions Against Provider - Provider will adhere to the requirements as set forth in PARTNERSHIP's Provider Manual and notify PARTNERSHIP by certified mail within five (5) days of Provider learning of any action taken which results in restrictions on Provider staff privileges, membership, employment for a medical disciplinary cause or reason as defined in the California Business & Professions Code, Section 805, regardless of the duration of the restriction or exclusion from participating in the Medi-Cal Program in accordance with the Standards of Participation.

Financial and Accounting Records – Provider shall maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to Services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the Services to be rendered, and payments to be made hereunder or in connection herewith.

Reports – Provider agrees to submit reports as required by PARTNERSHIP and/or relevant Governmental Agencies, including, but not limited to, DHCS. (MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2G, and Title 22, CCR Sections 53250(c)(5) and 53867).

2.1.13 Compliance with Member Handbook - Provider acknowledges that Provider is not authorized to make nor will Provider make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.

2.1.14 Promotional Materials - Provider consents to be identified as a Participating Provider in written materials published by PARTNERSHIP, including, without limitation, marketing materials prepared and distributed by PARTNERSHIP and, display promotional materials provided by PARTNERSHIP within his/her office.

2.1.15 Compliance with PARTNERSHIP Policies and Procedures - Provider agrees to comply with all policies and procedures set forth in the PARTNERSHIP Provider Manual. The Provider Manual is available through PARTNERSHIP website at www.Partnershiphp.org. PARTNERSHIP may modify the Provider Manual from time to time. In the event the provisions of the Provider Manual are inconsistent with the terms of this Agreement; the terms of this Agreement shall prevail.

2.1.16 Cultural and Linguistic Services – Provider shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. Provider shall comply with PLAN's language assistance program standards developed under California Health and Safety Code Section 1367.01 and Title 28 CCR Section 1300.67.04 and shall cooperate with PLAN by providing any information necessary to assess compliance. PLAN shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. Provider has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in PARTNERSHIP Provider Manual.

2.1.17 Provider Locations and Services – This Agreement will apply to Services provided by the Provider for any location set forth in this Agreement. Upon execution of this Agreement, if the Provider renders Services at a location not listed in this Agreement, Provider understands that any new site(s) not listed in the Agreement may be added upon notice to PARTNERSHIP of new site(s), verification of new site's Medi-Cal enrollment, and successful completion of PARTNERSHIP's Credentialing requirements, if applicable. Further, any new site(s) added to this Agreement will be subject to the same reimbursement rates set forth in the Agreement.

(a) In the event the Provider begins providing Services under another Tax Identification Number(s) and/or billing NPI that is not currently contracted with PARTNERSHIP, upon written agreement of the Parties, that new Tax Identification Number(s) and /or billing NPI will become subject to the Agreement.

(b) In the event the Provider acquires or is acquired by, merges with or otherwise becomes affiliated with another Participatin Provider that is currently contracted with PARTNERSHIP, this Agreement, and the current agreement between PARTNERSHIP and the other Participating Provider will each remain in effect and will continue to apply to each separate entity as they did prior to acquisition, merger or affiliation unless otherwise agreed to in writing by the parties.

(c) Any assignment of this Agreement is subject to Section 10.

2.2 PARTNERSHIP is responsible for:

2.2.1 Member Assignment – PLAN shall communicate new Member assignments to Provider as soon as possible, but in any event no later than ten (10) business days after ECM authorization.

a) PLAN shall follow Member's preferences for a specific ECM Provider, if known, to the extent practicable.

b) If the Member's assigned PCP is a contracted ECM Provider, PLAN shall assign the Member to the PCP as the ECM Provider unless the Member has expressed a different preference or PLAN identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

c) If the Member's receives services from a Specialty Mental Health Plan for SED, SUD, and/or SMI, and the Member's behavioral health provider is a contracted ECM Provider, PLAN shall assign the Member to that behavioral health provider as the ECM Provider unless the Member has expressed a different preference or PLAN identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

d) For children enrolled in CCS and when the Member's CCS Case Manager is affiliated with a contracted ECM Provider, PLAN shall assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or family has expressed a different preference or PLAN identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

e) PLAN shall notify the Member's PCP if different from the ECM Provider, of the assignment to the ECM Provider within ten (10) business days of the date of the assignment.

f) PLAN shall document the Member's ECM Lead Care Manager in its system of record.

g) PLAN shall permit Members to change ECM Providers at any time and implement any requested ECM Provider change within thirty (30) days.

2.2.2 Payment for Authorized Service Only - PARTNERSHIP will reimburse Provider for Services that are Medically Necessary, and if required, properly authorized by PARTNERSHIP Medical Director (or his/her designee).

2.2.3 ECM Program

a) PLAN shall inform Members about ECM and how to access it.

b) PLAN shall manage and respond promptly to requests for ECM directly from Members and on behalf of Members from ECM Providers, other providers and community entities, and the Member's guardian or Authorized Representative ("AR"), where applicable.

c) PLAN shall be responsible for Authorizing ECM for Members, whether they are identified by PLAN or if the Member or a family member, AR, guardian, caregiver, authorized support person or external entity requests that the Member receives ECM. ECM Authorization or a decision not to Authorize occurs as soon as possible and in accordance with applicable law and the Provider Manual.

d) PLAN shall be responsible for assigning all Members Authorized to receive ECM to an appropriate ECM Provider.

e) PLAN shall develop and disseminate Member-facing written materials about ECM for use by Provider and Participating Providers. This material shall:

   i. Explain ECM and how to request it.

   ii. Explain that ECM participation is voluntary and can be discontinued at any time.

   iii. Explain that the Member must authorize ECM-related data sharing.

   iv. Describe the process by which the Member may choose a different Lead Care Manager or ECM Provider.

   v. Meet the standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13: Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3: Written Member Information, of the Medi-Cal Contract.

f) PLAN shall ensure accurate and up-to-date Member-level records are maintained for the Members authorized for ECM.

g) PLAN shall notify Provider when ECM has been discontinued.

h) PLAN shall notify the Member of the discontinuation of ECM and ensure the Member is informed of their right to appeal and the appeals process by way of the Notice of Action process as described in Exhibit A, Attachment 13, Provision 8: Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14: Member Grievance and Appeals, of the Medi-Cal Contract and pursuant to state and federal law.

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

a) Member assignment files, defined as a list of Members Authorized for ECM and assigned to Provider;
b) Encounter and/or claims data;
c) Physical, behavioral, administrative, and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members; and
d) Reports of performance on quality measures and/or metrics, as requested.

2.2.5 IT Structure - PLAN shall have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

a) Consume and use claims and Encounter Data, as well as other data types used to identify Populations of Focus;

b) Assign Members to ECM Providers;

c) Keep records of all Members receiving ECM who have given consent to receive ECM and authorizations necessary for sharing personally identifiable information among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by PLAN;

d) Securely share data with ECM Providers;

e) Receive, process, and send claims, encounters and invoices from ECM Providers to DHCS;

f) Receive and process supplemental reports from ECM Providers;

g) Send ECM supplemental reports to DHCS; and

h) Open, track, and manage referrals to ILOS Providers.

2.2.6 Defined Standards – PLAN shall use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Provider and with DHCS, to the extent practicable.

