SAN FRANCISCO HEALTH PLAN
ENHANCED CARE MANAGEMENT
FEE FOR SERVICE PROVIDER AGREEMENT

This Enhanced Care Management Fee For Service Provider Agreement ("Agreement") is entered into and effective this 1st day of July, 2023 ("Effective Date") between San Francisco Health Authority, a local governmental entity doing business as the **San Francisco Health Plan** (hereinafter collectively referred to as, "SFHP" or "Health Plan") and the City and County of San Francisco acting by and through the **San Francisco Department of Disability and Aging Services** (hereinafter, "Provider"). Provider and SFHP are individually and collectively sometimes referred to in this Agreement as the "Party" or "Parties."

RECITALS

SFHP operates a prepaid health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and provides healthcare benefits to its Members who are entitled to such benefits by contract between the Health Plan and the California Department of Health Care Services (DHCS), the IHSS Public Authority, and/or the City and County of San Francisco; and

Provider is properly qualified and licensed within the State of California to provide the services described in this Agreement, and desires to participate in Health Plan's network of contracting providers to provide health care services to Health Plan's members; and

Provider shall participate in the lines of business indicated in Exhibit A (Services, Rates and Location), pursuant to the terms and conditions of this Agreement; and

Provider and Health Plan are duly authorized to execute this Agreement for the services contemplated hereunder, and all required actions have been properly taken by both parties for its execution and performance.

Article I.
Definitions

1.1. **Acute Condition** means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

1.2. **Authorization (Authorized)** is a procedure for obtaining SFHP's prior approval, in accordance with SFHP's utilization management policies and procedures, for services provided to Members which are Covered Services.

1.3. **Claims Operations Manual** is the document or series of documents created, maintained, updated, and distributed from time to time by Plan that describes the Plan's claims policies and procedures and other claims requirements of Provider. The Claims Operations Manual is incorporated into this Agreement and made part hereof. The current Claims Operations Manual can be accessed online on SFHP's web site at: https://www.sfhp.org/providers/provider-tools/provider-manual/.

1.4. **Clean Claim** is a fully completed claim form and any additional information that contains substantially all the required data elements necessary (including any essential documentation) for accurate adjudication without the need for additional information from outside Health Plan's system or additional review from other entities.

1.5. **Confidential Information** includes but is not limited to: (a) Individually Identifiable Health Information; (b) personal and financial information concerning Health Plan, Members, Health Professionals, hospitals, or other Health Plan providers (including information related to credentialing proceedings, quality reviews, malpractice suits, and peer review); (c) personally-identifiable information subject to federal, state, and local confidentiality laws; and (d) proprietary business information and trade secrets.

1.6. **Continuity of Care Services** are those Covered Services rendered by terminated Participating Providers to Members undergoing a course of treatment at the time of termination with such terminated Participating Provider or non-Participating Providers, when a newly covered Member who, at the time the Member's coverage became effective, was receiving services from the non-Participating Provider, pursuant to California Health & Safety Code Section 1373.96 and/or the Benefit Program. Continuity of Care Services include completion of Covered Services for: (1) the duration of an Acute Condition; (2) up to twelve (12) months for a serious chronic condition; (3) the duration of pregnancy and the immediate postpartum period or in the event a Member presents written diagnosis of a maternal mental health condition from the treating provider, up to twelve (12) months from the diagnosis or end of pregnancy, whichever is later; (4) completion of Covered Services for a terminal illness; (5) up to twelve (12) months care of a newborn child between birth and age thirty-six (36) months; and (6) performance of surgeries or other procedures scheduled to occur within one hundred eighty (180) calendar days if Authorized by Health Plan as part of a documented course of treatment.

1.7. **Covered Services** are all Medically Necessary healthcare and related services which Health Plan is obligated to provide pursuant to the Member's Evidence of Coverage.

1.8. **DHCS** means the California Department of Health Care Services.

1.9. **DHHS** means the United States Department of Health and Human Services.

1.10. **DMHC** means the California Department of Managed Health Care.

1.11. **Evidence of Coverage** is the document that describes in detail the benefits, limitations and exclusions of coverage. The Evidence of Coverage can be accessed online on SFHP's web site at: https://www.sfhp.org/programs/medi-cal/benefits/

1.12. **Health Professional** means a person holding a license or certificate, appropriate to provide health care services in the State of California.

1.13. **HIPAA** refers to the federal Health Insurance Portability and Accountability Act of 1996 and attendant privacy and security regulations, as amended from time to time.

1.14. **HITECH** refers to the Health Information Technology for Economic Clinical Health Act passed as part of the American Recovery and Reinvestment Act of 2009.

