

**SECOND AMENDMENT TO THE ENHANCED CARE MANAGEMENT
PROVIDER SERVICES AGREEMENT**

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

and

Shasta County Health and Human Services Agency

This Amendment to the Enhanced Care Management Provider Services Agreement (“**Agreement**”) is entered into between Partnership HealthPlan of California, a public entity (“**PARTNERSHIP**”), and **Shasta County Health and Human Services Agency**, (collectively referred to as “**PROVIDER**”). In the event of a conflict between this Amendment and any other provision of the Agreement, this Amendment will control. Any capitalized term utilized in this Amendment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this Amendment. If a capitalized term used in this Amendment is not defined in the Agreement or this Amendment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

WHEREAS the parties acknowledge PARTNERSHIP is obligated to ensure its contracts with Network Providers comply with all relevant laws and regulations and the provisions of the agreement between the Department of Health Care Services (“DHCS”) and PARTNERSHIP (“Medi-Cal Contract”);

WHEREAS the parties acknowledge PROVIDER is a Network Provider;

WHEREAS PARTNERSHIP must amend the Agreement to reflect compliance with recent updates to the Medi-Cal Contract; and

WHEREAS the parties also desire to amend the Agreement for an increase in rates.

NOW, THEREFORE, in consideration of the foregoing, the Agreement is amended as follows:

- I. Effective Date: The Effective Date for the provisions set forth below within this Section I. is June 1, 2023.
 - A. The section entitled “Recitals” is revised to add next in order Subsection “E” as follows:
 - E. Whereas PARTNERSHIP uses software provided by Collective Medical Technologies, Inc., a PointClickCare company (“Collective Medical”) for sharing Members’ data. Pursuant to this Agreement, Provider will have access to Collective Medical software for the sole purpose of providing ECM Services to Members.

- B. Section 6, “INSURANCE AND INDEMNIFICATION”, Subsection 6.6, “PARTNERSHIP Indemnification” is deleted in its entirety and replaced as follows:

6.6 PARTNERSHIP Indemnification — To the fullest extent permitted by law, PARTNERSHIP shall indemnify and hold harmless Provider, its elected officials, officers, employees, agents, and volunteers against all claims, suits, actions, costs, expenses (including, but not limited to, reasonable attorney's fees of County Counsel and counsel retained by Provider, expert fees, litigation costs, and investigation costs), damages, judgments, or decrees arising from the work or the provision of services undertaken pursuant to this Agreement by PARTNERSHIP, or by any of PARTNERSHIP’s subcontractors, any person employed under PARTNERSHIP, or under any subcontractor, or in any capacity, except when the injury or loss is caused by the sole negligence or intentional wrongdoing of Provider.

PARTNERSHIP shall also, at PARTNERSHIP’s own expense, defend Provider, its elected officials, officers, employees, agents, and volunteers, against any claim, suit, action, or proceeding brought against Provider, its elected officials, officers, employees, agents, and volunteers, arising from the work or the provision of services undertaken pursuant to this Agreement by PARTNERSHIP, or any of PARTNERSHIP’s subcontractors, any person employed under PARTNERSHIP, or under any Subcontractor, or in any capacity.

PARTNERSHIP shall also defend and indemnify Provider for any adverse determination made by the Internal Revenue Service or the State Franchise Tax Board and/or any other taxing or regulatory agency and shall defend, indemnify, and hold harmless Provider with respect to PARTNERSHIP’s “independent contractor” status that would establish a liability on Provider for failure to make social security deductions or contributions or income tax withholding payments, or any other legally mandated payment.

The provisions of this section are intended to be interpreted as broadly as permitted by applicable law. These provisions shall survive the termination, expiration, or cancellation of this Agreement.

- C. Section 9, “GENERAL PROVISIONS”, Subsection 9.13 “Counterparts” is deleted in its entirety and replaced as follows:

9.13 Counterparts/Electronic, Facsimile, and PDF Signatures — This agreement may be executed in any number of counterparts, each of which will be an original, but all of which together will constitute one instrument. Each Party of this agreement agrees to the use of electronic signatures, such as digital signatures that meet the requirements of the California Uniform Electronic Transactions Act (“CUETA”) Cal. Civ. Code §§ 1633.1 to 1633.17), for executing this agreement. The Parties

further agree that the electronic signatures of the Parties included in this agreement are intended to authenticate this writing and to have the same force and effect as manual signatures. Electronic signature means an electronic sound, symbol, or process attached to or logically associated with an electronic record and executed or adopted by a person with the intent to sign the electronic record pursuant to the CUETA as amended from time to time. The CUETA authorizes use of an electronic signature for transactions and contracts among Parties in California, including a government agency. Digital signature means an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature, and shall be reasonably relied upon by the Parties. For purposes of this section, a digital signature is a type of "electronic signature" as defined in subdivision (i) of Section 1633.2 of the Civil Code. Facsimile signatures or signatures transmitted via pdf document shall be treated as originals for all purposes.