2.3 Member Eligibility - Provider will verify Medi-Cal Member eligibility with PARTNERSHIP prior to admission for inpatient services at assigned HOSPITAL and prior to rendering Services. Prior Authorization from PARTNERSHIP is not a guarantee of Medi-Cal Member eligibility with PARTNERSHIP or eligibility in the State Medi-Cal Program.

2.3.1 The notification will be provided via telephone, facsimile, mail or electronic media, listing all pertinent data regarding the eligibility of Medi-Cal Members who have chosen or have been assigned to Provider. Such data will be updated on or about the twenty-fifth (25th) of the each month.

2.3.2 PARTNERSHIP will maintain (or arrange to have maintained) records and establish and adhere to procedures as will reasonably be required to accurately ascertain the number and identity of Medi-Cal Members.

SECTION 3
SCOPE OF SERVICES TO BE PROVIDED

3.1 Management of Care - The Parties acknowledge and agree that this Agreement specifies the ECM Services to be provided by Provider *(Managed Care Plan Contract (MCP), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867)*.

3.2 ECM Requirements

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

a) If Provider subcontracts with other entities to administer ECM functions, Provider shall ensure agreements with such Subcontractors for the provision of ECM bind the Subcontractors to the terms and conditions that are enumerated in this Agreement, and that its Subcontractors comply with all requirements in this Agreement and the Medi-Cal Contract, including the ECM Provisions. Such Subcontracts are subject to the approval of PLAN and Regulatory Agencies, if required by Applicable Requirements.

3.2.2 Provider shall:

a) Ensure each Member receiving ECM has a Lead Care Manager;

b) Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;

c) Alert PLAN to ensure non-duplication of Services in the event that a Member is receiving care management or duplication of Services from multiple sources; and

d) Follow PLAN instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

e) Ensure that each Member automatically Authorized for ECM as a prior enrollee in a Whole Person Care ("WPC") pilot and identified by the WPC Lead Entity as belonging to an ECM Population of Focus, is assessed within six (6) months of Authorization for ECM, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

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

3.2.4 Provider shall participate in all mandatory, ECM Provider-focused ECM training and technical assistance provided by PLAN, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training per requirements described in Exhibit A, Attachment 7, Provision 5: Network Provider Training, of the Medi-Cal Contract.

3.3 ECM Core Service Components - Provider shall provide all core service components of ECM to each assigned Member, in compliance with PLAN's policies and procedures, as follows:

3.3.1 Outreach and Engagement of PLAN Members into ECM.

3.3.2 Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:

a) Engaging with each Member Authorized to receive ECM primarily through in-person contact;

i. When in-person communication is unavailable or does not meet the needs of the Member, Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.

b) Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Plan;

c) Developing a comprehensive, individualized, person-centered Care Plan by working with the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) as

appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;

d) Incorporating into the Member's Care Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;

e) Ensuring the Care Plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and as identified in the Care Plan; and

f) Ensuring the Care Plan is reviewed, maintained, and updated under appropriate clinical oversight.

3.3.3 Enhanced Coordination of Care, which shall include, but is not limited to:

a) Organizing patient care activities, as laid out in the Care Plan, sharing information with those involved as a part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Plan;

b) Maintaining regular contact with all ECM Providers, that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs;

c) Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, necessary community-based and social services, including housing, as needed;

d) Providing support for Member engagement in treatment including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;

e) Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and

f) Ensuring regular contact with the Member and their family member(s), AR, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the Care Plan.

3.3.4 Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:

a) Working with Members to identify and build on successes and potential family and/or support networks;

b) Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and

c) Supporting the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

3.3.5 Comprehensive Transitional Care, which shall include, but is not limited to:

a) Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;

b) For Members who are experiencing or are likely to experience a care transition:

i. Developing and regularly updating a transition of Care Plan for the Member;
ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center, and communicating with the appropriate care team members;
iv. Coordinating medication review/reconciliation; and
v. Providing adherence support and referral to appropriate services.

3.3.6 Member and Family Supports, which shall include, but are not limited to:

a) Documenting Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between Provider, ECM Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), and PLAN, as applicable;

b) Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management,

in accordance with all Applicable Requirements, including, but not limited to, those pertaining to privacy and confidentiality;

c) Ensuring Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);

d) Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;

e) Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and

f) Ensuring that the Member has a copy of his/her Care Plan and information about how to request updates.

3.3.7 Coordination of and Referral to Community and Social Support Services, which shall include, but is not limited to:

a) Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services which may be offered by PLAN as ILOS; and

b) Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

3.4 Discontinuation of ECM – When ECM is discontinued, Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).

3.4.1 Provider shall notify PARTNERSHIP to discontinue ECM for Member when any of the following circumstances are met:

a. The Member has met all Care Plan goals for ECM;
b. The Member is ready to transition to a lower level of care;
c. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
d. Provider has not been able to connect with the Member after multiple attempts.

3.5 Consultation with Medical Director - Provider may at any time seek consultation with Medical Director on any matter concerning the treatment of the Member.

3.6 Facilities, Equipment and Personnel – Provider shall provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement and consistent with the Medi-Cal Contact,

including, but not limited to, the ECM Provisions, and any other related DHCS guidance.

3.7 Provider Notice - Provider agrees to provide at least sixty (60) days notice to PARTNERSHIP prior to the opening of any new location and ninety (90) days prior to significantly changing capacity or Services furnished by Provider or the closing of any location.

3.8 Interpreter Services and Auxiliary Aids – Arrange interpreter services, and Auxiliary Aids such s Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) and American Sign Language, as necessary for Members at all facilities. As a means to fufill this requirement, Provider will access PARTNERSHIP's Interpretive Services, as appropriate *(MCP Contract Exhibit A, Attachment 6, Provision 14.B.17)*.

3.9 Nothing expressed or implied herein shall require the Provider to provide to or order on behalf of the Member, Services which, in the professional opinion of the Provider, are not Medically Necessary for the treatment of the Member's disease or disability.

3.10 Non-Discrimination

3.10.1 Members - Provider will provide ECM Services to Members in the same manner as such Services are provided to other patients/clients of Provider, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Managed Care Program. Subject to the foregoing, Provider will not subject Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, ethnic group identification, age, sex, gender, gender identity, political affiliation, health status, physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of PARTNERSHIP, filing a complaint as a Member of PARTNERSHIP, identification with any other persons or groups defined in Penal Code 422.56, or other protected status, in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), section 1557 of the Patient Protection and Affordable Care Act, and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination includes but is not limited to: denying any Member any Service or availability of a Facility; providing to a Member any Service which is different, or is provided in a different manner or as a different time from that provided to other Members under this Agreement except where medically indicated; subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Service; restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Services; treating a Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any

Services; and the assignment of times or places for the provision of Services, on the basis of a protected status.

3.10.2 For the purpose of this Section 3.13, health status includes the carrying of a gene, which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes include, but are not limited to, Tay-Sachs trait, sickle-cell trait, Thalassemia trait, and X-linked hemophilia.