1.15. **Individually Identifiable Health Information** means "individually identifiable health information" as defined in 45 CFR 160.103 and includes health information that: (i) is created by or received from a Health Professional, SFHP, or healthcare clearinghouse; and (ii) relates to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or payment for the provision of health care to an individual, which identifies or could reasonably be used to identify the individual.

1.16. **Medically Necessary** is defined as those services and supplies which have been established as safe and effective and are needed to protect life, to prevent significant illness or disability, or to treat an illness or injury, and which are furnished in accordance with generally accepted professional standards, and, as determined by SFHP, are: (i) consistent with the patient's health status symptoms or diagnosis, (ii) provided for the diagnosis and direct care and treatment of such patient's condition, (iii) not furnished primarily for the convenience of the patient or the provider, and (iv) furnished at the most appropriate level which can be provided safely and effectively to the patient.

1.17. **Medical Services** are Covered Services provided by Provider in accordance with its license(s) and/or certifications, and as further specified in Exhibit A, attached hereto and incorporated herein.

1.18. **Member(s)** is an individual who is enrolled in SFHP, who meets all the eligibility requirements for membership on the dates of service, and who has selected a physician, clinic, or medical home. Member also includes a child born to a Member for the period of time required by State law and/or applicable Evidence of Coverage.

1.19. **Member Grievance Procedures** are those procedures followed by Health Plan for the processing and resolution of all Member complaints.

1.20. **Non-Covered Services** are those services not covered, as determined by Health Plan, under any benefit program in which a Member participates

1.21. **Participating Providers** are those healthcare providers who have entered into a medical services agreement with Health Plan to provide Covered Services to a Member.

1.22. **Protected Health Information (PHI)** means "protected health information", as that term is defined under 45 CFR 160.103 and is covered under the HIPAA Privacy Rule and HIPAA Security Rule.

1.23. **Provider Manual** is the 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 other requirements of Provider. The Provider Manual is incorporated into this Agreement and made part hereof. The current Provider Manual can be accessed online on SFHP's web site at: https://www.sfhp.org/providers/provider-tools/provider-manual/.

1.20 **Regulating Agency** means the DHCS, DMHC, United States Department of Health and Human Services ("DHHS"), the Centers for Medicare and Medicaid Services ("CMS"), United States Department of Justice ("DOJ"), the California Attorney General, or any other local, state or federal government agency having jurisdiction over Health Plan activities, and to whom Health Plan or Provider has a contractual or legal obligation. Regulating Agency shall also include accreditation organizations under which Provider or Health Plan is obligated to comply with accreditation standards.

ARTICLE 2.
TERM AND TERMINATION

2.1. **Term.** The term of this Agreement is for one (1) year and shall commence on the Effective Date of the Agreement. Thereafter, the Agreement will automatically renew for an additional one (1) year term on the anniversary of the Effective Date if written notice from either Party is not

received by thirty (30) days before the anniversary of the Effective Date, up to a total of four (4) additional one (1) year renewals, with the Agreement having a maximum total duration of five (5) years, until terminated by either Party in accordance with this Agreement.

2.2. **Termination for Convenience.** Notwithstanding any other provision of this Agreement, after the first year of the term, either Party may terminate this Agreement for convenience at any time by giving at least one hundred eighty (180) calendar days prior written notice to the other Party.

2.3. **Termination with Cause.** If either Party defaults in the performance of any material term or condition of this Agreement, and the default is one which may be cured, the non-defaulting party shall provide written notice to the defaulting party of the material default. The defaulting party must then cure that default by a satisfactory performance within thirty (30) calendar days of written notice. If the defaulting party fails to cure the default and provide evidence of such cure to the non-defaulting party within that time, then this Agreement shall terminate at the conclusion of the cure period without any further notice being required. Notwithstanding the foregoing, if the default is one which cannot be cured in the sole discretion of Health Plan, Health Plan may terminate this Agreement by providing thirty (30) calendar days advanced written notice to Provider. Material defaults shall include, but are not limited to, a failure to uphold professional standards of care, Provider's failure to provide medical care at standards specified by Health Plan, a breach of any material term, covenant, or condition of this Agreement, and inability by a Party to pay its debt as it matures.

2.4. **Immediate Termination**. Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider, as applicable, by giving notice to Provider in the event of any of the following:

a) Provider's license or certificate to render Covered Services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the State licensing authority;

b) Provider is decertified or otherwise withdraws (whether or not voluntary) from the Medi-Cal Program;

c) Provider fails to maintain insurance (or self-insurance) required by this Agreement;

d) Provider loses credentialed status;

e) Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

f) Health Plan determines that Provider, its facility and/or equipment is insufficient to render Covered Services to Members;

g) Provider is excluded from participation in state health care programs pursuant to Section 1128 of the Social Security Act or otherwise excluded or terminated as a provider by any state or federal health care program;

h) Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

i) Health Plan determines that Covered Services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety; or

j) Provider breaches a term of this Agreement, which specifically indicates that a remedy for such breach is immediate termination.

