ENHANCED CARE MANAGEMENT PROVIDER SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

And

County of Mendocino dba Front Door for Families

This Enhanced Care Management Provider Services Agreement (the "Agreement") is entered into this _____, by Partnership HealthPlan of California, a public entity referred to as ("**PARTNERSHIP**") and between Front Door for Families 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
Front Door for Families

Signature: _____

Printed Name: DeNeese Parker

Title: Director

Date: 6/11/2025

PARTNERSHIP
Partnership HealthPlan of California

Signature: _____

Printed Name: Sonja Bjork

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

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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 – 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 Applicable Requirements - To the extent applicable to this Agreement and the duties, right, and privileges hereunder, all federal, State, County, and local statutes, rules, regulations, and ordinances, including, but not limited to, Welfare and Institutions Code and its implementing regulations, the Knox-Keene Health Care Service Plan Act and its implementing regulations, the Social Security Act and its implementing regulations, the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, the Health Information Technology for Economic and Clinical Health ("HITECH") Act, the Deficit Reduction Act of 2005 and its implementing regulations, the Federal Patient Protection and Affordable Care Act (Public Law 111-148) as amended by

the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"), the California Consumer Privacy Act of 2018 and its implementing regulations, the California Confidentiality of Medical Information Act; the Medi-Cal Contract; DHCS Medi-Cal Provider Manual; all Governmental Agency guidance, executive orders, instructions, letters, bulletins, and policies; and all standards, rules and regulations of accreditation organizations.

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

1.5 Authorized Representative - Any individual appointed in writing by a competent Member or potential Member, to act in place or on behalf of the Member or potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

1.6 California Children's Services ("CCS")-Eligible Condition - means a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.

1.7 California Children's Services ("CCS") Program - A state and county program providing Medically Necessary services to treat CCS-Eligible Conditions.

1.8 Care Management Plan - A written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, authorized representative, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs.

1.9 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.

1.10 Clean Claim - A claim that can be processed without obtaining additional information from the provider of the service or from a third party.

1.11 Community Supports - Substitute services or settings to those required under the California Medicaid State Plan that PARTNERSHIP may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

1.12 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.

1.13 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.

1.14 Covered Services - Those health care services set forth in Welfare and Institutions Code Section 14000 et seq. and 14131 et. seq. Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Sections 51301; and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6800. Covered Services include ECM Services.

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

1.16 Downstream Subcontractor - An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

1.17 Downstream Subcontractor Agreement - A written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of PARTNERSHIP's and Subcontractor's duties and obligations under the Medi-Cal Contract.

1.18 Emergency Medical Condition - A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably expect to result in one or more of the following: a) placing the health of the individual in serious jeopardy; b) serious impairment to bodily functions; c) serious dysfunction of any bodily organ or part, or d) death.

1.19 Emergency Services - Those inpatient and outpatient Covered Services by a qualified provider and needed to evaluate or stabilize an Emergency Medical Condition as defined in 42 CFR section 438.114 and Health & Safety Code section 1317.1(a)(1).

1.20 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 who meet ECM Populations of Focus eligibility criteria, 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.

1.21 ECM Lead Care Manager - A Member's designated ECM care manager who works for the ECM Provider organization or as staff of PARTNERSHIP, and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

1.22 ECM Provider - A provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to Members 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 Providers, 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.

1.23 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.

1.24 ECM Populations of Focus or Populations of Focus - Members belonging to the following populations: (i) Adult Populations of Focus: Members over the age of 21 who are: (a) experiencing homelessness; (b) high utilizers, (c) Serious Mental Illness ("SMI") or Substance Use Disorder (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 (ii) Children/Youth Populations of Focus: Members up to age 21 who are: (a) experiencing homelessness; (b) high utilizers; (c) experiencing Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis; (d) are enrolled in California Children's Services (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 individuals enrolled in foster and ages 26 and under); or (f) transitioning from incarceration.

1.25 Encounter Data - The information that describes health care interactions between Members and health care providers relating to the receipt of any item(s) or service(s) by a Member under this Agreement and subject to the standards of 42 CFR sections 438.242 and 438.818.

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

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

1.28 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.

1.29 Fraud, Waste, and Abuse - The intentional deception or misrepresentation made by persons, including, but not limited to, Provider, with the knowledge that such deception could result in some unauthorized benefit to themselves or some other person or entity. It also means practices that are inconsistent with sound fiscal and business practices or medical standards and result in an unnecessary cost to the Medi-Cal program or other

Benefit Plans, or in payment for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. Fraud, Waste, and Abuse includes any act that constitutes fraud under applicable federal or state law including 42 CFR § 455.2 and Welfare & Institutions Code section 14043.1(i), and the overutilization or inappropriate utilization of services and misuse of resources.

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

1.31 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 - Division of Medi-Cal Fraud and Elder Abuse ("DMFEA"), and any other agency which has jurisdiction over PARTNERSHIP or Medi-Cal (Medicaid) or Provider or Provider Group.

1.32 Health Equity - The reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

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

1.34 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 PCP, and c) other identifying data. The card is not proof of Member eligibility with PARTNERSHIP or proof of Medi-Cal eligibility.

1.35 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.

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

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

1.38 Medically Necessary or Medical Necessity - Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis treatment of disease, illness, or injury, as required under W&I Code Section 14059.5(a) and Title 22, CCR Section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development and attain, maintain, or regain functional capacity. When determining the Medical Necessity for a Member who is under the age of twenty-one (21), a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC Section 1396d(r)(5), as required by W&I Code sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health

condition.

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

1.40 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.