3.10.3 General Compliance – Pursuant to the requirements of the Medi-Cal Contract, Provider will not unlawfully discriminate, harass or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, ethnic group identification, national origin, age, sex, gender, gender identity, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of PARTNERSHIP, filing a complaint as a Member of PARTNERSHIP, denial of family care leave, identification with any other persons or groups defined in Penal Code 422.56, or other protected status. Provider will ensure the evaluation and treatment of Provider's employees and applicants for employment are free from discrimination and harassment. Provider will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et.seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4, Chapter 5 are incorporated into this Agreement by reference and made a part hereof as set forth in full. Provider will give notice of his obligations under this Section to labor organizations with which Provider has a collective bargaining or other agreement.

3.10.4 Provider agrees to provide cultural competency sensitivity, and diversity training to its workforce *(MCP Contract, Exhibit A, Attachment 9, Provision 13.E)*.

3.10.5 Provider shall include the nondiscrimination and compliance provisions of this Agreement in all Subcontracts, if any, to perform work under the Agreement.

3.11 Quality Improvement and Utilization Management Programs

3.11.1 Provider will participate in and cooperate with PARTNERSHIP's QI/UM Programs *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19)*, including, but not limited to, activities to improve the quality of care and services and member experience, credentialing and re-credentialing, peer review and any other activities required by PARTNERSHIP, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these QI/UM Programs. This includes participation in office reviews, chart and access audits and focused reviews. In addition, Provider will participate in the development of corrective action plans for any areas that fall

below PARTNERSHIP standards and ensuring medical records are readily available to PARTNERSHIP staff as requested. Provider cooperate with collection and evaluation of data for quality performance and agrees that PARTNERSHIP may use performance data for quality improvement activities.

a. Provider recognizes the possibility that PARTNERSHIP through utilization management and quality assurance processes may be required to take action requiring consultation with its Medical Director or with other physicians prior to authorization of Services or supplies or to terminate this Agreement.

b. In the interest of program integrity or the welfare of Medi-Cal Members, PARTNERSHIP may introduce additional utilization controls or quality improvement programs as may be necessary.

c. In the event of such change, a thirty (30) day notice will be given to Provider. The change may take effect immediately upon receipt by Provider of notice from the Medical Director but Provider may be entitled to appeal such action to the Grievance Review Committee, the Provider Advisory Group and then to PARTNERSHIP's Board of Commissions, per the Provider Manual.

d. If PARTNERSHIP delegates Quality Improvement Activities, Provider and PARTNERSHIP will enter into a separate delegation agreement that contains the provisions stipulated in the Medi-Cal Contract *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A)*.

SECTION 4
REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES

4.1 Payments - The Parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by Provider from PARTNERSHIP *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867)*.

4.2 Claim Submission – Provider will submit complete, timely, reasonable, and accurate claims or invoices, provider data, encounter data and reports according to all regulatory requirements for all Services rendered to Medi-Cal Members as described in PARTNERSHIP's Provider Manual.

4.2.1 Provider shall submit claims for the provision of Services to PARTNERSHIP using the national standard specifications and code sets to be defined by DHCS.

4.2.2 In the event Provider is unable to submit claims to PARTNERSHIP for Services using the national standard specifications and DHCS-defined code sets, Provider shall submit an invoice to PARTNERSHIP with an excel spreadsheet with the minimum set of data elements (to be defined by DHCS) necessary for PARTNERSHIP to convert the invoice to an encounter for submission to DHCS.

4.3 Timing of Payment – Provider is eligible to receive payment when ECM is initiated for any given Member. If Provider is an individual or group practice or practices in shared health facilities, PARTNERSHIP shall pay 90 percent of all clean claims within thirty (30) days of date of receipt and 99 percent of all clean claims within ninety (90) days. The date of receipt shall be the date PARTNERSHIP receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4.4 Timing of Claims or Invoices - All claims or invoices for reimbursement of Services must be submitted to PARTNERSHIP as soon as possible, but no later than within three hundred and sixty-five (365) days from the date of Services. Claims or invoices received on the 366th day form the date of service will be denied. PARTNERSHIP will make no exceptions or pro-rated payments beyond the twelve (12) month billing limit.

4.5 Entire Payment - Provider will accept from PARTNERSHIP compensation as payment in full and discharge of PARTNERSHIP's financial liability. Services provided to Medi-Cal Members by Provider will be reimbursed as listed hereunder in those amounts set forth in this Agreement and in accordance with PARTNERSHIP's Provider Manual policies and procedures. Provider will look only to PARTNERSHIP for such compensation. PARTNERSHIP has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to PARTNERSHIP are reduced by DHCS. Payment will be made in one or more or a combination of the following methodologies.

4.5.1 Fee-For-Service Payment (FFS) - PARTNERSHIP will reimburse Provider for ECM Services provided on a Per Enrollee Per Month basis as set forth in Attachment C of the Agreement for all properly documented ECM Services provided to Members, which have been properly authorized in accordance with PARTNERSHIP's Provider Manual. A summary enrollment report will accompany each payment identifying Members who are eligible for ECM Services for that month.

4.6 Medi-Cal Member Hold-Harmless – Provider agrees to hold harmless both the State and Members in the event PARTNERSHIP cannot or will not pay for Services performed by Provider pursuant to this Agreement *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867).*

4.6.1 Provider agrees not to balance bill any Member *(MCP Contract, Exhibit A, Attachment 8, Provision 6).*

4.7 Member Billing - Provider will not submit claims to or demand or otherwise collect reimbursement from a Member, or from other persons on behalf of the Member, for any

Service included under this Agreement and permitted by the Medi-Cal Contract. Provider may bill the Member for non-covered services if Member agrees in advance and in writing with signature affirming agreement that such services are not covered by PARTNERSHIP.

4.8 Coordination of Benefits - Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. Provider must bill the primary carrier before billing PARTNERSHIP for reimbursement of ECM Services and will at no time seek compensation from Members. Provider has the right to collect all sums as a result of Coordination of Benefits efforts for Services provided to Members with Other Health Coverage.

4.8.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and PARTNERSHIP's Provider Manual.

4.8.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the Medi-Cal Contract.

4.8.3 Provider will report to PARTNERSHIP the discovery of third party insurance coverage for a Medi-Cal Member within ten (10) days of discovery.

4.9 Third Party Liability - In the event that Provider provides Services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California 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 Provider pursuant to the terms of this Agreement.

4.9.1 Provider cooperate with the DHCS and PARTNERSHIP in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Services.

4.10 Subcontracts

4.10.1 All subcontracts between Provider and Provider's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Contract, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.

4.10.2 All Subcontracts and their amendments will become effective only upon written approval by PARTNERSHIP and applicable Governmental Agencies and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from Provider. Provider will notify Governmental Agencies and PARTNERSHIP when any Subcontract is amended or terminates. Provider will make available to PARTNERSHIP and Governmental Agencies, upon request, copies of all agreements between Provider and Subcontractor(s) for

the purpose of providing Services.