2.5. **Effect of Termination**. As of the date of termination, this Agreement will be considered of no further force or effect whatsoever, and each of the Parties will be relieved and discharged from its obligations, except that:

a) Termination of this Agreement will not affect any rights or obligations hereunder which have previously accrued, or will hereafter arise with respect to any occurrence prior to termination, and such rights and obligations will continue to be governed by the terms of this Agreement.

b) The following Sections of this Agreement, which by their nature extend beyond the expiration or termination of this Agreement, will survive the termination of this Agreement, as follows: 2.5 (Effect of Termination); 3.10 (Liability Insurance); 5.3 (Confidentiality of Member Health Information); 6.1 (Proprietary and Confidential Information); 6.2 (Confidentiality of PHI); 7.5 (Surcharges Prohibited); 7.7 (Provider Dispute Resolution); and 9.5 (Mutual Indemnification).

c) Provider shall continue providing services to Members who are under its care at the time of termination until the services being rendered to the Member are completed, or SFHP has arranged for the reasonable and medically appropriate transfer of the Member's care to another Participating Provider, whichever is sooner. Provider shall comply with all applicable requirements for Continuity of Care Services pursuant to applicable law, regulation, or regulatory directive. SFHP shall pay Provider for such post-termination services at the rates set forth in Exhibit A. SFHP shall use its best efforts to arrange for services to be performed by another Participating Provider as quickly as possible. Both Health Plan and Provider will cooperate to achieve an orderly and dignified transfer of Members, including the transfer of Member's medical records, patient files, or other pertinent information, to other Participating Providers.

ARTICLE 3.
REPRESENTATIONS, WARRANTIES, AND OBLIGATIONS OF PROVIDER

3.1. **Services to be Provided.** Provider shall provide the Covered Services to Members outlined in Exhibit A, which are Authorized by Health Plan, as described in the Provider Manual, prior to providing services (unless otherwise specifically indicated in Exhibit A). Authorizations are based on Medical Necessity of such Covered Services and are contingent upon Member's eligibility. When applicable, Provider shall provide such Covered Services in accordance with the orders of the prescribing or referring physician, the terms and conditions set forth in this Agreement, the Provider Manual, the Plan's Quality Improvement (QI) and Utilization Management (UM) programs, applicable regulatory requirements, accreditation organization standards, and applicable law.

3.2. **Eligibility.** Provider shall verify Member's eligibility prior to rendering Covered Services as described in the Provider Manual. Production of a Health Plan issued identification card is indicative of a person's status as a Member but will not be conclusive of such status. Provider is responsible for verifying a Member's eligibility with Health Plan and Health Plan shall have no responsibility, financial or otherwise, where Provider failed to properly verify Member eligibility.

3.3. **Standard of Care.** Provider shall maintain and cause its subcontractors to maintain duly licensed professional personnel, facilities, equipment, and services at a level and quality that equals or exceeds the generally accepted and professionally recognized standards of practice to perform Provider's duties and responsibilities under this Agreement and to meet all (i) applicable federal and state laws, (ii) licensing requirements (including, without limitation, the provisions of Title 22, California Code of Regulations Section 53230 and the accessibility requirements of the Americans with Disabilities Act), (iii) professional practices and standards, and (iv) professional and technical standards set forth in the Provider Manual and Health Plan QI and UM programs.

3.4. **Licensing and Compliance.** Provider represents that it (i) has and shall maintain any necessary license, certification, or government approval required to perform services in the State of California if required; (ii) is certified under Medicare and Medi-Cal if required; and (iii) meets all other regulatory requirements necessary to perform the services described in this Agreement and Medi-Cal policy. Provider represents that neither it nor any of its subcontracting providers who will provide Covered Services to Members have been debarred, excluded, or suspended from participation in any state or federal health care program. Provider understands that the moneys used to pay Provider under this Agreement are, in whole or in part, federal funds. All federal laws applicable to the use of federal funds apply to this Agreement.

3.5. **Provider Manual**. Provider shall comply with the Provider Manual and Claims Operations Manuals when performing any and all duties under this Agreement. The Provider Manual and Claims Operations Manual are an extension of this Agreement and incorporated herein by this reference.

3.6. **Interpreter Services.** Provider shall provide access to interpreter services for all limited English proficient (LEP) Members at all Provider facilities as described in the Provider Manual.

3.7. **Cultural & Linguistic Services**. Provider shall provide Covered Services to Members in a culturally, ethnically, and linguistically appropriate manner. Provider shall comply with Health Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with Health Plan by providing any information necessary to assess compliance.

