CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
ALLIED HEALTH CARE ENHANCED CARE MANAGEMENT SERVICES AGREEMENT

Sample Template

Central California Alliance for Health
Allied Health Care Enhanced Care Management Services Agreement

RECITALS

This Allied Health Care Enhanced Care Management Services Agreement ("Agreement") is made and entered into as of the Commencement Date specified herein, by and between Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, a California public entity, operating as Central California Alliance for Health ("Plan"), and Sample Template ("Provider"), with reference to the following facts:

WHEREAS, Plan has entered into or will enter into a contract or contracts with the State of California Department of Health Care Services ("DHCS") or other entities under which the Plan has agreed to arrange for the provision of health care services and benefits to eligible Santa Cruz, Monterey, Merced, San Benito, and Mariposa County Medi-Cal beneficiaries or other covered individuals under the programs identified in Exhibit A hereto.

WHEREAS, Provider desires to participate in Plan's network of contracting providers by providing Enhanced Care Management Services to Members.

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the parties hereto agree as follows:

ARTICLE I.
DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article I. Terms used in this Agreement which are defined by Law shall be interpreted consistent with such Laws.

1.1. Accreditation Organization. Accreditation Organization means any organization engaged in accrediting or certifying Plan or Providers.

1.2. Complete Claim. Complete Claim shall have the meaning set forth in Title 28 of the California Code of Regulations, Section 1300.71 (a)(2).

1.3. Commencement Date. Commencement Date is the date this Agreement becomes effective, as specified in Section 5.1.

1.4. Covered Services. Covered Services are those ECM Services authorized by Plan which are required by a Member pursuant to the coverage provisions of a Program, as further specified in the Program Requirements and in the applicable Member Group Contracts and Membership Contracts.

1.5. DHCS. DHCS is the State of California Department of Health Care Services, the agency responsible for administering the Medi-Cal program in California.

1.6. Emergency Services. Emergency Services are health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of Member (or in the case of a pregnant Member, the health of

the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

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

1.8. Enhanced Care Management Services ("ECM Services"). ECM Services are those Enhanced Care Management services authorized by Plan and provided by ECM Provider in accordance with its license upon referral from a Primary Care Physician or as otherwise permitted by and in accordance with the Plan's UM Program. ECM Services are further described in Exhibit J hereto.

1.9. ECM Assigned Member. ECM Assigned Member shall mean a Medi-Cal Member, as defined in Exhibit B, Section 2, who is enrolled in ECM and who has been assigned to an ECM Provider as their provider of ECM Services, pursuant to Plan's policies for such assignment as set forth in the Provider Manual, for the provision of ECM Services.

1.10. ECM Services Documentation. ECM Services Documentation means documentation developed by Participating Providers to support the ECM Services provided hereunder, including, without limitation, claims for payment, discharge summaries, medical records, emergency visit records and diagnostic reports.

1.11. ECM Provider**.** An ECM Provider is a provider of ECM Services. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM (as defined by DHCS and described in the Provider Manual).

1.12. Fiscal Year. Fiscal Year of Plan shall mean each twelve (12) month period beginning January 1st and ending December 31st.

1.13. Law. Law means any and all laws and regulations of the State of California or of the United States and all orders, instructions and other requirements of any government agency which are applicable to this Agreement.

1.14. Medi-Cal Provider Manual. Medi-Cal Provider Manual means the DHCS provider manual, issued by DHCS' fiscal intermediary.

1.15. Member. Member is an individual who is enrolled in a Program and who is determined to be eligible for membership in the applicable Program and is also identified as being eligible for ECM per Plan, as further described in Exhibit K, as of the date of service.

1.16. Member Group Contract(s). Member Group Contract(s) refers to the contracts between the Plan and various government agencies, including the State Medi-Cal Contract, as amended from time to time, under which the Plan has agreed to arrange for the provision of Covered Services to Members.

1.17. Member Payment. Member Payment means an amount (whether expressed as either a percentage of cost or as a specific dollar amount) that a Member is obligated to pay directly to a Participating Provider for a specific service in accordance with the Program under which he or she is covered and in accordance with any applicable Membership Contract. Member Payments shall include, but not be limited to, those payments commonly referred to as "coinsurance," "copayments," and/or "deductibles."

1.18. Membership Contract(s). Membership Contract(s) refers to the evidences of coverage or member handbooks, as amended from time to time, that the Plan issues to its Members and that include complete descriptions of the terms, conditions and benefits available to Members under applicable Programs.

1.19. Participating Provider(s). Participating Provider(s) are physicians, medical groups, IPAs, health care professionals, hospitals, facilities and other providers of health care services or supplies that have entered into written contracts directly or indirectly with Plan to provide ECM Services to Members pursuant to a Program.

1.20. Primary Care Physician ("PCP"). PCP is a Participating Provider who supervises, coordinates and provides initial and basic care to certain Members assigned or linked to such PCP. PCP must meet Plan's criteria for participation as a PCP. Primary Care Physicians must be physicians practicing in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology, or another specialty approved by Plan and DHCS.

1.21. Program. Program means any health care plan for the provision of Covered Services as more fully described in the Exhibits hereto, the Provider Manual, and any applicable Membership Contract(s), as each may be amended from time to time. The specific Program(s) under which Provider renders ECM Services are set forth on the Schedule of Programs attached as Exhibit A hereto, as may be amended from time to time.

1.22. Program Requirements. Program Requirements are those requirements as established under Law and through any Member Group Contracts and Membership Contracts applicable to specific Programs as summarized in the Exhibits hereto.

1.23. Provider Manual. Provider Manual means that document or series of documents created, maintained, updated and distributed from time to time by Plan that describes the Plan's policies and procedures and provides administrative and Program Requirements for Provider. The Provider Manual is incorporated into this Agreement and made a part hereof.

1.24. Provider Practitioners. Provider Practitioners are health care providers who have entered into direct contracts with Provider to assist Provider in the provision of ECM Services under the terms of this Agreement.

1.25. Quality Management and Improvement ("QI") Program. Quality Management and Improvement ("QI") Program are those standards, protocols, policies and procedures adopted by Plan to monitor and improve the quality of clinical care and quality of services provided to Members. A summary of the QI Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.26. Self-Referral Services. Self-Referral Services are those Covered Services, including Emergency Services, that Members may access without a referral as set forth for each Program in the Membership Contracts and Provider Manual. Self-Referral Services are subject to the Plan's UM Program.

1.27. Utilization Management ("UM") Program. Utilization Management ("UM") Program are those standards, protocols, policies and procedures adopted by Plan regarding the management, review and approval of the provision of ECM Services to Members. The UM Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.28. California Children Services Program ("CCS Program"). CCS Program means the program described under California Health and Safety Code Section 123800 et seq., and Title 22 of the CCR Section 51013 et seq.

1.29. California Children Services ("CCS Services"). CCS Services are Covered Services under the CCS Program, that are provided to Medi-Cal Members in accordance with California Children Services Program guidelines (including provider enrollment requirements), and the Provider Manual.

ARTICLE II.
DUTIES OF PROVIDER

2.1. ECM Services. Provider shall provide ECM Services, in accordance with the terms and conditions set forth in this Agreement, the Provider Manual, the Plan's QI and UM Programs, the applicable Program Requirements, applicable Accreditation Organization standards and the Law. Provider shall verify a Member's eligibility with Plan prior to rendering ECM Services. Provider shall comply with prospective, concurrent and post-service review requirements as specified in the UM Program. Provider shall ensure that ECM Services provided under this Agreement are readily available, accessible, appropriate, and provided in a prompt and efficient manner as required by applicable Law. Provider shall also comply with the specific requirements set forth in the ECM Services Schedule set forth in Exhibit J hereto. [Citation: DHCS APL 19-001 Item 1; Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 13.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867; (and any updated section numbers if amended in the future.)]

2.2. Provider Standards. The primary concern of Provider shall be the quality of ECM Services provided to Members. All ECM Services provided by Provider shall be provided by duly licensed, certified or otherwise authorized professional personnel in accordance with (i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) Plan's QI and UM Programs, (iii) applicable rules and regulations of California state medical boards, (iv) Law, and (v) the standards of Accreditation Organizations.

2.2.1. Licensure of Provider. Provider shall maintain in good standing at all times and ensure that any Provider Practitioners or other professionals that provide or assist Provider in the provision of ECM Services hereunder maintain in good standing at all times, any and all licenses, certificates, and/or approvals required under Law and by the Plan.

2.2.2. Notice of Audits. Provider shall notify Plan upon receiving any notice from any government agency with the regulatory or contractual authority to audit Provider or Provider Practitioners related to compliance with applicable Law.

2.2.3. Notice of Restrictions. Provider shall notify Plan immediately of any restriction placed upon a license or certification or any notice of material deficiency received from an Accreditation Organization.