1.41 Minor Consent Services - Covered Services of a sensitive nature that minor Members do not need parental consent to access, including, but not limited to, the following situations: a) sexual assault, including rape; b) drug or alcohol abuse for minors twelve (12) years or older; c) pregnancy; d) family planning; e) sexually transmitted diseases for minors twelve (12) years or older; f) diagnosis or treatment of infectious, contagious, or communicable diseases in minors twelve (12) years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and g) outpatient mental health care for minors twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or child abuse.

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

1.43 Non-Physician Medical Practitioner - A physician assistant, nurse practitioner, or certified mid wife authorized to provide primary care under physician supervision.

1.44 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.

1.45 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.

1.46 Population Needs Assessment - PARTNERSHIP's process for: a) identifying Member health needs and health disparities; b) evaluating health education, cultural & linguistic, delivery system transformation and quality improvement activities and other available resources to address identified health concerns; and 3) implementing targeted strategies for health education, cultural & linguistic, and quality improvement programs and services.

1.47 Program Data – Data that includes but is not limited to: grievance data, appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month.

1.48 Primary Care Provider ("PCP") - A Provider responsible for supervising, coordinating, and

providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologists (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.

1.49 Program Data - Data that includes but is not limited to: grievance data, appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month.

1.50 Provider Data - Information concerning Provider or Provider Group, including, but not limited to, information about the contractual relationship between Provider or Provider Group, Subcontractors, and Downstream Subcontractors; information regarding the facilities where Services are rendered; and information about the area(s) of specialization of Physician and Physician Group, Subcontractors, and Downstream Subcontractors, as applicable.

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

1.52 Quality Improvement and Health Equity Committee ("QIHEC") - committee facilitated by PARTNERSHIP's Medical Director, or the Medical Director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.

1.53 Quality Improvement and Health Equity Transformation Program ("QIHETP") - The systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the Medi-Cal Contract.

1.56 Senior and Person with Disability (SPD) Member - A Member who falls under a specific SPD aid code as defined by DHCS._

1.57 Sensitive Services - Covered Services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes Covered Services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a Member with the capacity to legally consent to the specific Covered Service.

1.58 Subcontractor – An individual or entity that has a subcontractor agreement with PARTNERSHIP that relates directly or indirectly to the performance of PARTNERSHIP's obligations under the Medi-Cal Contract.

1.59 Social Drivers of Health (SDOH) - The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

1.60 Specialist Physician or Specialist - A physician who has completed advanced education

and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those specialists listed in Welfare & Institutions Code Section 14197. A Specialist has entered into an agreement with PARTNERSHIP and who is licensed to provide medical care by the Medical Board of California, and is enrolled in the State Medi-Cal Program.

1.61 Template Data - Data reports submitted to DHCS by PARTNERSHIP, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

1.62 Treatment Authorization Request ("TAR") - The Treatment Authorization Request form approved by PARTNERSHIP for the provision of Non-Emergency Services. Those Non-Emergency Services that require a Treatment Authorization Request form approved by PARTNERSHIP are set forth in the Provider Manual. Certain FFS procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

1.63 Urgent Care Services – Those Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

1.64 Utilization Management Program - The program(s) approved by PARTNERSHIP, which are designed to review and monitor the utilization of Covered Services, including the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Such program(s) are set forth in PARTNERSHIP's Provider Manual.

1.65 ECM Quality Improvement Program (ECM QIP) – Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Medi-Cal Members according to the standards set forth in statute, regulations, and PARTNERSHIP Agreement with DHCS. The ECM 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.

1.66 Working Days - means Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays website.

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 as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004 and any subsequent APLs. If APL 19-004 does not apply to Provider, Provider must comply with PARTNERSHIP'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, all ECM program requirements in the Medi-Cal Contract, APLs (including but not limited to the requirements regarding the use of a care management documentation system), Policy Letters (PLs), the State Plan, the ECM Policy Guide, and the Medi-Cal Provider Manual.

d. Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities..

e. Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways, in accordance with Exhibit A, Attachment III, Provision 5.2.11.C: Cultural and Linguistic Programs and Committees, 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 Community Support 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 Management Plan that can be shared with other providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop

and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

h. Provider shall comply with all requirements, policies, and procedures described in PARTNERSHIP's ECM Model of Care and all applicable DHCS APLs, which are incorporated by reference herein.

i. Provider must ensure accurate and up-to-date Member-level records related to the provision of ECM Services are maintained for Members authorized for ECM who are assigned to Provider.

2.1.4 ECM Services - Provider shall provide those ECM Services, as set forth in Attachment C, 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 PARTNERSHIP, to determine if the Member is eligible for ECM, consistent with PARTNERSHIP's process for such requests, including use of the email address and dedicated phone line that PARTNERSHIP has designated for this purpose. 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 Drivers of Health; and Long-Term Services and Support ("LTSS") needs.

2.1.6 Member Assignment

a. Provider shall immediately accept all Members assigned by PARTNERSHIP 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 an ECM Lead Care Manager who interacts directly with the Member and/or their family member(s), legal guardian(s), Authorized Representatives, caregivers, and other authorized support persons as appropriate, The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services that address Social Drivers of Health 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 within five (5) Working Days 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 PARTNERSHIP 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 PARTNERSHIP's Quality Improvement and Utilization Management Programs ("QI/UM") Program.