4.10.3 All agreements between Provider and any Subcontractor will require Subcontractor to comply with the following:

a. Records and Records Inspection – Subcontractor will maintain and make available to Governmental Agencies, upon request, copies of all Subcontracts, and will: (i) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Agreement, available at all reasonable times for audit, inspection, examination, or copying by Governmental Agencies, including, but not limited to, DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees; (ii) Retain all records and documents for a minimum of ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10)*.

b. Surcharges – Subcontractor will not collect a Surcharge for Services for a Medi-Cal Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Medi-Cal Member within fifteen (15) days of the occurrence and will notify PARTNERSHIP of the action taken. Upon notice of any Surcharge, PARTNERSHIP will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Medi-Cal Member and deducting the amount of the Surcharge and the expense incurred by PARTNERSHIP in correcting the payment from the next payment due to Provider.

c. Notification – Subcontractor will notify relevant Governmental Agencies and PARTNERSHIP in the event the agreement with Subcontractor is amended or terminated. Notice will be given in the manner specified in Section 10.4 Notices.

a. Assignment – Subcontractor will agree that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from relevant Governmental Agencies and PARTNERSHIP.

b. Transfer - Subcontractor agrees to assist PARTNERSHIP in the transfer of care in the event of a Subcontract termination for any reason *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12)*.

4.10.4 Additional Requirements - Be bound by the provisions of Section 9.7, Survival of Obligations After Termination, and Section 7.5, Provider Indemnification and Hold Harmless.

4.11 Overpayments or Recoupment - Provider shall report to PARTNERSHIP when Provider

has received an overpayment. Parties agree that there shall be a limit on recoupment of all overpayments by PARTNERSHIP and underpayments or denials to Provider of twelve (12) months from the date payment or denial was made to Provider. Further, Parties agree that no time limit will apply to any overpayment caused by fraud, waste or misrepresentation on the part of Provider. Pursuant to 42 CFR § 438.608(d), PARTNERSHIP is required to annually report Provider overpayments to DHCS. Overpayment is any payment made to Provider by PARTNERSHIP to which Provider is not entitiled under Title XIX of the Social Security Act.

(a) Provider will return the overpayment to PARTNERSHIP within sixty (60) calendar days after the date on which the overpayment was identified, and notify PARTNERSHIP in writing of the reason for overpayment (42 CFR 438.608(d)(2)).

(b) Provider will reimburse PARTNERSHIP within sixty (60) days of such request, unless it contests the request in writing that states the basis upon which Provider believes the claim or payment was not overpaid.

(c) Provider acknowledges and agrees that, in the event that PARTNERSHIP determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Agreement, PARTNERSHIP shall have the right to recover such uncontested amounts from Provider. If payment of uncontested recoupment is not received by PARTNERSHIP within sixty (60) days from PARTNERSHIP's mailing notice, PARTNERSHIP reserves the right to recoupment or offset from current or future amounts due from PARTNERSHIP to Provider.

(d) This right to recoupment or offset shall extend to any amounts due from Provider to PARTNERSHIP including, but not limited to, amounts due because of:

(i) Payments made under this Agreement that subsequently determined to have been paid at a rate that exceeds the payment required under this Agreement.
(ii) Payments made for Services provided to a Member that is subsequently determined to have not been eligible on the date of Service.
(iii) Unpaid Conlan reimbursement owed by Provider to Member. Refers to *Conlan v. Shewry, 2006.*

SECTION 5
<u>MEDICAL RECORDS</u>

5.1 <u>Medical Record</u> – Provider shall ensure that a medical record will be established and maintained for each Member who has received ECM Services. Each Member's medical record will be established upon the first visit to Provider. The record will contain information normally included in accordance with generally accepted practices and standards prevailing in the professional community.

5.1.1 Provider will facilitate the sharing of information with other ECM Providers in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.

5.1.2 Provider will ensure records are available to authorized PARTNERSHIP personnel in order for PARTNERSHIP to conduct its Quality Improvement and Utilization Management Programs to the extent permitted by law.

5.1.3 Provider will ensure that medical records are legible.

5.1.4 Provider will maintain such records for at least ten (10) years from the close of the State's fiscal year in which this Agreement was in effect.

5.2 Records and Inspection Rights

5.2.1 Access to Records – Provider agrees to make all of its premises, facilities, equipment, books, records, Encounter Data, contracts, computer, and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor as set forth in Exhibit E, Attachment 2, Provision 20, of the Medi-Cal Contract, as follows:

a. By PARTNERSHIP and Governmental Agencies, or their designees, at all reasonable times at Provider's place of business or at such other mutually agreeable location in California;
b. For a term of at least ten (10) years from final date of the Agreement period or from the date of completion of any audit, whichever is later;
c. If Governmental Agencies, including, but not limited to, DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, Governmental Agencies may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal program. seek recovery of payments made to Provider, impose other sanctions provided under the State Plan, and direct PARTNERSHIP to terminate the Agreement due to fraud *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h))*.

d. PARTNERSHIP will pay for the cost of copying Records, $0.10 per page, not to exceed $20.00 per record. The ownership of Records will be controlled by applicable law and furnished under the terms of this Agreement,. Upon request from PARTNERSHIP, Provider agrees to produce records within thirty (30) days of receipt of request.

e. Provider shall permit PARTNERSHIP, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during

normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review Provider's work performed or being performed hereunder, Provider's locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy Records and any other books, accounts and materials relevant to the provisions of services under this Agreement.

5.2.2 Maintenance of Records – Provider will maintain records in accordance with the general standards applicable to such book and record keeping and in accordance with applicable law, and PARTNERSHIP.

a. Records will include all encounter data, working papers, reports submitted to PARTNERSHIP, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members for a term period of at least ten (10) years.

b. Provider will retain all Records for a period of at least ten (10) years from the close of DHCS' fiscal year in which this Agreement was in effect.

c. Provider's obligations set forth in this Section 6.2 will survive the termination of this Agreement, whether by rescission or otherwise.

d. Provider will not charge the Member for the copying and forwarding of their medical records to another provider.

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

5.4 Patient Confidentiality

a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et. seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted

thereunder

b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members will be protected by Provider and his/her staff from unauthorized disclosure.

c. Provider may release Medical Records in accordance with applicable law pertaining to the release of this type of information.

d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by Provider, Provider: (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to PARTNERSHIP all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than PARTNERSHIP or any Governmental Agency which is statutorily authorized to have oversight responsibilities, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to PARTNERSHIP or maintain such information according to written procedures sent by PARTNERSHIP as issued by Governmental Agencies for this purpose.

SECTION 6
INSURANCE AND INDEMNIFICATION

6.1 Insurance - Throughout the term of this Agreement and any extension thereto, Provider will maintain appropriate insurance programs or policies as follows:

6.1.1 Each individual participating Provider covered by this Agreement will secure and maintain, at its sole expense, liability insurance of at least One Million Dollars ($1,000,000) per person per occurrence, and Three Million Dollars ($3,000,000) in aggregate, including "tail coverage" in the same amount whenever claims made malpractice coverage is involved. Notification of PARTNERSHIP by Provider of cancellation or material modification of the insurance coverage or the risk protection program will be made to PARTNERSHIP at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to PARTNERSHIP upon execution of this Agreement.

6.2 General Liability Insurance - In addition to Subsection 7.1 above, Provider will also maintain, at its sole expense, a policy or program of comprehensive liability insurance (or other risk protection) with minimum coverage including and no less than Three Hundred Thousand Dollars ($300,000) per person for Provider's property, together with a combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars ($300,000). Documents evidencing such coverage will be provided to

PARTNERSHIP upon request. Provider will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PARTNERSHIP.