2.2.4. No Conflicts. Provider is not subject to any agreements or obligations that would interfere with Provider's ability to enter into or perform its obligations under this Agreement in accordance with its terms.

2.2.5. Credentialing. Provider shall meet Plan's credentialing standards as specified in the Provider Manual and must be approved by the Plan before providing ECM Services to Members. Provider shall respond to requests from Plan for credentialing information. Failure to timely respond to such requests shall be grounds for termination pursuant to Section 5.2 hereto.

2.2.5.1. Provider and Provider Professionals are required to complete screening and enrollment pursuant to the Department of Health Care Services (DHCS) guidelines.

2.2.6. Right to Withdraw. Plan reserves the right to immediately withdraw from Provider any or all Members in the event that the health or safety of Members is endangered by the actions of Provider or if Provider ceases to maintain required licenses, hospital privileges, or ceases to meet Plan's credentialing criteria.

2.2.7 Change in Status or Information. Provider shall immediately notify Plan in writing of any change in licensure status, any change in information provided to Plan through the credentialing process, and any change in address or practice status.

2.3. Provider Practitioners. Provider shall enter into written agreements with Provider Practitioners which shall be consistent with the terms and conditions of this Agreement and requirements of Law. Provider warrants that each Provider Practitioner through whom it will provide ECM Services shall maintain a current, unrestricted license in California applicable to the Provider Practitioner's practice and appropriate clinical privileges, and meet the Plan's credentialing requirements as described in the Provider Manual. Provider will notify Plan of the Provider Practitioners and other health care professionals that will be providing ECM Services to Members, and any changes to such Provider Practitioners. Provider represents, warrants, and certifies that Provider and Provider Practitioners have not been terminated from Medicare/Medi-Cal/Medicaid and have not been placed on the suspended or ineligible provider list for such programs.

2.4. Restriction, Suspension or Termination of Provider Practitioners. Provider shall provide immediate written notice to the Plan if (i) a Provider Practitioner ceases to meet the licensing/certification requirements or other professional standards as described in Provider's medical staff bylaws, or (ii) Provider suspends, materially reduces or terminates the medical staff privileges of a Provider Practitioner. In such event, Provider shall also immediately restrict, suspend, or terminate a Provider Practitioner from providing or arranging ECM Services to Members. If Provider fails to act as required by this Section with respect to any of its Provider Practitioners, Plan shall have the right to terminate this Agreement to protect the health and safety of its Members.

2.5. Access and Availability. Provider shall comply with the access and availability requirements and conditions for each applicable Program as required by Law and as further delineated in the Provider Manual, including but not limited to prompt scheduling of appointments and availability of ECM Services.

2.6. Acceptance and Transfer of Members. Provider may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients. Provider shall not request or demand the transfer, discharge, or removal of any Member for reasons of the Member's need for, or utilization of, ECM Services, except in accordance with the procedures established by Plan for such action. Provider shall not request or demand the transfer, discharge or removal of any Member while the Member is hospitalized or is in the middle of a course of treatment and a determination has been made that interruption of care would be detrimental to the health of the Member. Provider shall not refuse or fail to provide or arrange ECM Services to any Member.

2.7. Medical Records. Provider shall maintain all patient medical records relating to ECM Services provided to Members, in such form and containing such information as required by the Provider Manual, QI and UM Programs, Accreditation Organizations and Law. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review by Provider and Plan pursuant to the QI Program. Medical records shall be maintained in a form and physical location which is accessible to Provider, Plan, government agencies and Accreditation Organizations. Upon request and within the timeframe requested, Provider shall provide to Plan, at Provider's expense, copies of Member medical records for purposes of conducting quality assurance, case management and utilization review, credentialing and peer review, claims processing, verification and payment, resolving Member grievances and appeals and other activities reasonably necessary for the proper administration of the applicable Program consistent with Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by Law.

2.8. Insurance. Provider shall maintain professional and general liability insurance in the minimum amounts required by Law but not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate for coverage for each Provider and its agents and employees during the term of this Agreement and for a period of seven (7) years following termination. In the event Provider procures a "claims made" policy as distinguished from an occurrence policy, Provider shall procure and maintain prior to termination of such insurance, continuing tail or extended reporting coverage for a period of not less than seven (7) years following such termination.

Provider, at its sole cost and expense, shall also maintain throughout the term of this Agreement, workers' compensation insurance as required by the State of California and general liability insurance, including but not limited to premises, personal injury and contractual liability insurance, in an applicable amount dependent on Credentialing review or a minimum amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate, combined single limit, bodily injury and property damage, to insure Provider and its employees, agents, and representatives against claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the performance of any ECM Services provided under this Agreement, (ii) the use of any property and facilities of the Provider, and (iii) activities performed in connection with this Agreement.

All insurance required of Provider under this Agreement shall be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best financial strength rating of A- or better and are classified by A.M. Best as being of financial size category VIII or greater. Provider may substitute comparable self-insurance coverage for the insurance coverage required by this Section only upon the prior written approval of Plan.

A certificate of insurance shall be issued to Plan prior to the Commencement Date and upon each renewal of the insurance coverage specified in this Section. The certificate shall provide that Plan shall receive thirty (30) days prior written notice of cancellation or material reduction in the insurance coverage specified in this Section. Notwithstanding anything to the contrary, if Provider has a claims-made based policy and such policy (or policies) is cancelled or not renewed, Provider agrees to exercise any option contained in the policy (or policies) to extend the reporting period to the maximum period permitted; provided, however, that Provider need not exercise such option if the superseding insurer will accept all prior claims. Notwithstanding any other provision of this Agreement, Provider's failure to provide the certificate of insurance shall be grounds for immediate termination of this Agreement.

2.9. Notice of Charges. Provider shall notify Plan immediately of the issuance of any formal charges against Provider or any professional delivering ECM Services on behalf of Provider by any governmental authority or licensing or Accreditation Organization which would, if sustained, impact the Provider's ability to comply with its duties and obligations pursuant to this Agreement.

2.10. Administrative Requirements. Provider agrees to perform its duties under this Agreement in accordance with Plan's administrative guidelines, policies and procedures as set forth in this Agreement, the Provider Manual, the Medi-Cal Provider Manual and Law. In the event of a conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. In the event of a conflict between the Medi-Cal Provider Manual and either this Agreement or the Provider Manual, this Agreement or the Provider Manual, as applicable, will govern.

2.11. Data Requirements.

2.11.1. General Data and Information. Provider shall maintain and provide at no cost to Plan, upon written request, any and all information required by Plan, Law, government agencies or Accreditation Organizations. Provider shall submit such information and data to Plan in the format and within the time periods specified by Plan. Provider shall allow Plan personnel reasonable on-site access to Provider records in connection with Plan's QI Program, UM Program or for other valid purposes. Provider shall accurately and completely maintain all information and data required by this Agreement, including medical records, necessary to characterize the scope and purpose of ECM Services provided to Members for the time period required by Law.

2.11.2. ECM Services Documentation. Upon reasonable request and as required by the Provider Manual, Provider shall provide Plan with ECM Services Documentation at no cost to Plan. Provider will utilize and cooperate with Plan reporting tools for ECM Services Documentation as set forth in the Provider Manual. All ECM Services Documentation shall be provided on a timely basis and shall be supported by information recorded in the applicable Member's medical chart. By signing this Agreement, Provider hereby attests to the accuracy, completeness and truthfulness of all ECM Services Documentation provided pursuant to this Agreement. Provider shall provide additional

attestations as requested by the Plan to support the accuracy, completeness and truthfulness of the ECM Services Documentation.

2.11.2.1. Without limiting Section 2.11.2 above, Provider shall provide encounter data in the format of a claim to Plan within thirty (30) days of the provision of ECM Services to ECM Provider's ECM Assigned Members, if Provider is paid capitation for such Members. Such encounter data shall contain the elements and shall be on the form and in the format as set forth in the Provider Manual.

2.12. HIPAA Compliance. Provider represents and warrants that it is presently and shall remain at all relevant times compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and any other relevant federal laws related to data sharing. Provider represents and warrants with respect to all Protected Health Information ("PHI"), (as defined under 45 C.F.R. § 164.501), that it is a Covered Entity under 45 C.F.R. Section 164.501 (and not a business associate of Plan), and that it shall use all appropriate safeguards to prevent the use or disclosure of PHI other than as allowed by Law.

2.13. Identification of California Children's Services Eligible Conditions. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification, referral and treatment of Members with suspected California Children's Services ("CCS") eligible conditions.

2.14. Training. Provider and its Provider Practitioners and staff will participate in applicable training programs available through the Plan as required by any applicable Member Group Contract or as required by the Plan to address any Plan policies and procedures. The Plan will notify Provider of any training program that must be completed pursuant to a Member Group Contract and the timeframe for completing such required training.