II. Effective Date. The Effective Date for the provisions set forth below in this Section II. is September 1, 2023.

A. Attachment C, Enhanced Care Management Fee Schedule, Enhanced Care Management Provider Rates, is no longer effective within the Agreement. Attachment C-A2, Enhanced Care Management Fee Schedule, Enhanced Care Management Provider Rates, as set forth in Attachment #1 of this Amendment takes effect in place of Attachment C immediately on September 1, 2023.

III. Effective Date. The Effective Date for the provisions set forth below in this Section III. is January 1, 2024.

A. Section 1, "DEFINITIONS", is deleted in its entirety and replaced as follows:

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 the attachments and/or exhibits 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 and its implementing regulations, 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, All Plan Letters, 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") — A State and County program providing Medically Necessary services to treat CCS-Eligible Conditions.
- 1.7 California Children's Services ("CCS")-Eligible Condition - 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.
- 1.8 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.

Any reference to “Care Plan” throughout the Agreement are replaced by and shall have a meaning identical to “Care Management Plan”.

- 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.

All references throughout the Agreement to “In Lieu of Services” and/or “ILOS” are replaced by and shall have a meaning identical to “Community Supports”.

- 1.12 Contract Year — The 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 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.
- 1.17 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.

- 1.18 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.
- 1.19 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.
- 1.20 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.

- 1.21 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.
- 1.22 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).
- 1.23 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 section 438.242 and 438.818.
- 1.24 Encounter Form — Form submitted electronically to PARTNERSHIP in a HIPAA compliant 837 format to report the ECM Services provided to Medi-Cal Members.
- 1.25 Enrollment — The process by which a Medi-Cal Beneficiary selects or is assigned to PARTNERSHIP by DHCS.
- 1.26 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.
- 1.27 Fiscal Year of Partnership HealthPlan of California — The twelve (12) month period starting each July 1.
- 1.28 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.

- 1.29 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.
- 1.30 Health Equity — The reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.
- 1.31 Hospital — Any acute, general care or psychiatric hospital licensed by the DHCS and contracted with PARTNERSHIP.
- 1.32 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.
- 1.33 Medi-Cal Managed Care Program — The program that PARTNERSHIP operates under its Medi-Cal Contract with the DHCS. Medi-Cal Member is subject and terms of the relationship and agreement between PARTNERSHIP and the Medi-Cal Member.
- 1.34 Medi-Cal Provider Manual — The Medical Services Provider Manual issued by DHCS.
- 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 Medical Home — A model of organization of primary care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

- 1.37 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 or 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.
- 1.38 Medicare — The federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.
- 1.39 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.
- 1.40 Minor Consent Services — Those Covered Services of a sensitive nature that minor Member 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.
- 1.41 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.

- 1.42 Non-Physician Medical Practitioner — A physician assistant, nurse practitioner, or certified mid wife authorized to provide primary care under physician supervision.
- 1.43 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.
- 1.44 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.
- 1.45 PLAN — Refers to Partnership HealthPlan of California.
- 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 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.

All references to “Primary Care Physician” are hereby deleted in their entirety and replaced with “Primary Care Provider” throughout the Agreement.

- 1.48 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.
- 1.49 Provider Data — Information concerning PROVIDER, including, but is not limited to, information about the contractual relationship between PROVIDER, information regarding the facilities where Covered

Services are rendered; and information about the area(s) of specialization of Participating Providers, as applicable.

- 1.50 Provider Group — A group of Participating Providers, that are a duly organized business entity who have entered into an Agreement with PARTNERSHIP.
- 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”) — A 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.
- 1.54 Senior and Person with Disabilities (“SPD”) Member — A Member who falls under a specific SPD aide code as defined by DHCS.
- 1.55 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.
- 1.56 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.
- 1.57 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, is licensed to provide medical care by the Medical Board of California, and is enrolled in the State Medi-Cal Program.

- 1.58 Template Data — PROVIDER data that includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives that PROVIDER provides to PARTNERSHIP and PARTNERSHIP reports to DHCS.
- 1.59 Treatment Authorization Request ("TAR") — The Treatment Authorization Request form approved by PLAN for the provision of Non-Emergency Services. Those Non-Emergency Services that require a Treatment Authorization Request form approved by PLAN are set forth in the Provider Manual.
- 1.60 Urgent Care Services — Those Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.
- 1.61 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.
- 1.62 Working Days — means Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays website.

- B. Section 2, "QUALIFICATIONS, OBLIGATIONS AND COVENANTS", Subsection 2.1.3, "Participation Requirements", is deleted in its entirety and replaced with the following:

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.