6.3 Workers' Compensation - Provider's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code.

6.4 PARTNERSHIP Insurance - PARTNERSHIP, at its sole cost and expense, will procure and maintain a professional liability policy to insure PARTNERSHIP and its agents and employees, acting within the scope of their duties, in connection with the performance of PARTNERSHIP's responsibilities under this Agreement.

6.5 Provider Indemnification - Provider will indemnify, defend, and hold harmless Medi-Cal Members, the State of California, PARTNERSHIP, and their respective officers, agents, and employees from the following.

a. Provider Claims - Any and all claims and losses accruing or resulting to Provider or any of its Subcontractors or any person, firm, corporation or other entity furnishing or supplying work, services, materials or supplies in connection with the performance of this Agreement.
b. Third Party Claims - Any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by Provider , its agents, employees and Subcontractors, in the performance of this Agreement.
c. Sanctions – Any and all sanctions imposed upon PARTNERSHIP by a State or Federal Agency as a result of Provider's non-compliance with the terms and conditions of this Agreement.

6.6 PARTNERSHIP Indemnification - PARTNERSHIP will indemnify, defend, and hold harmless Provider, and its agents, and employees from any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by PARTNERSHIP, its officers, agents or employees, in the performance of this Agreement.

SECTION 7
GRIEVANCES AND APPEALS

7.1 Appeals and Grievances

7.1.1 The Parties acknowledge and agree that the PARTNERSHIP's Provider Manual contains Provider's right to submit an appeal or a grievance. Provider and PARTNERSHIP agree to and will be bound by the decisions of PARTNERSHIP appeal and grievance mechanisms *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18).*

7.1.2 Provider may file a formal provider grievance as outlined in the PARTNERSHIP appeal processes outlined in PARTNERSHIP's Provider Grievance Policy, located in PARTNERSHIP's Provider Manual.

a) A formal provider grievance may be filed in writing through United States postal service or in-person at any of PARTNERSHIP's offices within forty-five (45) working days of the occurrence of the determination or action that is subject of the grievance. PARTNERSHIP has fifteen (15) working days from the date the grievance is received to resolve the grievance. If the resolution is not satisfactory to Provider, Provider may request a Provideer Grievance Review Committee (PGRC) meeting. PARTNERSHIP and Provider will be advised of decision within ten (10) working days after the meeting is held.

7.1.3 Provider will cooperate with PARTNERSHIP in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the PARTNERSHIP grievance procedure set forth in PARTNERSHIP's Provider Manual.

7.2 Responsibility.

7.2.1 It is the responsibility of PARTNERSHIP's Executive Director for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system. The Executive Director will be assisted in this process by the staff Directors of Health Services and Provider Relations.

7.3 Dispute Resolution and Arbitration – All outstanding disputes, including disuputes unable to be resolved through the Grievance Review Committee, shall be resolved through binding arbitration in accordance with the dispute resolution process outlined below *(Cal Health & Safety Code § 1367(h)(1))*. All disputes are subject to the provisions of the California Government Claims Act (Government Code § 905 et seq.).

7.3.1 Provider may only initiate arbitration proceedings involving UM decisions or claim denials based on lack of Medical Necessity, after the formal grievance process outlined in 8.1.1. and 8.1.2 has been completed, including review of the dispute by the Provider Grievance Committee.

7.3.2 Meet and Confer – The Parties agree to meet and confer within thirty (30) days of a written request by either party in an effort to resolve any dispute between them. At each meet and confer meeting, each Party shall be represented by persons at the Director level or higher who are authorized to enter into agreements resolving the dispute. Meet and confer discussions and all documents prepared for those discussions such as agendas, spreadsheets, chronologies and the like shall not be subject to discovery, offered as evidence or admitted in evidence in any proceeding. The Parties intend their meet and confer be protected to at least the same degree as they would be if they were conducted through a mediator. If the parties cannot settle the disputes between them, after completing the Meet and Confer process, the

dispute shall be submitted, upon the motion of either party, to arbitration under the appropriate rules of the American Arbitration Association (AAA). All such arbitration proceedings will be administered by the AAA; however, the arbitrator will be bound by applicable state and federal law, and will issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that all arbitration proceeding will take place in Sacramento County, California, that the appointed arbitrator will be encouraged to initiate hearing proceedings within thirty (30) days of the date of his/her appointment, and that the decision of the arbitrator will be final and binding as to each of them. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for such error. The arbitrator(s) shall have the power to grant all legal and equitable remdies available under California law, including, but not limited to, preliminary and permanent private injuctions, specific performance, reformation, cancellation, accounting and compensatory damges; provided, however, that the arbitrator(s) shall not be empowered to award punitive damages, penalties, forfeitures or attorney's fees. Each party shall be responsible for their own attorney fees. The party against whom the award is rendered will pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award, or take an appeal pursuant to the provisions of the California Civil Code.

7.3.3 Administration and Arbitration Fees - In all cases submitted to AAA, the parties agree to share equally the AAA administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees will be advanced by the initiating party subject to final apportionment by the arbitrator in the award.

7.3.4 Enforcement of Award - The parties agree that the arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce said award. Costs of filing may be recovered by the party, which initiates such action to have an award enforced.

7.3.5 Impartial Dispute Settlement - Should the parties, prior to submitting a dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, joint request for such services may be made to the AAA, or the parties may initiate such other procedures as they may mutually agree upon at such time.

7.3.6 Initiation of Procedure - Nothing contained herein is intended to create, nor will it be construed to create, any right of any Medi-Cal Member to independently initiate the arbitration procedure established in this Article. Further, nothing contained herein is intended to require arbitration of disputes regarding professional negligence between the Member and Provider.

7.3.7 Administrative Disputes - Notwithstanding anything to the contrary in this Agreement, any and all administrative disputes which are directly or indirectly

related to an allegation of PCP malpractice may be excluded from the requirements of this Article.

7.4 Peer Review and Fair Hearing Process - A Provider determined to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to PARTNERSHIP's Peer Review Committee. The Provider will be notified in writing of the Peer Review Committee's recommendation and advised of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict, or terminate the provider affiliation, or to institute a monitoring procedure, or to implement continuing educational requirements.

SECTION 8
TERM, TERMINATION, AND AMENDMENT

The Parties acknowledge and agree the term of the Agreement, including the beginning, and end dates as well as methods of extension, renegotiation and termination are included in this Agreement *(MCP Contract Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867)*.

8.1 Initial Term and Renewal - This Agreement will be effective as of the date indicated and will automatically renew at the end of one (1) year and annually thereafter unless terminated sooner as set forth below. Further, this Agreement is subject to DHCS approval and this Agreement will become effective only upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the Agreement, and has failed to approve or disapprove the proposed Agreement within sixty (60) calendar days of receipt *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, 53250(c)(3) and 53867)*.

8.2 Termination Without Cause - Either party upon ninety (90) days prior written notice to the other party may terminate this Agreement without cause.