ARTICLE III.
DUTIES OF PLAN

3.1. Plan Communications. Plan shall establish a system of Member identification, communicate the requirements of the Provider Manual to Participating Providers, and identify Participating Providers to Members. Plan shall be responsible for providing applicable notification to Members upon notification of termination of Provider.

3.2. Records. Plan shall maintain and furnish such records and documents as may be required by applicable Law, and shall create, maintain and transmit such records and documents in accordance with generally accepted industry standards and the requirements of applicable Laws.

3.3. Licensure. Plan shall maintain such licenses as are necessary for the performance of its obligations hereunder.

3.4. Limitations. Plan makes no representations or guarantees concerning the number of Members that will be referred to Provider or otherwise access services under this Agreement. Plan shall not be obligated to include Provider in all Participating Provider directories or in all Programs or to utilize or market Provider for all services available from Provider.

3.5. Continuation of Care. In the event this Agreement is terminated due to Plan's insolvency, Plan shall provide for continuation of ECM Services to Members for the duration of the period for which payment has been made by DHCS to Plan, as well as for inpatient admissions until discharge. Plan shall comply with its legal obligations to ensure continuity of care for its Members pursuant to California Law.

ARTICLE IV.
COMPENSATION

4.1. Submission of Claims. Provider agrees to submit to Plan all fee-for-service Complete Claims, as applicable, for ECM Services rendered to eligible Members, as well as compete and accurate encounter data, as specified per Section 33 of Exhibit B and Section 12 of Exhibit K. Complete Claims shall be submitted to the location described in the Provider Manual within one (1) year of the provision of ECM Services and in the format specified in the Provider Manual. Complete Claims will be paid within the timeframe required by Law as applicable to each Program. If Plan is the secondary payor, coordination of benefits claims may be submitted within ninety (90) days after the primary payor's date of payment or date of contest, denial or notice, if such period is longer than one (1) year. Plan may deny payment for claims not submitted by Provider within the timeframe set forth above and in accordance with the billing procedures set forth in the Provider Manual. Provider agrees that Plan will be materially damaged by late claim submittals and agrees to waive any right to assert that it is entitled to payment for claims asserted beyond the time periods specified above, unless Provider submits a dispute pursuant to Section 6.5 and shows good cause for delay.

4.2. Submission of Invoices. In the event Provider is unable to submit claims to Plan for ECM Services using the national standard specifications and DHCS-defined code sets, Provider shall submit an invoice to Plan with a minimum set of data elements (to be defined by DHCS) necessary for Plan to convert the invoice to an encounter for submission to DHCS. Provider shall also follow any invoice requirements described in the Provider Manual. For purposes of clarity, any reference to claims in this Agreement applies to invoices if Provider submits invoices as claims for payment of ECM Services.

4.3. Payment. Plan shall pay Provider for ECM Services rendered to eligible Members in accordance with the provisions of this Agreement, including Exhibit H hereto, and the Provider Manual. Provider agrees to accept such amounts paid by Plan, and any applicable Member Payment, as payment in full.

4.4. Adjustments to Payments. Only those charges for ECM Services billed in accordance with the Plan's claims coding standards will be payable. If Plan determines that services rendered are inappropriate, coding practices do not comply with Plan standards, payment is not in accordance with the terms of this Agreement or services were provided to a patient who was not or is no longer an eligible Member as of the date of service, Plan may deny, reduce, or otherwise adjust payment to Provider. The Plan may also adjust payment rates as specified in Exhibit H for the following reasons:

4.4.1. Adjustments to Fee Schedules. In the event a government program (including, without limitation, the Medi-Cal Program, as defined in Exhibit B) revises a payment rate or a procedure or revenue code under a Program fee schedule pursuant to which payments are determined under this Agreement, Plan may, in order to ensure payment according to the current fee schedule, adopt such adjustments in the same manner and on the same effective date as adopted by the government program.

4.4.2. Audit and Recovery. Plan, or the Plan's third party designee, shall have the right to conduct periodic audits of all records maintained by the Provider with respect to all payments received by Provider from Plan for ECM Services rendered to Members during the term of this Agreement. If an audit shows that the Plan has overpaid any claim or if Plan identifies an overpayment through any other process, Plan will send a written request for the reimbursement of the overpayment within one year (365 days) of the date of the claim overpayment as required by applicable Law, unless the overpayment was caused in whole or in part by Provider's fraud or misrepresentation, in which case Plan shall not be limited to 365 days. If Provider does not contest the Plan's request for reimbursement of the overpayment within thirty (30) days in writing or reimburse the Plan, the Plan may offset or recoup the amounts overpaid against amounts due and owing from Plan to Provider. If Provider contests a request for reimbursement, then Provider shall send a written notice to Plan stating the basis for which the claim was not overpaid and the matter shall be resolved in accordance with the Plan's provider dispute resolution process in Section 6.5 of this

Agreement and the Provider Manual. This provision shall survive the termination of this Agreement.

4.5. Coordination of Benefits. Provider agrees to comply with the Plan's coordination of benefits ("COB") policies and procedures, as applicable, as specified in this Agreement, the Provider Manual, the Membership Contracts, and any applicable Law.

4.5.1. Member Screening. Provider agrees to screen each Member receiving ECM Services to determine if the Member has Medicare coverage or other health coverage, and agrees to provide such information to Plan upon request.

4.5.2. Plan is Primary. When Plan is primary under the Plan's coordination of benefits rules, Plan shall pay Provider, as set forth in this Agreement, the amount due for ECM Services rendered to Members.

4.5.3. Plan is Secondary. When Plan is secondary under the Plan's coordination of benefits rules, Plan shall pay for ECM Services according to the Plan's policies and procedures as set forth in the Provider Manual. Plan will deny claims from Provider if it fails to first make recoveries from other health care coverage sources.

4.5.4. Refund. If following payment by Plan for ECM Services Provider discovers that it is entitled to payment or receives payment from another payor that is primary to Plan, Provider shall notify Plan and promptly refund any amount overpaid by Plan.

4.6. Claim Correction Requests and Disputes. If Provider believes Provider is entitled to any payment for an ECM Service from Plan, or for payment in excess of the amount the Plan has paid or indicated it will pay, then Provider shall not directly or indirectly bill for or seek to collect from Plan any such payment or additional payment for ECM Services beyond the amount that Plan has paid or indicated it will pay for such ECM Services except pursuant to either a request for a claim correction submitted to the Claims Department as specified in the Provider Manual, or pursuant to a dispute filed with Plan as specified in Section 6.5 of this Agreement and the Provider Manual.

4.7. Hold Harmless. Provider agrees that, in no event, including but not limited to nonpayment by Plan, insolvency of Plan, breach of this agreement, or denial of claims by Plan due to Provider's failure to properly submit claims, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or any person acting on behalf of a Member to whom ECM Services have been provided in accordance with the terms of this Agreement or any Program, or the State of California for ECM Services provided pursuant to this Agreement. This does not prohibit Provider from collecting Member Payments as specifically provided under any applicable Member Group Contract or Membership Contract or from pursuing claims against the applicable primary payor. Failure to comply with this Section shall be deemed a material breach of this Agreement and Provider may be terminated for cause pursuant to Section 5.2.2 of this Agreement as the result of such failure. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including insolvency of Plan. [Citation: DHCS APL 19-001 Item 15; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.13 and Title 22, CCR, Sections 53250(e)(6) and 53867; (and any updated section numbers if amended in the future.)]

4.8. No Surcharges. Provider understands that surcharges against Members are prohibited and that Plan will take appropriate action if surcharges are imposed. A "surcharge" is an additional fee which is charged to a Member for an ECM Service but which is not a Member Payment as provided for under the applicable Member Group Contract and Membership Contract.

4.9. Reporting of Surcharges and Member Payments. Provider will report to Plan all surcharge and Member Payment monies paid by Member directly to Provider and shall refund all surcharges.

4.10. No Charge for non-ECM Services. Provider shall not charge a Member for a service which is not an ECM Service unless, in advance of the provision of such service, the Member has been notified by Provider that the particular service will not be covered and Provider obtains a written statement in a form acceptable to the Plan, signed by the Member or the person responsible for paying for services rendered that he or she shall be responsible for payment of charges for such service.

4.11. Payments Following Termination of this Agreement. Following termination of this Agreement and during the continuing care period described in Section 5.10 hereto, Plan shall compensate Provider at the applicable Program payment rates set forth in Exhibit H to this Agreement for providing ECM Services to Members until such Members are assigned to other Plan Participating Providers.

4.12. No Inducement to Deny ECM Services. Provider acknowledges and agrees that this Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit medically appropriate health care services.