3.8. **Equal Treatment**. Provider shall not differentiate or discriminate in the scheduling of appointments, the treatment of Members, the quality of services, or in any other respect, against Health Plan Members. Additionally, Provider shall not discriminate against Members on the basis of race, color, national origin, ancestry, religion, sex, marital status, health status, sexual orientation, physical, sensory or mental handicap, age, socioeconomic status, participation in publicly financed programs of health care, or because any grievance or complaint has been filed by such Member. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability, regardless of payor.

3.9. **Member Grievance Procedures**. As set forth in the Provider Manual, Provider shall promptly notify Health Plan of receipt of any complaints from or on behalf of Members and any professional liability claims filed or asserted regarding services provided by, or on behalf of, Provider. Provider shall cooperate with Health Plan's Member Grievance Procedure in resolving Members' complaints regarding Provider's provision of services and/or any other matter related to Provider. Provider shall cooperate with Health Plan's resolution of any such complaints or grievances.

3.10. **Liability Insurance**. Provider shall insure Provider and its agents, servants, and employees against any claims for damages directly or indirectly connected with the performance of this Agreement, including, the rendering of any health care service, the use of any Provider property or equipment, or any other activities, performed by Provider or by Provider's agents, servants or employees in connection with this Agreement. The Parties acknowledge that the City and County of San Francisco is self-insured for many requirements listed below, and such self-insurance meets the requirements listed below. Provider, at its sole cost and expense, shall procure and maintain the following policies of insurance:

a) Medical Professional and Liability Insurance or an equivalent program of self-insurance for bodily injury, property damage and personal injury in an amount no less than one million ($1,000,000) dollars for each occurrence, with a general aggregate of three million ($3,000,000) dollars applying. If such insurance is written on a commercial claims-made form, following termination of this Agreement, coverage shall survive for the maximum reporting periods available from insurance sources but in no event for less than five years following termination of this Agreement.

b) Comprehensive or Commercial Form General Liability Insurance (contractual liability included) with limits in an amount no less than one million ($1,000,000) dollars for each occurrence, with a general aggregate of three million ($3,000,000) dollars applying. However, if such insurance is written on a claims made form, following termination of this Agreement, coverage shall survive for a period of not less than three years.

c) Worker's Compensation Insurance in a form and amount covering Provider's full liability under the Workers' Compensation Insurance and Safety Act of the State of California, as amended from time to time.

d) Such other insurance in such amounts which from time to time may be reasonably required by the mutual consent of Provider and Health Plan against other insurable risks relating to performance.

e) If any policy includes an aggregate limit or provides that claims investigation or legal defense costs are included in such aggregate limit, the aggregate limit will be double the occurrence limits specified above. Insurance policies must be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best rating of A:VIII or better. All insurance policies carried by Provider, whether specified herein or otherwise, shall contain endorsements waiving the insurer's rights of subrogation against Health Plan. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall give Health Plan prompt written notice, but in no event less than fifteen (15) business days' notice, of any claims against Provider's coverage by or regarding a Health Plan Member.

f) Any insurance provided by Provider or its subcontractors or drivers shall be primary to any coverage available to Health Plan. Any insurance or self-insurance maintained by Health Plan and its officials, officers, employees, agents or volunteers, shall be in excess of Provider's insurance and shall not contribute with it. Procurement of insurance by Provider shall not be construed as a limitation of Provider's liability or as full performance of Provider's duties to indemnify, hold harmless and defend Health Plan under this Agreement.

g) Provider, upon execution of this Agreement, shall furnish Health Plan with Certificates of Insurance evidencing compliance with all requirements.

h) Provider shall provide thirty (30) days advance written notice to Health Plan of any modification, change or cancellation of any of the above insurance coverages.

3.11. **Public Record**. Provider understands that this Agreement and all information received will be public records on file with DHCS and/or DMHC, unless specifically exempted by statute. Similarly, the Agreement and related records held by Provider, as part of the City and County of San Francisco, are public records subject to disclosure excepts as exempted by statute or local ordinance.

3.12. **Health Plan Name and Logo**. Provider shall not use Health Plan's name and/or logo without Health Plan's prior written consent. Health Plan shall not use City's or Provider's name and/or logo without City's prior written consent.

3.13. **Provider Directory.** Health Plan and Provider hereby agree to comply with the requirements of the law in regard to provider directories, including, but not limited to, California Health & Safety Code Section 1367.27. Health Plan will develop a directory to be distributed to Health Plan Members in accordance with such applicable laws.

a) As applicable, Provider shall inform Health Plan within five (5) business days when either of the following occur:

i. Provider is not accepting new patients.

ii. If Provider had previously not accepted new patients, Provider is currently accepting new patients

b) Provider shall comply with notifications from Health Plan requesting verification of Provider information or the submission of any additions, deletions, or modifications within specified time frames to enable compliance with Health & Safety Code Section 1367.27 and as further described in Health Plan's Provider Manual.