2.1.7 Provider Outreach and Member Engagement - Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with PARTNERSHIP'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 shall focus on building relationships with Members. 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

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 Applicable Requirements including, but not limited to 42 CFR section 438.206, Welfare & Institutions Code section 14197, 28 CCR section 1300.67.2.2, the Medi-Cal Contract, and PARTNERSHIP's timely access policies and procedures as set forth in PARTNERSHIP's Provider Manual. ECM Services shall be provided

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, Community Supports 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 required by law, Provider must obtain Member's authorization to share information with PARTNERSHIP and all others involved in the Member's care to maximize the benefits of ECM, and Provider must provide PARTNERSHIP with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with 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 program requirements, and 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 (using national standard specifications and code sets to be defined by DHCS) and other supplemental reporting, as applicable.

c. Failure of Provider to follow PARTNERSHIP's Policies and Procedures, reporting requirements, sub contractual 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, in accordance with DHCS APL 22-017, 22 CCR section 53856, and the Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.14 (*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. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.6, 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 PARTNERSHIP'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 PARTNERSHIP by providing any information necessary to assess compliance. PARTNERSHIP 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. Provider shall ensure that its cultural and Health Equity linguistic services programs align with PARTNERSHIP's Population Needs Assessment. Provider agrees to provide cultural competency, Health Equity, sensitivity, and diversity training to its workforce, including employees and staff at key points of contact with Members, on an annual basis, in accordance with the Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.11, Subsection C (*Diversity, Equity and Inclusion Training*).

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 Participating 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 – PARTNERSHIP shall communicate new Member assignments to Provider as soon as possible, but in any event no later than ten (10) Working Days after ECM authorization.

a. PARTNERSHIP 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, PARTNERSHIP shall assign the Member to the PCP as the ECM Provider unless the Member has expressed a different preference or PARTNERSHIP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

c. If a Member's receives services from a Mental Health Plan for SED,SUD, and/or SMI, and the Member's behavioral health provider is a contracted

ECM Provider, PARTNERSHIP shall assign the Member to that behavioral health provider as the ECM Provider unless the Member indicates otherwise or PARTNERSHIP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

d. For Members enrolled in CCS and when the Member's CCS Case Manager is affiliated with a contracted ECM Provider, PARTNERSHIP shall assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or family has indicated otherwise or PARTNERSHIP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

e. PARTNERSHIP 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. PARTNERSHIP shall document the Member's ECM Lead Care Manager in its system of record.

g. PARTNERSHIP 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. PARTNERSHIP shall inform Members about ECM and how to access it.

b. PARTNERSHIP 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. PARTNERSHIP shall be responsible for Authorizing ECM for Members, whether they are identified by PARTNERSHIP 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. PARTNERSHIP shall be responsible for assigning all Members authorized to receive ECM to an appropriate ECM Provider.

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

i. Explain ECM and how a Member may request it.

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

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

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

v. Meet the standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment III, Subsection 5.2.11.C (*Cultural and Linguistic Programs and Committees*) and in Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*) of the Medi-Cal Contract.

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

g. PARTNERSHIP shall notify Provider when ECM has been discontinued.

h. PARTNERSHIP shall notify the Member of the discontinuation of the ECM benefit 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 III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*) and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal* System) of the Medi-Cal Contract and APL 17-006.

2.2.4 Data Sharing – PARTNERSHIP shall follow DHCS guidance on data sharing and provide to Provider the following data at the time of assignment and periodically thereafter:

a. Member assignment files, defined as a list of Members authorized for ECM and assigned to Provider;
b. Encounter Data and claims data (using national standard specifications and code sets to be defined by DHCS);
c. Physical, behavioral, administrative, and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all Members assigned to Provider; and
d. Reports of performance on quality measures and metrics, as requested.

2.2.5 Data System Requirements and Data Sharing to Support ECM - PARTNERSHIP 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 and those listed in listed in Exhibit A, Attachment III, Section 4.4.6 (*Member Identification for ECM*);

b. Assign Members to ECM Providers;

c. Keep records of all Members receiving ECM authorizations necessary for sharing personally identifiable information between PARTNERSHIP and ECM Provider and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by PARTNERSHIP;

d. Securely share data with ECM Providers and other providers in support of ECM;

e. Receive, process, and send Encounter Data (using national standard specifications and code sets to be defined by DHCS) 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 Community Supports Providers.

2.2.6 Encounter Data, Provider Data, Program Data, Template Data Reporting - Provider agrees to provide, complete, accurate, reasonable, and timely Encounter Data, Provider Data, Program Data, and Template Data, and any other reports or data as needed by PARTNERSHIP, in order for PARTNERSHIP to meet its data reporting requirements to DHCS. Provider agrees to comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1.2 (*Encounter Data Reporting*), Section 2.1.4 (*Network Provider Data Reporting*), Section 2.1.5 (*Program Data Reporting*), and Section 2.1.6 (*Template Data Reporting*) of the Medi-Cal Contract.

2.2.7 Defined Standards – PARTNERSHIP 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.

Adequate Network or Staff – Provider must maintain adequate networks and staff to ensure that it has sufficient capacity to provide and coordinate care for ECM Services in accordance with 22 CCR section 53853, Welfare & Institutions Code section 14197, 28 CCR section 1300.67.2.2 and all requirements in the Medi-Cal Contract.

2.4 Member Emergency Preparedness Plan - For purposes of this Section, "Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

2.4.1 Provider shall annually submit evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859 to PARTNERSHIP.

2.4.2 Provider shall advise PARTNERSHIP as part of the Emergency Plan; and

2.4.3 Provider shall notify PARTNERSHIP within 24 hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

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 ordered, referred, or rendered by Provider. *(Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.1 and Title 22, CCR, Sections 53250(c)(1) and 53867).*

3.2 ECM Requirements

3.2.1 Provider must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-cost and high-need Members in distinct Populations of Focus, through systematic coordination of services and comprehensive care management. Provider shall ensure the ECM approach is community-based, interdisciplinary, high-touch and person-centered.

a. Provider shall maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering ECM Services under this Agreement, and will ensure that all such contracts are in writing. 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 PARTNERSHIP and Regulatory Agencies, if required by Applicable Requirements.