ARTICLE V.
TERM AND TERMINATION

5.1. Term. The term of this Agreement shall commence on _____, _____ (the "Commencement Date"), and shall expire on December 31 of the same year of the Commencement Date. The Plan will provide written notification to Provider of the Commencement Date of this Agreement. Thereafter, the term of this Agreement shall be automatically extended for a one (1) year term on each succeeding January 1 (the "Renewal Date"), unless terminated by either party as provided herein. [Citation: DHCS APL 19-001 Item 4; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.2 and Title 22, CCR, Sections 53250(c)(4) and 53867; (and any updated section numbers if amended in the future.)]

5.2. With Cause Termination of Agreement. Either Plan or Provider may terminate this Agreement for cause as set forth below, subject to the notice requirement and cure period set forth below.

5.2.1. Cause for Termination of Agreement by Provider. The following shall constitute cause for termination of this Agreement by Provider:

5.2.1.1. Non-Payment. Material failure by Plan to make any payments due Provider hereunder within forty-five (45) days of any such payment's due date and Plan's failure to cure such failure to make such payments due to Provider within the cure period provided at Section 5.2.3, below.

5.2.1.2. Breach of Material Term and Failure to Cure. Plan's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2. Cause for Termination of Agreement by Plan. The following shall constitute cause for termination of this Agreement by Plan:

5.2.2.1. Breach of Material Term and Failure to Cure. Provider's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2.2. Insolvency. Provider becomes insolvent, as reasonably determined by Plan.

5.2.2.3. Failure to Comply with Standards. Provider fails to provide ECM Services in accordance with the standards set forth in this Agreement and Plan's QI Program and UM Program. Plan reserves the right to immediately transfer from Provider any Members and cease

referrals of any or all Members in the event the health or safety of Members is endangered by the actions of Provider, or as a result of continuation of this Agreement.

5.2.3. Notice of Termination, Cure Period and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "terminating party") shall provide written notice of termination to the other party specifying the breach or deficiency with sufficient information to allow the receiving party to identify the actions necessary to cure such breach. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the terminating party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the terminating party within the Cure Period or if the breach or deficiency is not curable, the terminating party shall have the right to provide written notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period. The Agreement shall terminate thirty (30) calendar days following receipt of the written notice of failure to cure or at such later date as may be specified in such notice. During the Cure Period and the period following the Cure Period, Plan may begin transferring Members to other Participating Providers. Notwithstanding the above, in the event Plan provides notice of termination as the result of a breach by Provider and the Plan reasonably determines the health and safety of Members is endangered by the actions of Provider or any Provider Practitioner, Plan shall have the right to terminate the Agreement immediately.

5.3. Automatic Termination Upon Revocation of License or Certificate. This Agreement shall automatically terminate upon the revocation, suspension or restriction of any license, certificate or other authority required to be maintained by Provider or Plan in order to perform the services required under this Agreement or upon the Provider's or Plan's failure to obtain such license, certificate or authority. In addition, this Agreement shall automatically be terminated if: (i) Provider is excluded from participation in the Medicare program or is subjected to sanctions imposed by the Medicare program or the Medicaid program; (ii) Provider's professional liability insurance or any other Provider insurance required under this Agreement is cancelled, non-renewed, or is no longer in effect; or (iii) Provider fails to comply with Section 2.2 of this Agreement.

5.4. Termination of Member Group Contract. If any Member Group Contract terminates, this Agreement shall automatically terminate with respect to Members covered under the Member Group Contract on the date the Member Group Contract and any continuing care obligations under the Member Group Contract terminate.

5.5. Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving the other party at least one hundred twenty (120) days prior written notice.

5.6. Termination if No Agreement on Provider Manual Modifications or Material Changes to Agreement. This Agreement may be terminated pursuant to the terms specified in Section 6.8.2 and 6.8.3.

5.7. Transfer of Medical Records. Following termination of this Agreement, at Plan's request, Provider shall copy all requested Member medical records in the possession of Provider and forward such records to another provider of ECM Services designated by Plan, provided such copying and forwarding is not otherwise objected to by such Members. The cost of copying the Members' medical records shall be borne by Provider. Provider shall maintain the confidentiality of such Member medical records at all times.

5.8. Repayment Upon Termination. Within one hundred eighty (180) calendar days of the effective date of termination of this Agreement, an accounting shall be made by Plan of the monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) calendar days of such accounting.

5.9. Termination Not an Exclusive Remedy. Any termination by either party pursuant to this Article V is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement. Notwithstanding the foregoing, the parties agree to

waive any and all rights they may have to assert claims for or recover exemplary or punitive damages against the other party.

5.10. Continuing Care Obligations of Provider. If this Agreement is terminated for any reason, Provider shall continue to provide ECM Services to Members, including any Members who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the first to occur of (i) a period of one hundred and twenty (120) days following termination of this Agreement or such longer period required for any Member as required by Law, or (ii) the date Plan provides written notice to Provider that it has made arrangements for all Members to receive services from another Participating Provider of ECM Services. In addition, Provider will continue to provide ECM Services to any Members who cannot be transferred within the time period specified above for Members who are hospitalized upon the expiration of the continuing care period, for Members who are entitled to continuing care as the result of their condition pursuant to Law, and otherwise in accordance with Plan's legal and contractual obligations to ensure continuity of care for its Members.

ARTICLE VI.
GENERAL PROVISIONS

6.1. Independent Contractor Relationship. The relationship between Plan and Provider is an independent contractor relationship. Neither Provider nor its employees or agents are employees or agents of Plan. Neither Plan nor its employees or agents are partners, employees or agents of Provider.

6.2. Indemnification. Provider shall indemnify and hold harmless Plan and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability (including reasonable costs of defense) arising out of or related to the performance or nonperformance by Provider, its employees or agents of any ECM Services or other services to be performed or arranged by Provider under this Agreement; provided, however, that Provider shall not be responsible for indemnifying Plan for Plan's own acts or omissions.

6.3. Member Grievances. Plan shall be responsible for resolving Member claims for benefits under the Programs and all other claims against Plan. Provider will immediately refer Members to contact Plan or deliver any written complaint to Plan for handling pursuant to Plan's Member Grievance Procedures. Provider shall comply with all final determinations made by Plan through the Member Grievance Procedures.

6.4. Disputes Between Provider and Member. Any controversies or claims between Provider and a Member arising out of the performance of this Agreement by Provider, other than claims for benefits under the Program, are not governed by this Agreement. Provider and the Member may seek any appropriate legal action to resolve such controversy or claim deemed necessary. Provider will provide written notice to Plan of any dispute between Provider and Member.

6.5. Disputes Between Plan and Provider. Any claim, dispute, or other matter arising out of, relating to, or in any way connected with this Agreement, shall be addressed through the Plan's provider dispute resolution procedure as set forth in the Provider Manual. Provider will be informed of any changes to the provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. If the procedure set forth in this Section has been exhausted and such matter is not resolved to the satisfaction of the parties, either party may pursue any available legal remedy. For clarity, Provider shall be required to comply with the claims presentation requirements and all other requirements of the Government Claims Act. Venue shall be in Santa Cruz, Monterey, Merced, San Benito or Mariposa County. Plan retains all immunities applicable to public entities to which it is entitled by law.

6.6. Notice. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, or by Federal

Express or other overnight courier that guarantees next day delivery, or by facsimile transmission or electronic transmission (including but not limited to email and/or DocuSign). The addresses, email address or facsimile number specified on the signature page shall be the addresses for delivery or mailing of notice. The parties may change the names, addresses, email addresses and facsimile numbers noted above through written notice in compliance with this Section. Notices shall be effective upon receipt.

6.7. Assignment. Neither this Agreement nor any portion of this Agreement shall be assigned, transferred or pledged in any way by Provider and shall not be subject to execution, attachment or similar process without the prior written consent of Plan. A change of ownership through the sale of Provider's stock or assets may be deemed an assignment requiring consent pursuant to this Section. [Citation: DHCS APL 19-001 Item 14 and Title 22, CCR, Sections 53250(e)(5) and 53867; (and any updated section numbers if amended in the future.)]

6.8. Amendments. Except as provided herein, no amendments or modifications to this Agreement shall be valid unless made in writing and signed by both Provider and Plan, and unless any required regulatory approvals are obtained.

6.8.1. Legally Required Modifications. The Plan may amend this Agreement at any time in order to comply with Law or any requirements of a private sector Accreditation Organization, as reasonably interpreted by the Plan. Plan shall notify Provider of such legally required modification. Such amendment shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.1.1. DHCS Member Group Contract Modifications. Plan shall notify Provider of new requirements added to Plan's Member Group Contract with DHCS that are relevant to the Provider's performance under this Agreement in advance of the effective date of the requirement. Such notice shall constitute an amendment to this Agreement and such amendment shall not require Provider's consent. Provider must comply with the new requirement within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. [Citation: DHCS APL 19-001 Item 24; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.15; (and any updated section numbers if amended in the future.)]