3.14. **Additional Disclosures**. Subject to the terms of this Agreement, Provider will immediately notify Health Plan in writing upon gaining knowledge of the occurrence of any of the following events:

a) The license or accreditation status of Provider or any employee or subcontractor of Provider is suspended, revoked, terminated, or subjected to terms of probation or other restriction (including, without limitation, appearance on a state or federal exclusion list; or any citation, charge, complaint, or investigation for failure to meet any required standard or legal obligation);

b) Provider learns that it has become a defendant in a legal action filed by a Member related to services provided under this Agreement or is required to pay damages in any such action by way of judgment or settlement;

c) A petition is filed under the bankruptcy laws of the United States for bankruptcy or reorganization on behalf of Provider, or a receiver is appointed over all or any portion of the Provider's assets;

d) Provider's insurance is canceled, terminated, not renewed or materially modified; or

e) An act of nature or the occurrence of any other event which has a materially adverse effect on Provider's ability to perform its obligations hereunder.

3.15. **Credentialing**. Provider (including, for purposes of this Section 3.15, in relation to Health Professionals employed by Provider or contracted by Provider to provide services under this Agreement) shall cooperate with Health Plan's credentialing program and shall disclose to Health Plan information and documents relating to credentials, qualifications, and performance. Provider shall immediately notify Health Plan of any legal, ethics, or other actions against Provider or its license, or any material change in professional liability insurance coverage or premiums as a result of malpractice actions, or any change in hospital privileges including, without limitation, any reduction, suspension, or termination of such privileges. Such actions include, but are not limited to, actions by the applicable state regulatory board, professional associations, or hospitals. Provider authorizes Health Plan to receive reports on demand from the state licensure agencies, professional associations, educational institutions and other agencies who may maintain data relating to the legal status, litigation history, or clinical performance of Provider. Provider shall comply with Health Plan's credentialing policies, as may be amended from time to time to reflect changing regulatory or contractual obligations of Health Plan including the completion and submission of all necessary documents that Health Plan determines to be necessary for the successful evaluation of Provider's ability to meet Health Plan's credentialing standards.

3.16. **Quality Improvement**. Provider shall cooperate with Health Plan's Quality Improvement Committee to the extent that specific issues are raised related to health care services delivered to Members. Provider agrees to participate in Health Plan's Quality Improvement Program, as set forth in the Provider Manual. In addition, Provider agrees to allow the Health Plan to use Provider's performance data for the Quality Improvement Program.

ARTICLE 4.
RIGHTS, REPRESENTATIONS, WARRANTIES, AND OBLIGATIONS OF HEALTH PLAN

4.1. **Administration and Licensure**. Health Plan shall perform the necessary functions for the proper administration of the plan and maintain its licensure in good standing to conduct its business operations within the State of California.

4.2. **Authorizations/Utilization Management**. Health Plan shall process Authorizations within required timeframes for the treatment of Members using the Authorization and utilization management criteria which have been developed by Health Plan, including determination of Medical Necessity. Provider will provide Health Plan to all records and information systems necessary for Health Plan to perform utilization management for Members.

4.3. **Eligibility Information**. Health Plan shall provide access to eligibility verification of Members as set forth in the Provider Manual.

4.4. **Benefits and Medical Necessity Determinations**. Health Plan shall have the final decision making authority between the Parties for payment of claims for health services rendered to Members, determination of Medical Necessity and Covered Services, determination of eligibility, and determination of Member's benefits subject to Health Plan's Member Grievance Procedures and to Section 7.5 (Provider Dispute Resolution). Provider shall refer Members who have inquiries or disputes regarding such coverage to the Health Plan for response and resolution. Notwithstanding the foregoing or any other provision of this Agreement, in no case will Health Plan deny payment to Provider for Covered Services rendered to Members for which Provider obtained prior Authorization, concurrently reviewed, or approved as Medically Necessary by Health Plan.

4.5. **Directory and Use of Names**. Health Plan will develop a provider directory which will be distributed to Members and in compliance with applicable law. Health Plan shall be allowed to use Provider's information (including without limitation, name, logo, address(es), telephone number, email address (if available), hours of operation, level of accessibility of facilities, language(s) spoken, national provider identifier number (NPI), California license number and license type, and services provided in Health Plan's provider directory as well as other materials commonly distributed for purposes related to the administration of a Benefit Program. Health Plan shall otherwise obtain Provider's prior written consent for any other use.