3.2.2 Provider shall:

a. Ensure each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate;

b. The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Drivers of Health, regardless of setting;

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

d. Alert PARTNERSHIP to ensure non-duplication of Services in the event that a Member is receiving care management or duplication of Services from multiple sources;

e. Follow PARTNERSHIP instruction and participate in efforts to ensure ECM and other care management services are not duplicative; and

f. Ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

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 Community Supports 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 PARTNERSHIP, including in-person sessions, webinars, and/or calls, as necessary, in addition to participating in and completing all necessary trainings regarding the Medi-Cal Program conducted by PARTNERSHIP in accordance with the Medi-Cal Contract, Network Provider training per requirements described in Exhibit A, Attachment III, 7, Section 3.2.5

(Network Provider Training), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (Provider Relations), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in and Exhibit A, Attachment III, Section 5.1.1, Subsection C.3) (Members' Right to Advance Directives) of the Medi-Cal Contract, and any other requirements set forth therein.

3.3 ECM Core Service Components - Provider shall provide all core service components of ECM to each assigned Member, in compliance with PARTNERSHIP'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 Management Plan;

c. Developing a comprehensive, individualized, person-centered Care Management Plan with input from the Member and their family members, legal guardians, AR, caregiver, and other authorized support persons as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;

d. Incorporating into the Member's Care Management 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 Management Plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and as identified in the Care Management Plan; and

f. Ensuring the Care Management 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 Management 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 Management Plan;

b. Maintaining regular contact with all 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 refers to and follows 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 to engage Member in their treatment including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;

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

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

Member;

ii. Evaluating the Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions to, from and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and 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 and 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 members, AR, guardian, caregiver, and/or authorized support persons and ensuring all appropriate authorizations are in place to ensure effective communication between Provider, ECM Providers, the Member and/or their family members, guardian, caregiver, and/or authorized support persons, and PARTNERSHIP, as applicable;

b. Ensuring all required authorizations are in place to ensure effective communication between ECM Providers, PARTNERSHIP, and the Member and their family members, AR, legal guardians, caregivers, and authorized support persons, as applicable;

c. Activities to ensure the Member and their family members, AR, guardian, caregiver, and authorized support persons are knowledgeable about the Member's conditions, 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, federal, state, and local privacy and confidentiality laws;

d. Ensuring the Member's Lead Care Manager serves as the primary point of contact for the Member and their family members, AR, legal guardians, caregivers, and/or authorized support persons;

e. Identifying supports needed for the Member and their family members, AR, legal guardians, caregivers, and authorized support persons to manage the Member's condition and assist them in accessing needed support services;

f. Providing for appropriate education of the Member and their family members, AR, legal guardians, caregivers, and authorized support persons, as applicable, about care instructions for the Member; and

g. Ensuring that the Member and their family members, AR, legal guardians,

caregivers, and authorized support persons, as applicable, have a copy of the Member's Care Management 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 the Member, including services that address SDOH needs, such as housing, and services which maybe offered by PARTNERSHIP as Community Supports; and

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

3.4 Discontinuation of ECM

3.4.1 Provider shall notify PARTNERSHIP to discontinue ECM for a 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 – Provider shall comply with language assistance standards developed pursuant to H&S Code section 1367.04 and provide interpreter services and Auxiliary Aids such as Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) and American Sign Language, as necessary for Members at all facilities. As a means to fulfill this requirement, Provider will access PARTNERSHIP's Interpretive Services, as appropriate *(Medi-Cal Contract Exhibit A, Attachment III, Provision 3.1.6.A.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 Provider shall comply with all laws and regulations applicable to its operations and to the provision of services hereunder. Provider shall not discriminate against Members on the basis of race, color, creed, religion, language, sex, gender, gender identity, gender expression, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, ethnic group identification, health status, age , physical or mental disability, medical condition (including cancer), genetic information, pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, or identification with any other persons or groups defined in Penal Code 422.56, or status as a Member of PARTNERSHIP, or filing a complaint as a Member of PARTNERSHIP. Members may exercise their patient rights without adversely affecting how they are treated by Provider. Provider shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. Provider shall fully comply with all Applicable Requirements that prohibit discrimination, including, but not limited to, Title I and II of the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, of 1973, 45 C.F.R. Part 80 and 84, Title 28 CFR Part 36, Title IX of the Educational Amendments of 1973, California Government Code Sections 7405 and 11135, California Confidentiality of Medical Information Act at Civil Code Section 51 et seq., the Unruh Civil Rights Act, W&I Code section 14029.91, 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. Discrimination includes, but is not limited to, denying any Member any Covered Service or availability of a facility; providing to a Member any Covered 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 Covered Service; restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered 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 Covered Services; the assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, sexual orientation, identification with any other persons or groups defined in Penal Code section 422.56, or any other protected category of the Members to be served; utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and potential Members.

3.10.2 For the purpose of this Section 3.10, genetic information 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 – During the performance of this Agreement, Provider, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, sex, gender, gender identity, gender expression, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, ethnic group identification, health status, age , physical or mental disability, medical condition (including cancer), genetic information, pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, identification with any other persons or groups defined in Penal Code 422.56, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Provider, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Provider, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), and following) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0 and following), and the requirements of Exhibit E, Provision 1.28, Subsections A–F (*Equal Opportunity Employer*) of the Medi-Cal Contract, which are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining.