6.8.2. Provider Manual Modifications. If Plan materially amends a manual or a policy or procedure document referenced in the Agreement ("Provider Manual Modification"), Plan will provide at least forty five (45) business days' notice to Provider, and Provider will have the right to negotiate and agree to the change. If the parties cannot agree to the Provider Manual Modification, Provider will have the right to terminate the Agreement prior to the implementation of the Provider Manual Modification.

6.8.3. Material Changes to Agreement. For Providers compensated on a fee-for-service basis, Plan may amend a material term to the Agreement by providing a minimum of ninety (90) business days' notice of its intent to change a material term of the Agreement ("Material Change Notice"). Provider shall have the right to negotiate and agree to the change within thirty (30) business days of Provider's receipt of the Material Change Notice ("Right to Negotiate") by providing written notice of such intent within the thirty (30) business day period. Provider shall have the right to terminate the Agreement effective ninety (90) business days following the receipt of the Material Change Notice if Provider does not exercise Provider's Right to Negotiate or no agreement is reached during the ninety (90) business day period and if Provider provides notice of its intent to terminate prior to the expiration of the ninety (90) business day period. The material change shall become effective ninety (90) business days following the Material Change Notice if Provider does not exercise its Right to Negotiate or does not provide timely notice of its intent to terminate as described above. The parties may agree to the material change at any time during the ninety (90) business day period by mutual written agreement.

6.8.4. Non-Material Amendments to Agreement. The Plan may notify Provider of amendments to non-material terms of this Agreement. Such amendments shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.5. Program Benefit Changes. Program benefit changes shall be effective upon implementation, following receipt of any required regulatory approvals.

6.8.6. This Agreement and amendments hereto shall become effective only as set forth in the DHCS Member Group Contract, as applicable. When required by Law, amendments to this Agreement shall be in writing and submitted by Plan to the DHCS for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes, which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. [Citation: DHCS APL 19-001 Item 3 and Title 22, CCR, Sections 53250(c)(3) and 53867; (and any updated section numbers if amended in the future.)]

6.9. Confidential and Proprietary Information.

6.9.1. Information Confidential and Proprietary to Plan. Provider shall maintain confidential all information designated in this Section. The information which Provider shall maintain confidential (the "Confidential Information") consists of: (i) any information containing the names, addresses and telephone numbers of Members which has been compiled by Plan; (ii) the financial arrangements between Plan and any of Plan's Participating Providers, including Provider; and (iii) any other information compiled or created by Plan which is proprietary to Plan and which Plan identifies in writing to Provider.

6.9.2. Non-Disclosure of Confidential Information. Provider shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Provider may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of Plan. Upon the effective date of termination of this Agreement, Provider shall provide and return to Plan the Confidential Information in their possession in the manner specified by Plan.

6.9.3. Plan Names, Logos and Service Marks. Provider shall obtain the written consent of Plan prior to using Plan's name, product names, logos and service marks in any of Provider's promotional, marketing or advertising materials or for any other reason.

6.10. Solicitation of Plan Members. Provider shall not engage in solicitation of Members without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee or contractor of Provider or their respective assignees or successors during the term of this Agreement, and during the twelve (12) months immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members to disenroll from the Program or discontinue their relationship with Plan. Provider agrees that Plan shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Provider to enforce its rights under this Section in a manner consistent with and to the extent permitted by California law.

6.11. No Restrictions on Discussing a Member's Health Care. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider or its Provider Practitioners from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

6.12. Invalidity of Sections of Agreement. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

6.13. Survival. The following provisions of this Agreement shall survive the termination of this Agreement: Sections 2.7, 2.8, 2.11, 2.12, 3.5, Article IV, Sections 5.7, 5.8, 5.9, 5.10, 6.2, 6.4, 6.5, 6.9, 6.10, 6.11 and any other section where survival of termination is required by Law.

6.14. Waiver of Breach. The waiver by either party to this Agreement of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

6.15. Entire Agreement. This Agreement, including all exhibits, attachments, addenda, and amendments hereto and the Provider Manual contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

6.16. Incorporation of Exhibits and Attachments. The schedules, exhibits, addenda, and attachments to this Agreement and the Provider Manual are integral parts of this Agreement and are incorporated in full herein by this reference.

6.17. Authority to Bind. Each signatory of this Agreement represents and warrants individually on behalf of himself or herself, and the party on whose behalf he or she executes this Agreement, that he or she is duly authorized to execute this Agreement.

ARTICLE VII.
GOVERNING LAW AND REGULATORY REQUIREMENTS

7.1. Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California, except where preempted by federal law, and the laws of the United States of America. [Citation: DHCS APL 19-001 Item 2; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.4 and Title 22, CCR, Sections 53250(c)(2) and 53867; (and any updated section numbers if amended in the future.)]

7.2. Americans with Disabilities Act of 1990. Provider's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

7.3. Civil Rights Act of 1964. Provider will comply with Title VI of the Civil Rights Act of 1964 and any implementing regulations that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

7.4. Language Assistance. Provider agrees to comply with the Plan's Language Assistance Program as detailed in the Plan's Policies and Procedures and Provider Manual.

7.5. Certification. As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, Provider certifies to the best of Provider's knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are $100,000 or more,

Provider shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Provider shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities", in accordance with its instructions. Provider shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Provider. Provider shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.

7.6. Antifraud Plan. Provider agrees to comply with Plan's antifraud plan, as detailed in the Provider Manual. Provider will immediately notify Plan of (i) investigations of Provider or Provider's employees in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. Provider acknowledges that Plan may share information about any suspected fraud, waste or abuse with DHCS. [Citation: MCP Contract, Exhibit E, Attachment 2, Provision 27; (and any updated section numbers if amended in the future.)]

7.6.1. Plan may receive information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral and Plan is required to keep such information confidential, until formal criminal proceedings are made public (FWA Confidential Information). Plan would be receiving this FWA Confidential Information as a DHCS business associate in order to facilitate Plan's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Plan must receive and maintain this FWA Confidential Information in its capacity as a Medi-Cal managed care plan and will use the FWA Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Plan is required to share thFis FWA Confidential Information with Provider, Provider is required to keep such information confidential. [Citation: MCP Contract, Exhibit A, Attachment III, Provision 1.3.2.D.6; (and any updated section numbers if amended in the future)]

7.7. No Inducement for Referrals. The parties acknowledge and agree that: (1) they intend to comply with the safe harbor requirements set forth in 42 C.F.R. §1001.952(t); (2) in establishing the terms of the Agreement, including the exhibits, addenda and attachments hereto, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by the Agreement) for which payment may be made in whole or in part by a federal health care program on a fee-for-service or cost basis; and (3) neither party will shift the financial burden of the Agreement to the extent that increased payments are claimed from a federal health care program. Plan represents and agrees that it is an eligible managed care organization, as defined in 42 C.F.R. §1001.952(t). Provider represents and agrees that (a) Provider is a first tier contractor under the Agreement, defined as an individual or entity that has a direct contract with Plan, as the managed care organization, to provide or arrange for items or services; and (b) Provider cannot and will not claim payment in any form, directly or indirectly, from a federal health care program for items or services covered under the Agreement for Members enrolled in the Plan, except as provided in 42 C.F.R. §1001.952(t).

7.8 Compliance with Law. Provider and any subcontractor to Provider shall comply with the Program Requirements set forth in the exhibits hereto. Any provisions required to be included in the Agreement by applicable Law, including the Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code Section 1340 et seq.), Cal. Code of Regulations, Tit. 28, Section 1300.43 et seq., Cal. Welfare & Institutions Code Sections 14000 and 14200 et seq., and Cal. Code of Regulations, Tit. 22, Sections 53800 et seq., shall be binding upon and enforceable against the parties to the Agreement and shall be deemed incorporated herein whether or not expressly set forth in the Agreement, including the exhibits hereto.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the Commencement Date.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

By:_____

Print Name:_____

Title: _____

Date: _____

Plan Address and Facsimile Number for Notices:

Central California Alliance for Health
ATTN: Provider Services Director
1600 Green Hills Road
Scotts Valley, CA 95066
Facsimile Number: 831-430-5857
Email: pscontracts@ccah-alliance.org

SAMPLE TEMPLATE

By: _____

Print Name: _____

Title: _____

Date: _____

Provider Address and Facsimile Number for Notices:

Street: _____

City, State ZIP: _____

Facsimile Number: (_____)_____

Email*:_____

*Note – by inserting an email address on this line, Provider is consenting to allow Plan to send notices and amendments related to this Agreement electronically per Section 6.6 of this Agreement.