4.6. **Facility Site Review**. Health Plan will perform facility site review for Provider at all of Provider's offices as required by Health Plan pursuant to contractual and regulatory requirements and in compliance with Health Plan's quality improvement program. Provider agrees to abide by the quality improvement program requirements and to provide Health Plan access to facilities as necessary for the performance of complete facility site reviews.

4.7. **Additional Health Plan Rights and Remedies**. In the event that any Regulating Agency requires that Health Plan be able to take a specified action or actions with respect to Provider in the event that Provider does not satisfy regulatory requirements, then in such event this Agreement will be deemed to include the right of Health Plan, after providing written notice to Provider, to take such required action(s) or utilize such remedy(ies).

ARTICLE 5.
MEDICAL RECORDS

5.1. **Maintenance of Medical Records**. Provider shall maintain and require its subcontractors to maintain a medical record for each Member to whom Provider or its subcontractor renders Covered Services. The Member's medical record shall be in such form and detail as may be required by state and federal law, generally accepted and prevailing professional practice, and any federal, state, or local government agency, or by Health Plan. Such records shall be maintained in a current, detailed, organized, and comprehensive manner. Provider shall comply with all federal, state, and local confidentiality and Member record accuracy requirements.

5.2. **Retention of Records**. Provider shall retain all medical records, books, charges, and papers relating to Provider's provision of services to Members, the cost of such services, and payment received by Provider from Members (or others on their behalf). Provider shall retain all such records for at least ten (10) years after rendering Covered Services, and the records of a minor child shall be kept for a period of at least one (1) year after the minor has reached the age of eighteen (18) years, but in no event less than ten (10) years, or such longer time period as may be required by law.

5.3. **Confidentiality of Member Health Information**. Each Party shall comply with confidentiality, medical records and/or other applicable state and federal laws and regulations with regard to any and all information directly or indirectly accessed or used by the respective Parties and their personnel, including HIPAA, HITECH, and all regulations promulgated thereunder. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data, and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

5.4. **Compliance with NCQA and HEDIS Guidelines**. As applicable, Provider shall comply with the National Committee for Quality Assurance ("NCQA") and Healthcare Effectiveness Data and

Information Set ("HEDIS") guidelines and the requirements of any other applicable accrediting agency, as amended from time to time. Said compliance shall include, but not be limited to, cooperation with Health Plan by providing information required by Health Plan to demonstrate compliance with said NCQA and HEDIS guidelines and in such format as is compatible for submission to accrediting agencies.

5.5. **Member Access to Health Information**. Provider shall give Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law and Health Plan's Provider Manual.

ARTICLE 6.
CONFIDENTIALITY

6.1. **Proprietary and Confidential Information**. Each Party acknowledges that it will have access to Confidential Information. The Parties agree to hold Confidential Information in strict confidence and to disclose and use such Confidential Information only as authorized by this Agreement under applicable law or as otherwise required by law. Each Party shall exercise the same standard of care to protect such information as a reasonably prudent business entity would use to protect its own proprietary data.

6.2. **Confidentiality of PHI**. Each party assures the other that it will appropriately safeguard PHI of Members in its use and/or disclosure of such PHI pursuant to this Agreement, in accordance with confidentiality, medical records and/or other applicable state and federal law or regulation, including HIPAA, HITECH, and all regulations promulgated thereunder. Provider hereby agrees to the terms of the "San Francisco Health Plan HIPAA Privacy and Security Business Associate Agreement" attached hereto and incorporated herein as Exhibit C.

6.3. **Enforcement and Injunctive Relief**. Notwithstanding any other provisions of this Agreement, Provider and Health Plan agree that if any party violates any of the provisions of this Article, that the aggrieved party shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Article, including injunctive relief, without posting bond. Provider acknowledges that any unauthorized use or disclosure of Confidential Information and/or PHI would result in damage to Health Plan that may be intangible but nonetheless real, and that is incapable of complete remedy by an award of damages. Accordingly, any such violation shall give Health Plan the right to a court-ordered injunction or other appropriate order to specifically enforce the provisions of this Agreement.

ARTICLE 7.
REIMBURSEMENT

7.1 **Compensation**. SFHP agrees to pay Provider for Authorized Covered Services provided to Members in accordance with the terms of this Agreement and the attached Exhibit A. Provider agrees to accept such payment in full and final satisfaction for all Authorized Covered Services rendered to Members.