3.10.4 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 cooperate and participate in PARTNERSHIP's Quality Improvement and Utilization Management Programs and QIHETP, including and not limited to improving the quality of care and services and member experience, peer review and other activities required by PARTNERSHIP, the Governmental Agencies and any other regulatory and accrediting agencies and will comply with the policies and procedures associated with these Programs. Provider will cooperate with collection and evaluation of data for quality performance and agrees that PARTNERSHIP may use performance data for quality improvement activities. To facilitate PARTNERSHIP's Quality Improvement and Utilization Management Programs and QIHETP, PARTNERSHIP may conduct facility reviews, chart and access audits and focused reviews upon reasonable written notice to Provider. Provider shall comply with all final determinations rendered by PARTNERSHIP's QIHEC. Provider shall meet all quality management improvement requirements in this Agreement, the Medi-Cal Contract, Exhibit A, Attachment III, Section 2.2 (*Quality*

Improvement and Health Equity Transformation Program (*QIHETP*)), and any additional quality requirements set forth in associated guidance from DHCS for ECM.

3.11.2 In the event of underperformance by Provider in relation to its administration of ECM, DHCS may impose sanctions as described in the Medi-Cal Contract, Exhibit E, Section 1.19, (*Sanctions*).

a. 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.

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 *(Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.3 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 Eata 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, or, if applicable, a Subcontractor or Downstream Subcontractor, cannot or will not pay for Services ordered, referred, or rendered by Provider pursuant to this Agreement *(Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.13and Title 22, CCR, Sections 53250(e)(6) and 53867).*

4.6.1 Provider agrees not to balance bill any Member *(DHCS Contract, Exhibit A, Attachment III, Provision 3.1.6.A.14).*

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 – The 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, the DHHS Inspector General, the Comptroller General, DOJ, DMFEA, 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. (*Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.8), A.9), B.13), B.14).*) (

b. Surcharges – The 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 – The 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.

d. Assignment – The 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.

e. Transfer – The subcontractor will agree to assist PARTNERSHIP, or, if applicable, a Subcontractor or Downstream Subcontractor, in the transfer of Member's care in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) of the Medi-Cal Contract, in the event of termination of the Medi-Cal Contract, or the termination of this Agreement, or the termination of the subcontract for any reason. (*Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.11) and B.16*).

4.10.4 Additional Requirements – The subcontractor will agree to be bound by the provisions of Section 8.8, Survival of Obligations After Termination, and Section 6.5, Provider Indemnification.

4.11 Overpayments or Recoupment - 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 entitled under Title XIX of the Social Security Act.

a. Provider will report all overpayments to PARTNERSHIP within sixty (60) days of becoming aware of an overpayment from PARTNERSHIP. Provider will repay all overpayments within forty five (60) calendar days of reporting such overpayment to PARTNERSHIP or within 45 days of a written or electronic notice from PARTNERSHIP of an overpayment, and notify PARTNERSHIP in writing of the reason for overpayment in accordance with Exhibit A, Attachment III, Provision 1.3.6 (*Treatment of Overpayment Recoveries*) of the Medi-Cal Contract and 42 CFR 438.608(d)(2). Pursuant to 42 CFR Section 438.608(d), PARTNERSHIP is required to annually report Provider overpayments to DHCS. Overpayment is any payment made to Provider by PARTNERSHIP to which the Provider is not entitled under Title XIX of the Social Security Act.

b. If PARTNERSHIP identifies the overpayment, Provider will reimburse

PARTNERSHIP within thirty (30) Working Days of receipt of a timely written or electronic notice from PARTNERSHIP of an overpayment, unless Provider contests such overpayment within thirty (30) Working Days in writing and identifies the portion of the overpayment being contested and the specific reasons for contesting the overpayment.

c. Notwithstanding any other provision of this Agreement, if DHCS recoups funds from PARTNERSHIP for services provided by Provider within 36 months from the date of payment to Provider, the parties agree to meet and confer regarding recoupment of payments made to Provider.

d. 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.

e. 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.*

4.12 ECM Quality Improvement Program – At PARTNERSHIP'S sole discretion, PARTNERSHIP may implement an Enhanced Care Management Quality Improvement Program ("ECM QIP") for eligible contracted ECM Providers.

4.12.1 At PARTNERSHIP's discretion, Provider will be eligible to participate in the ECM QIP, which is designed to adhere to the requirements of the DHCS CalAIM program. The Provider must be contracted with PARTNERSHIP within the calendar year to be eligible for participation. PARTNERSHIP will make available on its website, the ECM QIP program specifications which will further describe the requirements and measurements of the program each calendar year.

4.12.2 PARTNERSHIP will determine the funding amount for the ECM QIP during the normal annual PARTNERSHIP budgeting process each calendar year. PARTNERSHIP reserves the sole right to make modifications or changes to the program; including funding allocations and or to discontinue the program upon notice.

4.13 Audits. If DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of Fraud, Waste, and Abuse, or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of Fraud, Waste, and Abuse, 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, Waste, and Abuse and/or a determination that Provider has not performed satisfactorily.

SECTION 5
MEDICAL RECORDS

5.1 Medical Record – 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 ECM Services ordered, referred, or rendered 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, Provision 1.22, (*Inspection and Audit of Records and Facilities*) of the Medi-Cal Contract, as follows:

a. In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees; and

b. At all reasonable times at Provider's place of business or at such other mutually agreeable location in California;

c. 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;

d. 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 *(42 CFR 438.3(h))*.

e. 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.

f. 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 all of its books and records in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later.