8.3 Immediate Termination for Cause by PARTNERSHIP - An immediate termination for cause made by PARTNERSHIP pursuant to this Section 9.3 will not be subject to the cure provisions specified in Section 9.4 Termination for Cause with Cure Period. PARTNERSHIP may terminate this Agreement immediately by written notice to Provider upon the occurrence of any of the following events:

8.3.1 Any act for which Provider's license, certification, Controlled Substance Permit, medical staff membership or clinical privileges at a Hospital is revoked, suspended or restricted in a manner that might materially affect Provider's ability to provide Services; or

8.3.2 A violation of any law or regulation that materially impairs Provider's ability to perform this Agreement

8.3.3 Provider has breached a contractual agreement with DHCS to provide care to Medi-

Cal beneficiaries that explicitly specifies inclusion on the Suspended and Ineligible Provider List as a consequence of the breach; or

8.3.4 Provider's death or disability. As used in this Subsection, the term "disability" means any condition which renders Provider unable to carry out his/her responsibilities under this Agreement for more than forty-five (45) working days (whether or not consecutive) within any twelve (12) month period; or

8.3.5 If PARTNERSHIP determines, pursuant to procedures and standards adopted in its UM/QI Programs, that Provider provided or arranged for the provision of Services to Medi-Cal Members which are not Medically Necessary or failed to provide or provided Services in a manner which violates the provisions of this Agreement or the requirements of PARTNERSHIP's Provider Manual; or

8.3.6 If PARTNERSHIP determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member; or

8.3.7 Provider is unable to meet financial obligations as described in this Agreement; or Provider closes his/her office and no longer provides Services; or

8.3.8 If Provider breaches Article 10.10, Marketing Activity and Patient Solicitation; or

8.3.9 Provider is convicted of a felony; or

8.3.10 Failure to maintain Provider's insurance as required by this Agreement; or

8.3.11 In the event Provider is suspended or excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act, including but not limited to, Medicare, Medi-Cal, or the Medicaid program in any state; or

8.3.12 Provider is convicted of a misdemeanor involving fraud, waste, and/or abuse of: a) of the Medi-Cal, Medicare, or any other government or commercial program, b) relating to a Member, or c) relating to the qualifications, functions, or duties of a Provider,

8.3.13 If DHCS discontinues ECM or the ECM Provisions are no longer in effect.

8.4 Termination for Cause With Cure Period - In the event of a material breach by either party other than those material breaches set forth in Section 8.3, Immediate Termination for Cause by PARTNERSHIP of this Agreement, the non-breaching party may terminate this Agreement upon thirty (30) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach during the thirty (30) day period, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.

8.5 Continuation of Services Following Termination - Should this Agreement be terminated, Provider will, at PARTNERSHIP's option, continue to provide Services to Medi-Cal Members who are under the care of Provider for certain conditions set forth below at the time of termination until the Services being rendered to the Medi-Cal Members by Provider are completed, unless PARTNERSHIP has made appropriate provisions for the assumption of such Services by another physician and/or provider. Provider agrees to accept payment at the contract rate in place at the time of termination which shall apply for up to six months following termination of the Agreement, and agrees to adhere to PARTNERSHIP policies and procedures.

8.5.1 Continuation of Services Conditions:

(a) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

(b) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period, or requires ongoing treatment to maintain remission or prevent deterioration.

(c) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Post-partum period begins immediately after childbirth and extends for approximately six (6) weeks

(d) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.

(e) The care of a newborn child between birth and age 36 months.

(f) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

8.6 Provider agrees to assist PARTNERSHIP in the transfer of care for Medi-Cal Members, pursuant to applicable provisions of the Medi-Cal Contract Exhibit E, Attachment 2, Provision 14, Phase out Requirements, Subparagraph B, in the event of termination of this Agreement or in the event of the Medi-Cal Contract termination, including but not limited to the transfer of Member medical records *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11)*. Payment by PARTNERSHIP for the continuation of Services by Provider after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to the Provider of photocopying such records will be reimbursed by the

PARTNERSHIP at a cost of $0.10 cents per page not to exceed $20.00 per record.

8.7 Medi-Cal Member Notification Upon Termination - Notwithstanding Section 9.3, Immediate Termination for Cause by PARTNERSHIP, upon the receipt of notice of termination by either PARTNERSHIP or Provider, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members Provider will notify Members that have had at least two visits in the previous six (6) months, thirty (30) days prior to the effective date of termination. PARTNERSHIP at its option, may immediately inform Medi-Cal Members of such termination notice. Such Medi-Cal Members will be required to select another ECM Provider prior to the effective date of termination of this Agreement.

8.8 Survival of Obligations After Termination -Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of Provider will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 8.5, Continuation of Services Following Termination; 2) Section 4.10.3a Records and Records Inspection; 4.11 Overpayments or Recoupments; and, 3) Section 6.5, Provider Indemnification and 4) 4.7 Medi-Cal Member Billing. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between Provider and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. Provider will assist PARTNERSHIP in the orderly transfer of Medi-Cal Members to the Participatin Provider they choose or to whom they are referred. Furthermore, Provider shall assist PARTNERSHIP in the transfer of care as set forth in the Provider Manual, in accordance with the Phase-out Requirements set forth in the Medi-Cal Contract.

8.9 Access to Medical Records upon Termination - Upon termination of this Agreement and request by PARTNERSHIP, Provider will allow the copying and transfer of medical records of each Medi-Cal Member to the ECM Provider assuming the Medi-Cal Member's care at termination. Such copying of records will be at PARTNERSHIP's expense if termination was not for cause. PARTNERSHIP will continue to have access to records in accordance with the terms hereof.

8.10 Termination or Expiration of PARTNERSHIP's Medi-Cal Contract - In the event the Medi-Cal Contract terminates or expires, prior to such termination or expiration, Provider will allow DHCS and PARTNERSHIP to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Contract, upon request by DHCS, Provider assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of Provider's Subcontractors, necessary for efficient case management of Medi-Cal

Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. In no circumstances will a Medi-Cal Member be billed for this service. Termination will require sixty (60) days advance written notice of intent to terminate, transmitted by Provider to PARTNERSHIP by Certified U S Mail, Return Receipt Requested, addressed to the office of PARTNERSHIP, as provided in Section 10.4.2 of this Agreement.

8.11 Amendment – This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS and shall become effective only as set forth in subparagraph C Department Approval – Non Federally Qualified HMOS of the Medi-Cal Contract.

8.11.1 This Agreement may also be amended by PARTNERSHIP upon thirty (30) days written notice to Provider.

8.11.2 If Provider does not give written notice of termination within thirty (30) days, as authorized by Section 9, Provider agrees that any such amendment by PARTNERSHIP will be a part of the Agreement. If Provider does not agree to the amendment, Provider may term this Agreement in accordance with Section 8.2.

8.11.3 Unless Provider, or DHCS notifies PARTNERSHIP that it does not accept such amendment, the amendment will become effective thirty (30) days after the date of PARTNERSHIP's notice of proposed amendment.

8.11.4 Amendments to this Agreement will be submitted to DHCS for prior approval at least thirty (30) calendar days before the effective date of any proposed material changes governing compensation, service, or term, as set forth in the Medi-Cal Contract. Proposed changes that are neither approved nor disapproved by DHCS shall be deemed approved by DHCS by operation of law thirty (30) calendar days after DHCS has acknowledged receipt or upon the date specified in the Agreement amendment, whichever is later.