7.2 **Payment Responsibility by Delegated Provider or Plan**. Provider acknowledges that Health Plan maintains contracts with delegated providers and delegated plans who receive capitation or fixed periodic payments from Health Plan for Covered Services and are responsible for

arranging for Covered Services through subcontract arrangements. Provider agrees to look solely to delegated provider/plan, and not Health Plan or Member, for payment of Covered Services rendered to Members, where delegated provider/plan receives a capitation or fixed periodic payment for Covered Services from Health Plan. Provider agrees that if Provider is or becomes a party to a subcontract, agreement or other arrangement with delegated providers/plans pertaining to services under this Agreement, payment will be made by the delegated provider/plan in accordance with such subcontract, agreement, or other arrangement with such delegated provider/plan.

7.3 **Payment**. SFHP will pay Provider within forty-five (45) working days of receipt of an uncontested Clean Claim that is the payment responsibility of Health Plan and not its delegated provider/plan. Provider shall submit claim(s) on the appropriate claim form and in accordance with the requirements and guidelines specified in the Claims Operations Manual. If for any reason it is determined that Health Plan overpaid Provider, Health Plan may deduct monies in the amount equal to the overpayment from any future payments to Provider after thirty (30) days written notice.

7.4 **Copayments and/or Deductibles**. Provider shall collect from Members any amounts identified by Health Plan as the responsibility of the Member, including applicable Copayments and/or deductibles.

7.5 **Surcharges Prohibited**. Except for applicable co-payments (if any), Provider shall not bill, collect from, or charge any Member or Member's representative(s), for services covered under the Members' Evidence of Coverage; nor may Provider impose any surcharges for the provision of Covered Services. In the event Health Plan receives notice of any such surcharges being applied to Member, Health Plan shall notify Provider of its violation of this Section and Provider shall immediately cease billing the Member or, if Provider has collected funds from a Member for Covered Services, Provider shall forthwith refund same to the Member. This provision shall not prohibit billing and collection for non-Covered Services rendered to Members, as described below. This Section shall survive termination of this Agreement.

7.6 **Charges for Non-Covered Services**. Provider shall not charge a Member for a service which is not a Covered Service unless Provider obtains a signed written acknowledgment by Member in advance of performance of the services clearly indicating that the services are not covered, the estimated cost of the services, and that the Member will be financially responsible for the Non-Covered Services. Additionally, Provider specifically agrees that Health Plan shall have no liability to compensate Provider for the provision of Non-Covered Services. Provider shall ensure that its subcontractors, agents, assignees, and trustees comply with this Section.

7.7 **Provider Dispute Resolution**. Provider may appeal any denial of authorization or payment, or other adverse action by SFHP, pursuant to SFHP's provider dispute resolution policies as described in the Claims Operations Manual. For complaints regarding Health Plan services, operations or procedures, other than disputes regarding claims payment, authorizations, or member grievances, Provider may register a complaint by calling Health Plan's Provider Relations Department or Customer Service Department. Provider shall include a description of the problem, all relevant facts, names of people involved, date of occurrence(s), and any supporting documentation regarding the complaint. Health Plan shall notify Provider and acknowledge the complaint within five (5) business days of receipt. Health Plan shall inform Provider in writing of the resolution and/or reasonable efforts made by Health Plan toward resolution within thirty (30) calendar days of receipt.

7.8 **Rate Adjustment**. In the event DHCS, CMS, or any other payor entity changes the rates payable to Health Plan during the term of this Agreement, Health Plan shall have the right to modify the rates to reflect changes of laws and regulations, changes in the State budget, changes to Regulating Agency policies, changes to Covered Services, or other changes which affect the revenue provided to Health Plan, by providing sixty (60) business days' written notice to Provider of Health Plan's intent to revise the rates ("Health Plan Notice"). Provider shall have the right to: (i) negotiate and agree to the change within thirty (30) business days of receipt of the Health Plan Notice, or (ii) to terminate the Agreement within sixty (60) business days from receipt of the Health Plan Notice. If no response is received by Provider exercising its right under the aforementioned subsections (i) or (ii), the changes reflected in the Health Plan Notice will be deemed accepted by Provider and will constitute an amendment to this Agreement, to be effective sixty (60) business days from the date of the Health Plan Notice (or as otherwise specified therein). Notwithstanding the foregoing, Provider will not have the right to reject any such change that is commensurate and proportionate to the changes made by DHCS, CMS, or other payor entity.

7.9 **Coordination of Benefits.**

a) Health Plan shall have the sole right to determine its coordination of benefits rules, in compliance with Title 28 of the California Code of Regulations, Section 1300.67.13.

b) Certain claims for Covered Services rendered to Members are claims for which another payor may be primarily or secondarily responsible under coordination of benefit rules. Health Plan and Provider shall cooperate in coordinating the applicable coordination of benefits rules.

c) Provider shall, upon the request of Health Plan, bill a payor which may be primary under applicable coordination of benefit rules for health services provided to Members when information regarding such primary payor becomes available to Provider.