C. Section 2, "QUALIFICATIONS, OBLIGATIONS AND COVENANTS", Subsection 2.1.5, "Identification of Members for ECM", is deleted in its entirety and replaced with the following:

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.

- D. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection 2.1.6, “Member Assignment”, is deleted in its entirety and replaced with the following:

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.

- E. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection 2.1.8, “Accessibility and Hours of Service”, is deleted in its entirety and replaced with the following:

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.

- F. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection 2.1.9, “Initiating Delivery of ECM”, is deleted in its entirety and replaced with the following:

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.

- G. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection 2.1.12, subparts “Credentialing”, “Actions Against Provider”, “Financial and Accounting Records”, and “Reports” are deleted in their entirety and replaced with the following:

2.1.12 a. 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.

- b. 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 restriction 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.
- c. 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.
- d. 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).

- H. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection 2.1.16, “Cultural and Linguistic Services”, is deleted in its entirety and replaced with the following:

- 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*).

- I. Section 2, "QUALIFICATIONS, OBLIGATIONS AND COVENANTS", Subsection 2.2.3, "ECM Program", is deleted in its entirety and replaced with the following:

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.
- J. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection 2.2, “PARTNERSHIP is responsible for:”, Subpart 2.2.4 “Data Sharing”, is deleted in its entirety and replaced with the following:

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.

K. Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subsection

2.2, “PARTNERSHIP is responsible for:”, Subpart 2.2.5, “IT Structure”, is deleted in its entirety and replaced with the following:

- 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 Medi-Cal Contract, 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.
- L. Within Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, Subpart 2.2.7, “Encounter Data, Provider Data, Program Data, Template Data Reporting”, is added next in order as a new Subpart to Subsection 2.2, “PARTNERSHIP is responsible for:”, as follows:

- 2.2.7 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.

- M. Subsection 2.4, “Adequate Network or Staff”, is added next in order as a new Subsection to Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, as follows:

2.4 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.

- N. Subsection 2.5, “Member Emergency Preparedness Plan”, is added next in order as a new Subsection to Section 2, “QUALIFICATIONS, OBLIGATIONS AND COVENANTS”, as follows:

2.5 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.

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

2.5.2 PROVIDER shall advise PARTNERSHIP as part of the Emergency Plan; and

2.5.3 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.

- O. Section 3, “SCOPE OF SERVICES TO BE PROVIDED”, Subsection 3.1, “Management of Care”, is deleted in its entirety and replaced with the following:

3.1 Management of Care - The parties acknowledge and agree that this Agreement specifies the ECM Services to be provided 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).

- P. Section 3, “SCOPE OF SERVICES TO BE PROVIDED”, Subsection 3.2, ECM Requirements, is deleted in its entirety and replaced with the following:

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

Q. Section 3, “SCOPE OF SERVICES TO BE PROVIDED”, Subsection 3.3 “ECM Core Service Components”, Subpart 3.3.6, Member and Family Supports, is deleted in its entirety and replaced with the following:

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.

- R. Section 3, "SCOPE OF SERVICES TO BE PROVIDED", Subsection 3.8, Interpreter Services and Auxiliary Aids, is deleted in its entirety and replaced with the following:

- 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).

- S. Section 3, “SCOPE OF SERVICES TO BE PROVIDED”, Subsection 3.10, Non-Discrimination, is deleted in its entirety and replaced with the following:

- 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.

- T. Section 3, “SCOPE OF SERVICES TO BE PROVIDED”, Subsection 3.11, Quality Improvement and Utilization Management Programs, is deleted in its entirety and replaced with the following:

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*).

3.11.3 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.

- U. Section 4, “REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES”, Subsection 4.1, “Payments”, is deleted in its entirety and replaced with the following:

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).).

- V. Section 4, “REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES”, Subsection 4.6, Medi-Cal Member Hold Harmless, is deleted in its entirety and replaced with the following:

4.6 Medi-Cal Member Hold-Harmless – PROVIDER agrees to hold harmless both the State and Members in the event PARTNERSHIP cannot or will not pay for Services ordered, referred, or rendered by PROVIDER pursuant to this Agreement (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.13 and Title 22, CCR, Sections 53250(e)(6) and 53867).

4.6.1 PROVIDER agrees not to balance bill any Member (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6.A.14).

- W. Section 4, “REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES”, Subsection 4.10, “Subcontracts”, is deleted in its entirety and replaced with the following:

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, 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”.
- X. Section 4, “REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES”, Subsection 4.11, “Overpayments or Recoupment”, is deleted in its entirety and replaced with the following:

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 sixty (60) calendar days of reporting such overpayment to PARTNERSHIP or within forty-five (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).
- 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*.

- Y. Section 4, "REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES", Subsection 4.12, "Audits", is added as a new Section as follows:

4.12 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.