If Provider chooses to opt out of receiving notices and amendments pertaining to this Agreement by email, Provider must initial here and leave email address line blank _____.

EXHIBIT A

SCHEDULE OF PROGRAMS

Provider has been approved to provide ECM Services under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

Medi-Cal Program: is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Merced, Monterey, Santa Cruz, San Benito and Mariposa Counties.

Alliance Care IHSS Health Program: Provider is not participating in this Program with Plan.

EXHIBIT B

MEDI-CAL PROGRAM ATTACHMENT

This Exhibit B sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to ECM Services provided to Members enrolled in and determined to be eligible for the Medi-Cal Program.

1. With respect to the Medi-Cal Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Medi-Cal Member Group Contract and Medi-Cal Member Handbook. Covered Services, including ECM Services, for Medi-Cal Members are set forth in Title 22 of the California Code of Regulations Section 51301 et seq., and Title 17 of the California Code of Regulations Section 6840 et seq. Information regarding ECM Services, excluded services, and certain health screening and preventive services for Medi-Cal Members is set forth in the Provider Manual.

2. With respect to the Medi-Cal Program, the term "Medi-Cal Member" shall mean an individual who is enrolled in Medi-Cal and who is determined to be eligible for membership in the Medi-Cal Program. A newborn of a Medi-Cal Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment.

3. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Rights to Monitor, as set forth in the DHCS Member Group Contract. [Citation: MCP Contract, Exhibit E, Attachment 2, Provision 20, Audit and Exhibit E, Attachment 2, Provision 21 (and any updated section numbers if amended in the future)] Inspection Rights:

   (A) by the California Department of Health Care Services ("DHCS"), Centers for Medicaid & Medicare Services ("CMS"), the United States Department of Health and Human Services ("DHHS") Inspector General, the Comptroller General, the United States Department of Justice ("DOJ"), the California Department of Managed Health Care ("DMHC"), and their designees;

   (B) at any time at the Provider's place of business, premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted, 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 years from the final date of the Contract period or from the date of completion of any audit, whichever is later, or such longer period as required by Law; and

   (E) including all ECM Services Documentation for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later, or such longer period as required by Law;

   (F) if DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time;

   (G) upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal Program, seek recovery of payments made to the Provider,

impose other sanctions provided under the State Plan, and direct Plan to terminate this Agreement due to fraud.

[Citation: DHCS APL 19-001 Item 8; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h) ; (and any updated section numbers if amended in the future.)]

4. Provider shall comply with all applicable monitoring provisions of the DHCS Member Group Contract and any applicable monitoring request by DHCS. [Citation: DHCS APL 19-001 Item 7; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.10, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867; (and any updated section numbers if amended in the future.)]

5. Plan shall share any utilization data Plan receives from DHCS with Provider. Provider agrees to receive and use the utilization data as able for the purpose of Member care coordination. To the extent that Provider is not equipped to receive the utilization data, Plan shall make it available to Provider. Member Payments are not permitted under the Medi-Cal Program. Provider shall not seek reimbursement of any such payments from Medi-Cal Members for any ECM Services provided under this Agreement. [Citation: DHCS APL 19-001 Item 23; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.14 and 42 CFR 438.208; (and any updated section numbers if amended in the future.)]

6. Provider agrees to submit reports as required by Plan. [Citation: DHCS APL 19-001 Item 6; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867; (and any updated section numbers if amended in the future.)]

7. If this Agreement terminates for any reason, Provider will assist the Plan in the transfer of care. Additionally, Provider will assist in the orderly transfer of necessary data and records to the Plan, a successor Plan, or DHCS. Provider will assist in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Provider will make available to Plan or DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director of DHCS. In no circumstances will a Medi-Cal Member be billed for this activity.

8. Provider shall notify DHCS in the event the Agreement is terminated or amended. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Notice should be mailed to the Department of Health Care Services, Medi-Cal Managed Care Division, County Organized Health Systems MS 4408, P.O. Box 997413, Sacramento, CA 95899. [Citation: DHCS APL 19-001 Item 13; Title 22, CCR, Sections 53250(e)(4) and 53867; (and any updated section numbers if amended in the future.)]

9. Provider agrees that the assignment or delegation of any part of this Agreement shall be void unless prior written approval is obtained from DHCS in those instances where prior approval is required. [Citation: DHCS APL 19-001 Item 14; and Title 22, CCR, Sections 53250(e)(5) and 53867; (and any updated section numbers if amended in the future.)]

10. Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child , and any other individual specified in Section 2.f, Member and Family Supports, of Exhibit J to this Agreement.

11. Prior to commencing services under the Agreement, Provider shall provide Plan with any necessary disclosure statements, including the statements set forth in Title 22 of the California Code of Regulations, Section 51000.35. Provider must also provide written disclosure of any prohibited affiliation under 42 CFR section 438.610. [Citation: MCP Contract Exhibit A, Attachment III, Provision 1.3.5.A; (and any updated section numbers if amended in the future)]

12. Provider, as applicable, shall ensure that Members are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Members for sterilization consistent with requirements of applicable Law.

13. Provider will comply with the Medi-Cal Minor Consent Services program, as applicable, which generally provides that minors do not need parental or legal guardian consent in order to access these services and Provider is prohibited from disclosing any information relating to Minor Consent Services without the express written consent of the minor Member. Minor Consent Services include treatment for the following:

    a. Sexual assault, including rape;

    b. Drug or alcohol abuse(for children 12 years of age or older);

    c. Pregnancy;

    d. Family planning;

    e. STDs and HIV/AIDS (in children 12 years of age or older); and

    f. NSMHS (for children 12 years of age or older) who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924. [Citation: MCP Contract Exhibit A, Attachment III, Provision 5.2.8.D; (and any updated section numbers if amended in the future)]

14. For Medi-Cal Members under the age of 21, the term "Medically Necessary" includes those standards set forth in Title 22 of the California Code of Regulations Sections 51340 and 51340.1.

15. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of payment and other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

16. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

17. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

18. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as

supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

19. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

20. In the event of the Provider's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Provider may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

21. By signing this Agreement, Provider agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto.

22. Provider shall comply with all applicable Federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act; and all other laws regarding privacy and confidentiality.

23. Provider shall comply with Plan's policies and procedures as described in the Provider Manual relating to the identification of Members that may be eligible for other Programs.

24. Provider shall make no claim for recovery of the value of ECM Services rendered to Members when such recovery would result from an action involving the tort or Workers Compensation liability of a third party, casualty liability coverage, or any other third-party liability which could result in recovery by the Medi-Cal Member of funds for which DHCS has lien rights under Welfare and Institutions Code Section 14124.70. Provider shall identify and notify Plan of cases in which such an action could result in recovery by the Member. Provider shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. DHCS retains the right to such third-party tort and Workers Compensation liability, and casualty liability recoveries with respect to Medi-Cal Members as set forth in Welfare and Institutions Code Section 14124.70 and following.

25. Provider agrees to 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 DHCS Member Group Contract's requirements for records related to recovery for litigation. [Citation: DHCS APL 19-001 Item 16; Citation: MCP Contract, Exhibit A, Attachment 6, Provision 13.B.10; MCP Contract, Exhibit E, Attachment 2, Provision 26, Records Related to Recovery for Litigation; (and any updated section numbers if amended in the future.)]

26. To the extent that Provider is at risk for non-contracting Emergency Services, Provider shall be subject to the applicable provisions in the DHCS Member Group Contract. In such instances, Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Plan. Emergency Services shall not be subject to authorization by Plan. [Citation: DHCS APL 19-001 Item 5; (and any updated section numbers if amended in the future.)]

27. Provider shall maintain and make available to DHCS, upon request, copies of all sub-subcontracts and ensure that all sub-subcontracts are in writing. Provider shall make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to the DHCS Member Group Contract available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. Provider shall retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Member Group Contract period or from the date of completion of any audit, whichever is later. [Citation: DHCS APL 19-001 Item 10; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.7; (and any updated section numbers if amended in the future.)]

    a. Provider is fully responsible for all duties and obligations set forth in this Agreement. However, Provider may enter into subcontracts or sub-subcontracts with other individuals, groups, or entities to fulfill its obligations and duties under the Agreement. Such individuals, groups, or entities may be a combination of network provider, subcontractor, and/or downstream subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements (as defined in the DHCS Member Group Contract) as required in the DHCS Member Group Contract, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Agreement, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as required in the DHCS Member Group Contract, as applicable. [Citation: MCP Contract Exhibit A, Attachment III, Provision 3.1.1.A; Exhibit A, Attachment I, Provision 1.0; (and any updated section numbers if amended in the future)]

28. In the event of a termination of the DHCS Member Group Contract or this Agreement, Provider agrees to assist Plan in the transfer of care of Members, in accordance with the phaseout requirements referenced in the DHCS Member Group Contract and in ensuring, to the extent practicable, continuity of Member-provider relationships. In doing so, Provider will make available to Plan and DHCS, as applicable, information maintained by Provider necessary for efficient case management of Members. In no circumstances will a Member be billed for this activity. Plan shall remain liable for the processing and payment of invoices and other claims for payment for ECM Services and other services provided to Members prior to the expiration or termination of the DHCS Member Group Contract. [Citation: DHCS APL 19-001 Item 11; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.11. & DHCS APL 19-001 Item 12; MCP Contract, Exhibit E, Attachment 2, Provision 15; (and any updated section numbers if amended in the future.)]