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 5.2.2 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, DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Provider's possession, in accordance with Exhibit E, Section 1.27 (*Litigation Support*) of the Medi-Cal Contract 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.

e. Confidential Information - Provider and any subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, private information, and any other confidential information to any unauthorized persons or entities.

f. Minor Consent Services - With respect to Minor Consent Services, Provider is prohibited from disclosing any information relating to such services without the express consent of the minor Member.

g. Sensitive Services - Notwithstanding any other provision of the Agreement, Provider will comply with all confidentiality requirements relating to the receipt of Sensitive Services, including, but not limited, those set forth in the CMIA.

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 6.1 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. Provider is entitled to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to, Provider's right to access PARTNERSHIP's dispute resolution mechanism and submit a grievance pursuant to H&S Section 1367(h)(1). *(Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.20).*

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 Provider 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 disputes 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))*. Notwithstanding the dispute resolution process, 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 7.1.1. and 7.1.2 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 remedies available under California law, including, but not limited to, preliminary and permanent private injunctions, specific performance, reformation, cancellation, accounting and compensatory damages; 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 Section. 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 Section.

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, phaseout, and termination are included in this Agreement *(Medi-Cal Contract Exhibit A, Attachment III, Provision 3.1.6.A.2 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 *(Medi-Cal Contract, Exhibit E, Provision 1.10.C 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 8.3 will not be subject to the cure provisions specified in Section 8.4 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 Section 9.9, 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; or

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

8.3.14 If PARTNERSHIP or DHCS determines that Provider has committed Fraud, Waste, or Abuse; or

8.3.15 If PARTNERSHIP or Governmental Agency determines that Provider has not performed satisfactorily.

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, Section 1.17, (*Phaseout Requirements*), Subparagraph B, in the event of termination of this Agreement for any reason or in the event of the Medi-Cal Contract termination. (*Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.11 and B.16)* 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 8.3, 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 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-CalMember or any persons acting on their behalf. Provider will assist PARTNERSHIP in the orderly transfer of Medi-Cal Members to the Participating 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 9.3.2 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 necessary Government Agencies, including as set forth in Exhibit A, Attachment III, Provision 3.1.2, Subsection A.2)Medi-Cal Contract.

8.11.1 PARTNERSHIP shall provide at least ninety (90) business days' notice of its intent to change a material term of this Agreement or a manual, policy, or procedure referenced in this Agreement, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter time frame for compliance, and Provider shall have the right to negotiate and agree to the change.

8.11.2 If Provider does not give written notice of termination within thirty (30) days, as authorized by Section 8, 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 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 agrees that assignment or delegation of this Agreement will be void unless prior written approval is obtained from DHCS. *(Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6 Subsections B.5) and B.6), 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 *(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 Applicable Requirements and all applicable laws and applicable regulations governing the Medi-Cal Contract, including but not limited to, the Knox-Keene Act, H&S Code Section 1340 *et seq.* (unless excluded under the Medi-Cal Contract); 28 CCR Section 1300.43 *et seq.*.; W&I Code Sections 14000 and 142000 *et seq.*; and 22 CCR Sections 53800 *et seq.*, 22 CCR Sections 53900 *et seq.* (*Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.4 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 the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs and provisions of the Medi-Cal Contract. (*Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.4*) 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, by PARTNERSHIP contracted physicians, or Provider within ten (10) days to PARTNERSHIP for investigation. Provider shall allow PARTNERSHIP to share such information with DHCS in accordance with the provisions of the PARTNERSHIP Provider Manual and Exhibit A, Attachment III, Provision 1.3.2, Subsection D (Contractor's Reporting Obligations) and Provision 1.3.2, Subsection D.6) (Confidentiality) of the Medi-Cal Contract.

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 9.9, 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 8.4, 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 and to the provision of Services hereunder. PARTNERSHIP shall inform Provider of prospective requirements added by State or federal law or DHCS related to the Medi-Cal Contract that impact obligations undertaken through this Agreement before the requirement would be effective, and Provider agrees to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS.

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 *(DHCS Contract, Exhibit A, Attachment III, Provision 3.1.6.B.11, 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 PARTNERSHIP. 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: 94-6000520

Billing NPI: 1174235378

1. Site or ECM PROVIDER Name: Front Door for Families

Address: 737 S. State St.
Ukiah, CA 95482

County: Mendocino

Phone number: 707-468-7061

Fax number:

Partnership # 23731 (internal use only): [Partnership #]

ATTACHMENT C

ENHANCED CARE MANAGEMENT FEE SCHEDULE ENHANCED CARE MANAGEMENT

County of Mendocino dba Front Door for Families

EFFECTIVE DATE: [Effective Date]

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	$ 400.00	PEPM
Successful Enrollment*	$ 150.00	One Time

*Successful Enrollment bundled payment includes payment for unsuccessful member outreach attempts made by provider for members who did not enroll in the ECM program.

Medi-Cal Rates. All percentage of Medi-Cal rates in this Attachment C apply to all applicable Medi-Cal procedure types except the Targeted Rate Increase procedures or subsequent provider payment increases funded by the managed care organization tax as directed by Proposition 35. The Targeted Rate Increase procedures are currently indicated by Medi-Cal procedure type X in the Medi-Cal Fee Schedule. PARTNERSHIP shall reimburse PROVIDER/HOSPITAL for Medi-Cal procedure type X and any future procedures indicated as Targeted Rate Increase procedures and or subsequent provider payment increases in accordance with DHCS final policy guidance.