- Z. Section 5, "MEDICAL RECORDS", Subsection 5.2, "Records and Inspections Rights", is deleted in its entirety and replaced with the following:

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.

5.2.3 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.

AA. Three new Subparts are added next in order as Subparts (e)-(g) in Section 5, "MEDICAL RECORDS", Subsection 5.4, "Patient Confidentiality", as follows:

- (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.

BB. Section 7, “GRIEVANCES AND APPEALS”, Subsection 7.1, “Appeals and Grievances”, Subpart 7.1.1, is deleted in its entirety and replaced with the following:

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).

CC. The first paragraph in Section 8, “TERM, TERMINATION, AND AMENDMENT”, is deleted in its entirety and replaced with the following:

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).

DD. Section 8, “TERM, TERMINATION, AND AMENDMENT”, Subsection 8.1, “Initial Term and Renewal”, is deleted in its entirety and replaced with the following:

- 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).

EE. New Subparts 8.3.14 and 8.3.15 are added next in order to Section 8, “TERM, TERMINATION, AND AMENDMENT”, Subsection 8.3, “Immediate Termination for Cause by PARTNERSHIP”, as follows:

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.

FF. Section 8, “TERM, TERMINATION, AND AMENDMENT”, Subsection 8.6, untitled, is deleted in its entirety and replaced with the following:

8.6 Transfer to Care - 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.

GG. Section 8, “TERM, TERMINATION, AND AMENDMENT”, Subsection 8.11, “Amendment”, is deleted in its entirety and replaced with the following:

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) of the 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.

HH. Section 9, "GENERAL PROVISIONS", Subsection 9.1, "Assignment", is deleted in its entirety and replaced with the following:

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).

II. Section 9, "GENERAL PROVISIONS", Subsection 9.6, "Governing Law", is deleted in its entirety and replaced with the following:

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.

JJ. Section 9, "GENERAL PROVISIONS", Subsection 9.8, "Reporting Fraud, Waste, and Abuse", is deleted in its entirety and replaced with the following:

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.

KK. Section 9, "GENERAL PROVISIONS", Subsection 9.15, "Compliance with Laws", is deleted in its entirety and replaced with the following:

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.

LL. Section 10, "RELATIONSHIP OF PARTIES", Subsection 10.2, "Oversight Functions", is deleted in its entirety and replaced with the following:

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 (Medi-Cal 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).

MM. Attachment X, Network Provider Medi-Cal Requirements, is no longer active within the Agreement. Attachment X-A2, Network Provider Medi-Cal Requirements, as set forth in Attachment #2 of this Amendment takes effect in place of Attachment X immediately on January 1, 2024.

SIGNATURES ON NEXT PAGE

IN WITNESS WHEREOF, the Amendment between PARTNERSHIP and PROVIDER is entered into by and between the Parties.

PROVIDER

Shasta County Health and Human Services Agency

Signature: _____

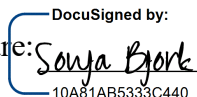
Printed Name: Kevin W. Crye

Title: Shasta County Board of Supervisors

Date: _____

PLAN

Partnership HealthPlan of California

Signature:  _____
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Printed Name: Sonja Bjork

Title: Chief Executive Officer

Date: 12/11/2023 | 9:53 AM PST

ATTEST:

DAVID J. RICKERT

Clerk of the Board of Supervisors

By: _____
Deputy

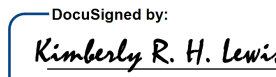
APPROVED AS TO FORM:

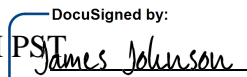
Gretchen M. Stuhr

Interim County Counsel

County Counsel

RISK MANAGEMENT

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347EB95AD66F426...
Kimberly R. H. Lewis
Senior Deputy County Counsel

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James Johnson
Risk Management Analyst III

ATTACHMENT # 1

ATTACHMENT C

ENHANCED CARE MANAGEMENT FEE SCHEDULE

ENHANCED CARE MANAGEMENT PROVIDER RATES

Shasta County WPC

EFFECTIVE DATE: SEPTEMBER 1, 2023

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

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

ATTACHMENT #2

**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, Subsection A.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, Subsection A.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, Subsection A.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, Subsection A.4).)
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, Subsection A.5).)

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, Subsection A.6.)

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, Subsection A.7.)

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) and 9); 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, Subsection A.10.)

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, Subsection A.11.)

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 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, Subsection A.13).)

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, Subsection A.15).)

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, Subsection A.16).)

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, Subsection A.17).)

17. PROVIDER must notify PARTNERSHIP within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor 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, Subsection A.18).)

18. PROVIDER must report to PARTNERSHIP, when it has received an Overpayment; return the Overpayment to PARTNERSHIP, within 60 calendar days of the date the Overpayment was identified; and notify PARTNERSHIP 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, Subsection A.19).)

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 for 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.)