29. As required under Plan's Language Assistance Program referenced in Section 7.4 of this Agreement, Provider agrees to provide interpreter services for Members at all Provider sites. Provider also agrees to comply with language assistance standards developed pursuant to Health & Safety Code § 1367.04. [Citation: DHCS APL 19-001 Item 17; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.17. & DHCS APL 19-001 Item 30; (and any updated section numbers if amended in the future.)]

30. Provider agrees to participate and cooperate in Plan's QI Program. [Citation: DHCS APL 19-001 Item 19 (and any updated section numbers if amended in the future.)]

31. If Provider is delegated any quality improvement functions as defined in the DHCS Member Group Contract, the provisions required in the Member Group Contract with DHCS regarding: (i) quality

improvement responsibilities and specific delegated functions; (ii) oversight, monitoring, and evaluation processes; (iii) reporting requirements and approval processes; and (iv) action/remedies if Plan's obligations are not met, are specifically stated in Plan's delegation agreements and are hereby incorporated by reference into this Provider Agreement. [Citation: DHCS APL 19-001 Item 20; MCP Contract, Exhibit A, Attachment 4, Provision 6.A; (and any updated section numbers if amended in the future.)]

32. Provider agrees to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program, including but not limited to, all applicable Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, All Plan Letters ("APLs") and contract provisions. [Citation: DHCS APL 19-001 Item 21; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.5; (and any updated section numbers if amended in the future.)]

33. Provider agrees that Plan may terminate this Agreement, revoke the delegation of activities or obligations, or specify other remedies, in instances where DHCS or Plan determines that Provider has not performed satisfactorily. [Citation: DHCS APL 19-001 Item 22; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.12, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867; (and any updated section numbers if amended in the future.)]

34. Provider will submit complete, accurate, reasonable, and timely provider data and/or encounter data needed by Plan in order for Plan to meet its provider data and/or encounter data reporting requirements to DHCS. [Citation: DHCS APL 19-001 Item 25; MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates. & DHCS APL 19-001 Item 26; Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates; (and any updated section numbers if amended in the future.)]

35. Provider is prohibited from balance billing any Member. [Citation: DHCS APL 19-001 Item 27; MCP Contract, Exhibit A, Attachment 8, Provision 6; (and any updated section numbers if amended in the future.)]

36. Provider, or Plan at Provider's request, will provide cultural competency, sensitivity, health equity, and diversity training to all employees and staff at key points of contact with Members. [Citation: DHCS APL 19-001 Item 28; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.16; (and any updated section numbers if amended in the future.)]

37. Notwithstanding anything to the contrary, Provider is entitled to, and Plan shall ensure that, all protections afforded to it under the Health Care Provider's Bill of Rights including, but not limited to the right to submit a grievance in accordance with Plan's formal process to resolve Provider grievances and to access Plan's dispute resolution mechanism referenced in Section 6.5 of this Agreement and pursuant to Health and Safety Code § 1367(h)(1). [Citation: DHCS APL 19-001 Items 18, 29 and 31; MCP Contract, Exhibit A, Attachment 6, Provision 13.B.20; Health & Safety Code §1375.7; Health & Safety Code §1367 (h)(1) (and any updated section numbers if amended in the future.)]

38. Provider agrees to (i) report to Plan when it has received an overpayment, (ii) return the overpayment to Plan within 60 calendar days of the date the overpayment was identified, and (iii) notify Plan in writing of the reason for the overpayment in accordance in accordance with the Member Group Contract and 42 CFR § 438.608(d)(2). [Citation: MCP Contract, Exhibit A, Attachment 6, Provision 13.B.19, Exhibit E, Attachment 2, Provision 34; 42 CFR § 438.608(d)(2).]

39. Plan has established a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in long-term care facilities, skilled nursing facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments. For the purposes of this Agreement, a "Member Emergency Preparedness Plan" means a required subsection of the Plan's Emergency Preparedness and Response Plan that details the required coordination between Plan and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency. As part of this Member Emergency Preparedness Plan, Provider is required to:

a. Annually submit evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859;

b. Advise Plan as part of the Network Provider's Emergency plan; and

c. Notify Plan 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.

[Citation MCP Contract Exhibit A, Attachment III, Provision 6.3.C.3; (and any updated section numbers if amended in the future)]

40. If DHCS, DMFEA, or US DOJ, or any other authorized state or federal agency, determines there is a credible allegation of fraud against Provider or any of Provider's subcontractors or downstream subcontractors, Plan will immediately suspend payments to Provider for which a state or federal agency determines there is a credible allegation of fraud. Provider must immediately suspend payments to any subcontractor or downstream subcontractor for which a state or federal agency determines there is a credible allegation of fraud (42 CFR § 438.608(a)(8)). In addition, Plan may conduct additional monitoring, temporarily suspend and/or terminate Provider. [Citation: MCP Contract Exhibit A, Attachment III, Provision 1.3.4.D; (and any updated section numbers if amended in the future)]

EXHIBIT C

COVERED TAX IDENTIFICATION NUMBER(S)

The Tax Identification Number(s) ("TIN(s)") listed below are the only TINs that apply to this Agreement. Any update to the TINs in this Exhibit C must be requested by Provider with a minimum of 60 days prior written notice given. Such requests are subject to the approval of the Plan and will require memorialization via an amendment to this Agreement.

TIN(s):
0

EXHIBIT D

ALLIANCE CARE IHSS HEALTH PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

EXHIBIT E

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EXHIBIT F

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EXHIBIT G

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EXHIBIT H

COMPENSATION SCHEDULE

1. Payment in Full. Provider agrees to accept payment rendered pursuant to this Exhibit H, and any applicable Member Payment, as payment in full for any ECM Services provided by ECM Provider to a Member approved by Plan for ECM Services, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 4.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 4.4 of this Agreement.

2. Definitions. The following definitions are applicable to this Exhibit H:

a. "Capitation Payment" shall mean the PEPM amount, as set forth in this Exhibit H, paid to Provider for the provision of ECM Services.

b. "New Medi-Cal Benefit" shall mean any new CPT or HCPCS code added by DHCS that was not part of the Medi-Cal Fee Schedule on April 1, 2021.

c. "PEPM" means per ECM Assigned Member per month.

3. Payment for ECM Services.

a. ECM Services. Plan will pay Provider for ECM Services provided to Members approved by Plan for ECM Services as set forth below in subsections i., ii., and iii.. Unless otherwise specified by Plan, ECM Services must be billed in accordance with Medi-Cal billing requirements.

i. Capitation Payments. Plan will pay Provider a PEPM capitation rate of six hundred twenty-five dollars ($625.00) for ECM Services provided to ECM Provider's ECM Assigned Members for the months in which Plan provides authorization for such Members to receive ECM Services (excluding outreach) by their assigned ECM Provider by the fifteenth (15th) day of the following month.

1) Capitation Payment Adjustment. If ECM Provider's submittal of encounter data in accordance with Section 2.11.2.1 of the Agreement for Provider's ECM Assigned Members during any full one month period indicates less than an average of 1 visits per ECM Assigned Members per one month period ("Data Benchmark"), Plan shall provide written notice to ECM Provider that ECM Provider shall be subject to a corrective action plan in accordance with Plan's policies. If during the three-month notice period ECM Provider takes material and substantial steps towards achieving the Data Benchmark, Plan will continue to compensate ECM Provider at the Capitation Payment rate specified in Section 3.a.i. above during and following the expiration of the three-month corrective action period. If ECM Provider does not achieve the Data Benchmark within three months, Plan may adjust ECM Provider's payment for the ECM Services referenced in Section 3.a.i. in accordance with Plan's policies.