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 applicable All Plan Letters. 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. The parties acknowledge and agree that this Agreement specifies the Covered Services to be ordered, referred, or provided under this Agreement. ((Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.1) and B.1.)

2. The parties acknowledge and agree that the term of the Agreement, including the beginning and end dates as well as methods of extension, renegotiation, phaseout, and termination, are included in this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.2) and B.2).)

3. The parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by Provider from PARTNERSHIP. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.3) and B.3).)

4. This Agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Medi-Cal Contract, including, but not limited to, the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq. (unless expressly excluded under the Medi-Cal Contract); 42 CFR section 438.230; 28 CCR Section 1300.43 et seq.; W&I Code Sections 14000 and 14200 et seq.; 22 CCR Sections 53800 et seq.; and 22 CCR Sections 53900 et seq. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.4) and B.7).)

5. Provider shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Agreement. including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, All Plan Letters, and provisions of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.5) and B.8).)

6. Provider must submit to PARTNERSHIP, either directly or through a designated subcontractor of PARTNERSHIP, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports and data as needed by PARTNERSHIP, in order for PARTNERSHIP to meet its reporting requirements to DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.6) and B.10).)

7. Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under this Agreement, and will ensure that all such contracts are in writing. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.7) and B.12).)

8. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer, and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, as set forth in Medi-Cal Contract, Exhibit E, Provision 1.22 (*Inspection and Audit of Records and Facilities)* as follows:

(a) In accordance with inspections and audits, as directed by DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), Department of Managed Health Care (DMHC), DHCS's External Quality Review Organization contractor, or their designees; and (b) At all reasonable times at Provider's place of business or at such other mutually agreeable location in California; (c) In a form maintained in accordance with the general standards applicable to such book or record keeping; (d) For a term of at least ten (10) years from final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later; (e) Including all Encounter Data in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the Medi-Cal Contract period or from the date of completion of any audit, whichever is later; (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.8), A.9), B.13) and B.14); Medi-Cal Contract, Exhibit E, Provision 1.22).)

9. Provider shall timely gather, preserve and provide to DHCS, CMS, Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Provider's possession, in accordance with the Medi-Cal Contract, Exhibit E, Section 1.27 (Litigation Support). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.10) and B.15).)

10. Provider must assist PARTNERSHIP as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) of the Medi-Cal Contract, in the event of Medi-Cal Contract termination for any reason. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.11) and B.16).)

11. Specification that this Agreement will be terminated, or subject to other remedies, if DHCS or PARTNERSHIP determine that Provider has not performed satisfactorily. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.12).)

12. Provider will hold harmless both the State and Members in the event PARTNERSHIP or, if applicable a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Provider pursuant to this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.13) and B.18).)

13. Provider shall not bill a Member for Medi-Cal Covered Services. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.14).)

14. PARTNERSHIP will inform Provider of prospective requirements added by federal or State law or DHCS related to the Medi-Cal Contract that impact obligations and functions undertaken

pursuant to the Agreement before the requirement is effective, and Provider agrees to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.15) and B.22).)

15. Provider must ensure that cultural competency, sensitivity, Health Equity, and diversity training is provided for Provider's staff at key points of contact with Members. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.16) and B.24).)

16. Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S Code section 1367.04. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.17) and B.25).)

17. Provider must notify PARTNERSHIP, and Provider's Subcontractor or Downstream Subcontractor, within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows PARTNERSHIP to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (Contractor's Reporting Obligations) and Subsection 1.3.2.D.6 (Confidentiality). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.18) and B.26).)

18. Network Provider must report to PARTNERSHIP, or PARTNERSHIP's Subcontractor or Downstream Subcontractor, when it has received an Overpayment; return the Overpayment to PARTNERSHIP, or PARTNERSHIP's Subcontractor or Downstream Subcontractor, within 60 calendar days of the date the Overpayment was identified; and notify PARTNERSHIP, or PARTNERSHIP's Subcontractor or Downstream Subcontractor, in writing of the reason for the Overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 (Treatment of Overpayment Recoveries) and 42 CFR section 438.608(d)(2). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections A.19) and B.27).)

19. The parties confirm Provider's right to all protections afforded to Provider under the Health Care Providers' Bill of Rights, as set forth in Health and Safety Code Section 1375.7, including, but not limited to, Provider's right to access PARTNERSHIP's dispute resolution mechanism and submit a grievance pursuant to Health and Safety Code Section 1367(h)(1). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.20).)

20. To the extent applicable, Provider must comply with 22 CCR sections 53866, 53220, and 53222 with regard to the submission and recovery of claims for services provided under the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.3.6.)

21. Provider agrees to receive training from PARTNERSHIP and receive notice from PARTNERSHIP of any changes to PARTNERSHIP's Grievance and Appeals policies and procedures. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 4.6, Subsection I.)

22. Provider must maintain grievance logs that include all required information set forth in 42 CFR section 438.416 and 22 CCR section 53858(e). Provider must submit those grievance logs to PARTNERSHIP so PARTNERSHIP can meet its reporting obligations to DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 4.6.8, Subsection A.)

23. Provider agrees to comply with the network adequacy and network ratio requirements per the Medi-Cal Contract. In the event Provider fails to meet network adequacy standards as set forth in

APL 21-006, PARTNERSHIP shall impose a corrective action plan and issue sanctions. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.13, Subsection D.)

24. This Agreement and any amendment thereto 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 with sixty (60) calendar days of receipt, as set forth in in the Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.2, Subsection A.2).)

25. This Agreement and all information received from Provider in accordance with the 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 III, Provision 3.1.12,; Welfare & Institutions Code 14452.)