8.11.5 In the event a change in law, regulation, or the Medi-Cal Contract requires an amendment to this Agreement, Provider's refusal to accept such amendment will constitute reasonable cause for PARTNERSHIP to terminate this Agreement pursuant to the termination provisions hereof.

SECTION 9
GENERAL PROVISIONS

9.1 Assignment - Provider that assignment or delegation of this Agreement will be void unless prior written approval is obtained from DHCS. *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867)*.

9.2 Severability - If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected,

impaired, or invalidated as a result of such decision.

9.3 Notices - Any notice required or permitted to be given pursuant to this Agreement will be in writing addressed to each party at its respective last known address. Either party will have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

9.3.1 Provider will notify DHCS in the event this Agreement 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 *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867)*. A copy of the written notice will also be mailed as first-class registered mail to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS. 4407, P.O. Box 997413
Sacramento, CA 95899-74133
Attention: Contracting Officer

9.3.2 Provider will notify PARTNERSHIP at the address listed herein. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached to:

Partnership HealthPlan of California
Provider Relations Department
4665 Business Center Drive
Fairfield, CA 94534

9.3.3 PARTNERSHIP will notify Provider at the address listed herein. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached to the address indicated on the signature page of this Agreement.

9.4 Entire Agreement - This Agreement, together with the Attachments, PARTNERSHIP's Provider Manual contains the entire agreement between PARTNERSHIP and Provider relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

9.5 Headings - The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

9.6 Governing Law - This Agreement will be governed by and construed in accordance with all laws and applicable regulations governing the Medi-Cal Contract *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c) and*

53867). The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of PARTNERSHIP. PARTNERSHIP and Provider agree to comply with all applicable requirements of DHCS, Medi-Cal Managed Care Pogram *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21)*. Further, this Agreement is subject to the requirements of Titles XVIII and XIX of the Social Services Act and the regulations promulgated thereunder.

9.7 Affirmative Statement, Treatment Alternatives - Provider may freely communicate with Members regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

9.8 Reporting Fraud, Waste and Abuse - Provider is responsible for reporting all cases of suspected fraud, waste and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by PARTNERSHIP Participating Providers within ten (10) days to PARTNERSHIP for investigation.

9.9 Marketing Activity and Patient Solicitation - Provider will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of PARTNERSHIP and DHCS.

9.9.1 Provider will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including, but not limited to, door-to-door marketing activities, mailers and telephone contacts.

9.9.2 During the period of this Agreement and for a one year period after termination of this Agreement, Provider and Provider's employees, agents or Subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which Provider render contracted Services to PARTNERSHIP Members.

9.9.3 In the event of breach of this Section 10.9, in addition to any other legal rights to which it may be entitled, PARTNERSHIP may at its sole discretion, immediately terminate this Agreement. This termination will not be subject to Section 9.4, Termination for Cause with Cure Period.

9.10 Nondisclosure and Confidentiality - Provider will not disclose the payment provisions of this Agreement except as may be required by law.

9.11 Proprietary Information - With respect to any identifiable information concerning a Case Managed Member that is obtained by Provider or its Subcontractors, Provider and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to PARTNERSHIP all requests for disclosure of such information, except requests for medical records in accordance with applicable law; will not disclose any such information to any party other than Governmental Agencies without PARTNERSHIP's prior written authorization, except as specifically permitted by law, this Agreement, or PARTNERSHIP's Medi-Cal Contract

with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Contract; and, will, at expiration or termination of this Agreement, return all such information to PARTNERSHIP or maintain such information according to written procedures provided by PARTNERSHIP for this purpose.

9.12 Non-Exclusive Agreement - To the extent compatible with the provision of Services to Medi-Cal Members for which Provider accepts responsibility hereunder, Provider reserves the right to provide professional services to persons who are not Members including Eligible Beneficiaries. Nothing contained herein will prevent Provider from participating in any other prepaid health care program.

9.13 Counterparts - This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.

9.14 HIPAA & Protected Health Information - Health Insurance Portability Accountability Act. Section 1171 (5) (e). PARTNERSHIP is required to comply with HIPAA standards. Provider is required to comply with HIPAA requirements and standards,the California Medical Information Act ("CMIA"), regarding the receipt, use and disclosure of Protected Health Information and Medical Information, and other obligations imposed by Regulatory Agencies, state laws applicable to the confidentiality of patients and medical information and to be in compliance with HIPAA standards as required by federal regulation.

(a) The Agreement between Provider and PARTNERSHIP includes the use of protected health information (PHI). PHI may be used for purposes of payment, treatment, and operations.
(b) Provider must protect PHI internally and within any organization with which Provider contracts for clinical or administrative services.
(c) Upon request, Provider must provide individuals with access to their PHI.
(d) If Provider identifies any inappropriate use of PHI or discovers a suspected security incident, breach, intrusion or unauthorized access, use or disclosure of Medi-Cal Member's PHI, Provider must notify PARTNERSHIP's Privacy Officer immediately.
(e) If this Agreement ends or is terminated, Provider agrees to continue to protect the PHI.

9.15 Compliance with Laws - Provider shall comply with all laws and regulations applicable to its operations to the provision of Services hereunder and to the extent possible, comply with the new requirements within 30 days of the effective date.

9.16 Compliance with Agreement – If PARTNERSHIP determines that Provider is in breach for failure to comply the terms of this Agreement, then PARTNERSHIP with good cause, upon written notice to Provider and in accordance with Section 8 of the Agreement may seek to impose an administrative and/or financial penalties against Provider and/or may seek to terminate the Agreement.

9.17 Corrective Action - PARTNERSHIP's written notice will outline the specific reasons, in PARTNERSHIP's determination, Provider is in non-compliance of this Agreement. Required actions for Provider to cure the breach will be set forth in the written notice. In the event Provider fails to cure those specific claims set forth by PARTNERSHIP within thirty (30) days of the receipt of the notice, PARTNERSHIP reserves the right to impose an administrative and/or financial sanctions and/or penalties against Provider and up to and including termination of the Agreement immediately upon notice to Provider. Notice an administrative and/or financial sanction and/or penalty will include the following information:

a. Effective date
b. Detailed findings of non-compliance
c. Reference to the applicable statutory, regulatory, contractual, PARTNERSHIP policy and procedures, or other requirements that are the basis of the findings
d. Detailed information describing the sanction(s)
e. Timeframes by which the organization or individual shall be required to achieve compliance, as applicable
f. Indication that PARTNERSHIP may impose additional sanctions if compliance is not achieved in the manner and time frame specified; and
g. Notice of a contracted Provider's right to file a complaint (grievance) in accordance with PARTNERSHIP policy and procedure.

9.18 Sanctions – If, due to Provider's non-compliance with this Agreement, administrative or monetary sanctions are imposed on PARTNERSHIP by a state or federal agency, PARTNERSHIP reserves the right to pass through any financial sanctions to Provider, as solely determined by PARTNERSHIP.

9.19 No Waiver – No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Agreement shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

SECTION 10
RELATIONSHIP OF PARTIES

10.1 Overview - None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent

Provider from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, Provider will provide written assurance to PARTNERSHIP that any contract providing commitments to any other prepaid program will not prevent Provider from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of Services required hereunder and the maximum capacity allowed under the Medi-Cal Contract.