2) Reversion to Capitation Payment. If following the capitation payment adjustment specified in Section 3.a.i.1. above, ECM Provider's submittal of encounter data for ECM Provider's ECM Assigned Members during any full three month period becomes equal to or greater than an average of 1 visit per ECM Assigned Members per one month period, Plan will provide ECM Provider with sixty (60) days prior written notice that Plan will compensate ECM Provider at the Capitation Payment rates specified in Section 3.a.i. above. Payment shall revert to the Capitation Payments as of the date specified in the Plan's notice to ECM Provider.

ii. Outreach Payment. ECM Provider will conduct outreach to Members approved by Plan for outreach, in accordance with Plan policies and this Agreement including but not limited to

Exhibits J and K of this Agreement. Plan will pay Provider an outreach payment of forty-four dollars ($44.00) per each outreach performed to Member, subject to the terms and conditions of this section.

a. The maximum outreach payment per Member shall not exceed six outreaches totaling two hundred and sixty-four dollars ($264.00).

b. ECM in person outreach is the preferred method because individuals eligible for ECM are considered the highest needs Members and engagement should focus on meeting the member where they are, which requires engagement primarily with the Member in the community or at Provider locations. Therefore, if ECM Provider only conducts outreach via a method that is not in person, and such outreach does not result in the Member enrolling in the ECM Program, Plan will not pay Provider for the unsuccessful outreach. In order to be eligible for payment of any outreach attempts that do not result in a Member enrolling in the ECM Program, a minimum of two outreach attempts must be done in-person.

c. If the Member enrolls in the ECM Program, Plan shall pay Provider the maximum amount for outreach of two hundred and sixty-four dollars ($264.00), regardless of the number of outreaches or method (i.e. in person or not in-person), along with a bonus payment of two hundred dollars ($200.00). The balance of the maximum outreach payment, if any, and bonus shall be paid to Provider upon Provider billing Plan for the Member's first enrolled ECM Service.

d If a Member declines to enroll in the ECM Program, Plan will pay provider for each outreach attempt prior to the declination, not to exceed to maximum outreach payment per Member in Section a.

e. Multiple outreaches performed by the same ECM Provider to the same Member on the same day will be paid as one single forty-four-dollar ($44.00) outreach payment.

f. Outreach payment will only be made by Plan for outreaches performed to each Member within the first six months of the Member becoming eligible for ECM Services as identified by Plan and shall not be paid if outreach is performed after the Member is enrolled in the ECM Program. By billing Plan for outreach, Provider attests to meeting the minimum requirements for outreach set forth by Plan policies.

Outreach Payment Examples:

Number of Outreaches + Method per Member	**Member ECM Enrollment Status**	**Total Outreach Payment per Member**	**Outreach Bonus Payment per Member**
2 in-person 1 not in-person	Member enrolls in ECM Program	$264	$200
6 not in-person	Member enrolls in ECM Program	$264	$200
1 in-person 5 not in-person	Member enrolls in ECM Program	$264	$200
2 in-person 3 not in-person	Member neither enrolls in ECM Program nor declines to enroll	$220	No bonus
1 in-person 3 not in-person	Member neither enrolls in ECM Program nor declines to enroll	No payment	No bonus
1 in-person 3 not in-person	Member declines to enroll in ECM Program	$176	No bonus
None	Member enrolls in ECM Program	No payment	No bonus

iii. As a condition of payment, Provider is required to provide ECM Services in accordance with Plan and DHCS requirements for providing ECM Services, including but not limited to, the requirements included in Exhibit J and K of this Agreement. Plan reserves the right to perform post-payment auditing of Provider's performance to ensure compliance with all applicable requirements for providing ECM Services. If Plan identifies that Provider is not providing ECM Services in accordance with applicable requirements, Plan may adjust or recover payments made for ECM Services per Section 4.4, Adjustments to Payments, of this Agreement.

b. New Medi-Cal Benefit. Notwithstanding anything to the contrary in this Exhibit, any New Medi-Cal Benefit may be paid per this Section of Exhibit H above; provided, however, that Plan reserves the right in its sole discretion to pay for any New Medi-Cal Benefit at one hundred percent (100%) of the amount which Plan will be reimbursed by DHCS.

EXHIBIT I

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EXHIBIT J

ECM SERVICES SCHEDULE

1. ECM Services. ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with Plan's Policies and Procedures, as follows:
    a. Outreach and Engagement of Plan Members into ECM.
    b. Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:
        i. Engaging with each Member authorized to receive ECM primarily through in-person contact;
            1. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
        ii. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.
        iii. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, authorized representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
        iv. Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorder (SUD), LTSS, oral health, palliative care, necessary community- based and social services, and housing;
        v. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and
        vi. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.
    c. Enhanced Coordination of Care, which shall include, but is not limited to:
        i. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;
        ii. Maintaining regular contact with all providers, that are identified as being a part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;
        iii. Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
        iv. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;

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

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

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

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

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

iii. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

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

i. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;

ii. For Members who are experiencing, or who are likely to experience a care transition:

1. Developing and regularly updating a transition of care plan for the Member;

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

3. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

4. Coordinating medication review/reconciliation; and

5. Providing adherence support and referral to appropriate services.

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

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

ii. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;

iii. Ensuring the Member's ECM Provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);

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

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

vi. Ensuring that the Member has a copy of their care plan and information about how to request updates.

g. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:

i. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by Plan as Community Supports; and

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

EXHIBIT K

ENHANCED CARE MANAGEMENT BENEFIT

1. Definitions.

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

2. ECM Provider Requirements.

    a. Provider Experience and Qualifications.

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

        ii. ECM Provider shall have experience and expertise with the services it will provide;

        iii. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM services requirements in the Member Group Contract;

        iv. ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary;

        v. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways;

        vi. ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports providers, to coordinate care as appropriate to each Member;

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

    b. Medicaid Enrollment/Vetting for ECM Providers.

        i. If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.

1. If APL 19-004 does not apply to an ECM Provider, the ECM Provider must comply with Plan's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

3. Identifying Members for ECM.

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

4. Member Assignment to an ECM Provider.

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

    b. ECM Provider shall immediately accept all Members assigned by Plan for ECM, with the exception that an ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.

        i. ECM Provider shall immediately alert Plan if it does not have the capacity to accept a Member assignment.

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

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

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

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

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

5. ECM Provider Staffing.

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

6. ECM Provider Outreach and Member Engagement.

    a. ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with Plan's Policies and Procedures.

    b. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

    c. ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek

care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.

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

1. Mail
2. Email
3. Texts
4. Telephone calls
5. Telehealth
6. ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and this Agreement.

7. Initiating Delivery of ECM.

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

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

c. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to Plan.

d. ECM Provider shall notify Plan to discontinue ECM under the following circumstances:

i. The Member has met their care plan goals for ECM;

ii. The Member is ready to transition to a lower level of care;

iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or

iv. ECM Provider has not had any contact with the Member despite multiple attempts.

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

8. ECM Requirements.

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

i. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its subcontractors comply with all requirements in this Agreement.

b. ECM Provider shall:

i. Ensure each Member receiving ECM has a Lead Care Manager;

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

iii. Alert Plan to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources; and

iv. Follow Plan instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

c. ECM Provider shall collaborate with area hospitals, Primary Care Physicians (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.

9. Training.

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

10. Data Sharing to Support ECM.

a. Plan will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

ii. Encounter and/or claims data;

iii. Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members; and

iv. Reports of performance on quality measures and/or metrics, as requested.

11. Claims Submission and Reporting.

a. ECM Provider shall submit claims for the provision of ECM Services to Plan per Section 4.1, Submission of Claims, of this Agreement using the national standard specifications and code sets to be defined by DHCS.

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

12. Quality, Oversight and Reporting.

a. ECM Provider acknowledges Plan will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with DHCS requirements, which may include audits and/or corrective actions.

b. ECM Provider shall respond to all Plan requests for information and documentation to permit ongoing monitoring of ECM.

c. ECM Provider shall submit the following data and reports to Plan to support Plan's oversight of ECM:

i. Encounter data.

1. ECM Provider must submit all ECM encounters to Plan using national standard specifications and code sets to be defined by DHCS.

2. ECM Provider shall be responsible for submitting to Plan all encounter data for ECM Services to Members, regardless of the number of levels of delegation and/or sub-delegation between Plan and the ECM Provider.

ii. Supplemental reporting.

1. ECM Provider shall submit ECM supplemental reports, on a schedule and in a format to be defined by DHCS or Plan.

d. ECM Provider shall track and report to Plan, in a format to be defined by Plan, information about outreach efforts related to potential Members to be enrolled in ECM.

13. Payment for ECM.

a. Plan shall pay Provider for the provision of ECM Services in accordance with the payment rates set forth in Exhibit H to this Agreement.

b. Provider is eligible to receive payment when ECM Services are initiated and authorized by Plan for any eligible Plan Member per the terms set forth in Article IV and Exhibit H to this Agreement.

c. Plan shall pay ninety percent (90%) of all Complete Claims from Provider within thirty (30) days of date of receipt and ninety-nine percent (99%) of all Complete Claims within ninety (90) days. The date of receipt shall be the date Plan receives the Complete Claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

ADDENDUM I

BUSINESS ASSOCIATE AGREEMENT

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