26. 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 Covered Services provided to a Plan 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 Covered Services provided to Plan 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 21-007; Welfare & Institutions Code 14124.70 – 14124.791). Notice shall be provided to DHCS in accordance with Exhibit E, Provision 1.26, Subsection C of the Medi-Cal Contract.

27. 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). (Medi-Cal Contract, Exhibit G.)

28. Provider agrees to provide PARTNERSHIP with the disclosure statement set forth in 22 CCR 51000.35, prior to commencing services under this Agreement. This Agreement and all information received from Provider in accordance with the subcontract requirements under the 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 III, Provision 3.1.12.)

29. Provider must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type. Provider shall provide verification of enrollment as well as a copy of the executed Medi-Cal Provider Agreement (DHCS Form 6208) between Provider and DHCS, if applicable. In the event PARTNERSHIP assisted Provider with the enrollment process, Provider consents to allow DHCS and PARTNERSHIP share information relating to the Provider application and eligibility, including but not limited to issues related to program integrity. Provider's enrollment documentation must be made available to DHCS, CMS or other authorized Governmental Agencies upon request. (APL 22-013; 42 CFR 438.602(b).)

30. Provider, and Provider's employees, officers and directors, shall comply with the conflict

of interest requirements set forth in Exhibit H of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit H, Provision A.)

31. Provider must make available to Members the clinical criteria used in assessing Medical Necessity for Covered Services. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.3, Subsection E.)

32. Provider must have systems in place to track and monitor referrals requiring prior authorization and must furnish documentation of such referrals to PARTNERSHIP and DHCS upon request. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 2.3, Subsection H.)

33. 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.)

34. The parties acknowledge that this Agreement and any amendments thereof shall become effective only upon approval by DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.2.B and Subsection 3.1.6.B.4).)

35. Provider agrees that assignment or delegation of this Agreement and any related subcontract will be void unless prior written approval is obtained from DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsections B.5) and B.6).)

36. Provider will comply with all monitoring provisions in the Medi-Cal Contract and any monitoring requests by DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B.11).)

37. Provider shall notify DHCS in the event this Agreement is amended or terminated for any reason. Notice is considered given when properly sent via the United States Postal Service as first-class registered mail to the address listed below, or when sent via email to DHCS at the email address designated by DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B.17).)

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

38. Provider must inform its subcontractors taking on delegated PARTNERSHIP functions of prospective requirements added by State or federal law or DHCS related to the Medi-Cal Contract that impact obligations and functions undertaken through the subcontract before the requirement would be effective, and the subcontractors must comply with the new requirements within 30 calendar days of the

effective date, unless otherwise instructed by DHCS. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B.23).)

39. Provider agrees and acknowledges that DHCS is a direct beneficiary of the Agreement with respect to all obligations and functions undertaken pursuant to this Agreement and that DHCS may directly enforce any and all provisions of the Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B.29).)

40. Provider agrees that in the event Provider delegates its duties under this Agreement to a third party, the third party will be a Downstream Subcontractor. Provider must enter into a written agreement with the Downstream Subcontractor and ensure the written agreement contains the provisions set forth in this Exhibit and all other requirements under the Agreement and the Medi-Cal Contract that are applicable to the specific obligations and functions that Provider delegates to the Downstream Subcontractor. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection B).)

41. Provider agrees to all remedies specified by the Agreement and the Medi-Cal Contract, including, but not limited to, revocation of delegated functions, imposition of corrective actions, and imposition of financial sanctions, in instances where DHCS or PARTNERSHIP determine Provider has not performed satisfactorily. Provider acknowledges that PARTNERSHIP must, upon discovery of Provider's noncompliance with the terms of the Agreement or any Medi-Cal requirements, report any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to the obligations under the Medi-Cal Contract to DHCS within three Working Days of the discovery or imposition. (DHCS APL 23-006.)

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EXHIBIT 1
PROVIDER OR PROVIDER 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.

IN WITNESS WHEREOF

DEPARTMENT FISCAL REVIEW:

By: _____
DeNeese Parker, Social Services Director

Date: 6/11/25

Budgeted: Yes
Budget Unit: 0446
Line Item: 82-5490
Org/Object Code: VRCalAIM
Grant: No
Grant No.: 'N/A'

COUNTY OF MENDOCINO

By: _____
JOHN HASCHAK, Chair
BOARD OF SUPERVISORS

Date: _____

ATTEST:
DARCIE ANTLE, Clerk of said Board

By: _____
Deputy

I hereby certify that according to the provisions of Government Code section 25103, delivery of this document has been made.

DARCIE ANTLE, Clerk of said Board

By: _____
Deputy

INSURANCE REVIEW:

By: _____
Risk Management

Date: 06/11/2025

CONTRACTOR/COMPANY NAME

By: _____
Sonja Bjork, Chief Executive Officer

Date: _____

NAME AND ADDRESS OF CONTRACTOR:

Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534
800-863-4155
nonprovidercontracting@partnershiphp.org

By signing above, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement

COUNTY COUNSEL REVIEW:

APPROVED AS TO FORM:

By: Charlotte Scott
COUNTY COUNSEL

Date: 06/11/2025

EXECUTIVE OFFICE/FISCAL REVIEW:

By: _____
Deputy CEO or Designee

Date: 06/11/2025

Signatory Authority: $0-25,000 Department; $25,001- 50,000 Purchasing Agent; **$50,001+ Board of Supervisors**
Exception to Bid Process Required/Completed ☐ N/A
Mendocino County Business License: Valid ☐
Exempt Pursuant to MCC Section: State Entity