10.2 Oversight Functions - Nothing contained in this Agreement will limit the right of PARTNERSHIP to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended. Provider will comply with all monitoring provisions in the Medi-Cal Contract and any monitoring requests by DHCS *(MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h) and Title 22, CCR, Sections 53250(e)(1) and 53867)*.

10.3 Provider-Patient Relationship - This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her Provider. Provider will be responsible for maintaining the professional relationship with Medi-Cal Members and are solely responsible to such Medi-Cal Members for all Services provided. PARTNERSHIP will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of Provider. Provider is allowed to freely communicate with Members regarding their health status, medical care and treatment options, alternative treatment, and medication treatment regardless of benefit coverage limitations. Members must be informed of risks, benefits and consequences of the treatment options, including the option of no treatment and make decisions about ongoing and future medical treatments. Provider must provide information regarding treatment options, including the option of no treatment in a culturally competent manner and consistent with the cultural competency, sensitivity, and diversity training as provided by the PLAN. Health care professionals must ensure that patients with disabilities have effective communication throughout the health system in making decisions regarding treatment options.

ATTACHMENT A
INFORMATION REGARDING OFFICERS, OWNERS, AND STOCKHOLDERS

List the names of the officers, owners, stockholders owning more than 5% of the stock issued by the physician, and major creditors holding more than 5% of the debt of the organization identified on the execution page of this Agreement. (This is a requirement of Title 22, CCR, Section 53250).

ATTACHMENT B
ECM SITE LOCATION(S)

List the site name(s), location(s) that apply to this Agreement. Add page if additional site information is applicable.

Tax Identification number:

Billing NPI:

1. **Site or ECM PROVIDER Name**: Sonoma County Department of Health Services

Address:

County: SONOMA

Phone number:

Fax number:

PHC # (internal use only): 22140

ECM Service County: 1/1/2022 Sonoma

Additional Service County(ies) - Only if applicable: 7/1/2022 :_________

Contract# (internal use only): Sonoma_County_Depart_004020

ATTACHMENT C

ENHANCED CARE MANAGEMENT FEE SCHEDULE

ENHANCED CARE MANAGEMENT PROVIDER RATES

Sonoma County Department of Health Services

EFFECTIVE DATE: January 1, 2022

ECM SERVICES

ECM services will be reimbursed on a per enrollee per month (PEPM) basis in accordance with the approved Treatment Authorization Request (TAR) on file.

Service	Rate	Frequency
ECM	$ 350.00	PEPM
Successful Enrollment	$ 150.00	One Time

Refer to the Provider Manual for additional billing criteria at www.Partnershiphp.org

ATTACHMENT X

NETWORK PROVIDER
MEDI-CAL REQUIREMENTS

This Attachment X sets forth the applicable requirements that are mandated by the DHCS Medi-Cal Contract with Partnership Healthplan (the "Medi-Cal Contract"), State and Federal Laws and Regulations and DHCS All Plan Letter # 19-001. This Attachment X is included in this agreement to reflect compliance with laws and DHCS's requirements for Provideras a contracted Network Provider. Any citations in this attachment are to the applicable sections of the Medi-Cal Contract or applicable law. This attachment will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this attachment and any other provision of the Agreement, this attachment will control with respect to Medi-Cal. Any capitalized term utilized in this attachment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this attachment. If a capitalized term used in this attachment is not defined in the Agreement or this attachment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

1. Provider agrees to timely gather, preserve and provide to DHCS, any records in Provider's possession in accordance with the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.16.)

2. To the extent that Provider is responsible for the coordination of care for Members, PARTNERSHIP agrees to share with the Provider any utilization data that DHCS has provided to PARTNERSHIP, and Provider agrees to receive the utilization data provided and use it as the Provider is able for the purpose of Member care coordination. (Medi-Cal contract, Exhibit A, Attachment 6, 14.B.23 and 42 CFR 438.208).

3. Before the requirement would be effective, PARTNERSHIP agrees to inform Provider of new requirements added by DHCS through subsequent contract amended to PARTNERSHIP's contract with DHCS, and Provider agrees, to the extent possible, to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Provider also agrees to comply with all applicable requirements imposed by subsequent federal and state laws and regulations, and MMCD Policy Letters. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.24.)

4. This Agreement and all information received from Provider in accordance with the subcontract requirements under the Medi-Cal Contract shall become public record on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of Provider, stockholders owning more than 5 percent of the stock issued by Provider and major creditors holding more than 5 percent of the debt of Provider will be attached to the Agreement at the time the Agreement is presented to DHCS. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.E; Welfare & Institutions Code 14452.)

5. Provider shall notify PARTNERSHIP and DHCS within ten (10) calendar days of discovery that any third party may be liable for reimbursement to PARTNERSHIP and/or DHCS for Services provided to a Member, such as for treatment of work related injuries or injuries resulting from tortious conduct of third-parties. Provider is precluded from

receiving duplicate payments for Services provided to Members. If this occurs, Provider may not retain the duplicate payment. Once the duplicate payment is identified, Provider must reimburse PARTNERSHIP. If Provider fails to refund the duplicate payment, PARTNERSHIP may offset payments made to Provider to recoup the funds. (APL 17-021; Welfare & Institutions Code 14124.70 – 14124.791). The DHCS notice is to be sent to:

Department of Health Care Services
Third Party Liability and Recovery Division
Workers' Compensation Recovery Program, MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

6. Provider shall report provider preventable condition ("PPC")-related encounters in a form and frequency as specified by PARTNERSHIP and/or DHCS. (Medi-Cal Contract, Exhibit A, Attachment 8, 15; 42 CFR 438.3(g).)

7. Provider will immediately report to PARTNERSHIP the discovery of a security incident, breach or unauthorized access of Medi-Cal Member protected health information (as defined in 45 CFR 160.103) or personal information (as defined in California Civil Code Section 1798.29). (Exhibit G, Provision H.1.)

8. Provider will submit network data as directed by PARTNERSHIP for PARTNERSHIP to meet its administrative functions and requirements set forth in the Medi-Cal Contract. Provider certifies that all data, including Encounter Data, submitted is complete, accurate, reasonable, and timely. Provider will promptly make any necessary corrections to the data, as requested by PARTNERSHIP, so that PARTNERSHIP may correct any deficiencies identified by DHCS in the time period required by DHCS. (Medi-Cal Contract, Exhibit A, Attachment 3, 1, 2.C and 2.G; APL 14-019, CFR 438.242 and 438.606.)

9. Provider must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type, if applicable. If requested by PARTNERSHIP, Provider shall provide verification of enrollment. (APL 17-019; 42 CFR 438.602(b).)

10. Provider represents and warrants that Provider and its affiliates are not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549. Further, Provider represents and warrants that Provider is not excluded from participation in any health care program under section 1128 or 1128A of the Social Security Act. (42 CFR 438.610.)

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EXHIBIT 1
PHYSICIAN OR PHYSICIAN GROUP DELEGATION AGREEMENT

(intentionally left blank unless provider is delegated for ECM services)

Providers delegated will be required to execute a separately attached Delegation Agreement.