7.10 **Third Party Liens**. Health Plan shall reserve its right to receive reimbursement pursuant to third party liens. Provider shall provide all information in its possession which is necessary to permit Health Plan to report Workers' Compensation and third-party lien information to the Department of Health Care Services.

ARTICLE 8.
DISPUTE RESOLUTION

8.1 Reserved.

8.2 **Small Claims Court**. Subject to the provisions of the California Government Claims Act (Government Code § 900 *et seq*.), if the amount in dispute by the Parties is within the jurisdictional limits of the small claims court, then such matter shall be submitted to the small claims court for resolution in lieu of arbitration. Such action shall take place in San Francisco, California.

8.3 **Limitation**. Any controversy, disagreement, dispute, or claim arising under this Agreement shall be deemed waived unless an action in small claims court or other legal action is initiated within the timeframe required to commence an action against a public entity under the California Government Claims Act.

ARTICLE 9.
GENERAL PROVISIONS

9.1 **Independent Contractors.** In the performance of each party's work, duties, and obligations pursuant to this Agreement, each of the Parties shall at all times act and perform as an independent contractor, and nothing in the Agreement shall be construed or deemed to create a relationship of employer and employee or partner or joint venture or principal and agent.

9.2 **No Volume Guarantee.** SFHP does not represent, warrant, or covenant any minimum volume of patients or Members to Provider.

9.3 **Non-Exclusivity.** This Agreement is non-exclusive and each Party shall have at all times the right to enter into agreements comparable to this Agreement with other persons or entities.

9.4 **Third Party Beneficiaries.** Neither Members nor any other third parties are intended by the Parties hereto to be third party beneficiaries under this Agreement, and no action to enforce the terms of this Agreement may be brought against either Party by any person who is not a party hereto.

9.5 **Mutual Indemnification.**

a) Provider shall defend, indemnify and hold SFHP, its officers, employees and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees) or claims for injury or damages caused by the acts or omissions of Provider, its officers, agents, or employees in the performance of this Agreement.

b) SFHP shall defend, indemnify and hold Provider, its officers, employees and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees) or claims for injury or damages caused by the acts or omissions of SFHP, its officers, agents, or employees in the performance of this Agreement.

9.6 **Notices.** Any notice required to be given hereunder shall be sent by: secure electronic mail or certified mail, postage pre-paid to the Parties and their respective copied entities, or in a format pre-determined and mutually agreed to by both Parties. The notice addresses for the Parties are:

To SFHP:
Chief Executive Officer
San Francisco Health Plan
PO Box 194247
San Francisco, CA 94119
yrichardson@sfhp.org

To Provider:
Executive Director
SF Dept. Disability & Aging Services
PO Box 7988
San Francisco, 94120-7988
kelly.dearman@sfgov.org

If Notice is Required to DHCS:
California Department of Health Care Services, Medi-Cal Managed Care Division
P.O. Box 997413, MS 4401
Sacramento, CA 95899-7413

9.7 **Partial Invalidity.** If for any reason any provision of this Agreement is held invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect without being impaired or invalidated in any way.

9.8 **Amendments**. No alteration and/or amendment of any terms or conditions of this Agreement shall be binding, unless reduced to writing and signed by the Parties hereto. Amendments may require regulatory approval; in the event a Regulating Agency disapproves either this Agreement or any subsequent amendment, the parties shall promptly meet and in good faith seek to modify the Agreement or amendment(s) in a manner which will receive approval and achieve the parties' intent. Notwithstanding the foregoing, Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, accreditation requirement, or regulation upon forty-five (45) business days' notice to Provider, unless a shorter timeframe is necessary for compliance.

9.9 **Non-Solicitation**. Provider will not engage in any activities involving the direct marketing or solicitation for enrollment to Members or eligible beneficiaries without the written approval of Health Plan and DHCS. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain. During the period of this Agreement and for a period of one year after termination, Provider and Provider's employees, agents and subcontractors shall not solicit or attempt to persuade any Member not to participate in the Medi-Cal Managed Care Program or any other Benefit Program for which Provider rendered Covered Services to Member. In the event of breach of this Section, in addition to any other of Health Plan's legal rights, Health Plan may, in its sole discretion, immediately terminate this Agreement. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

9.10 **Waiver of Breach.** The waiver of any breach of this Agreement by either Party shall not constitute a continuing waiver of any subsequent breach of either the same or any other provisions of this Agreement. No Party will be deemed to have waived any rights hereunder unless the waiver is made in writing and is signed by the waiving Party's duly authorized representative.

9.11 **Incorporation.** All exhibits referenced in this Agreement and attached hereto are incorporated herein by reference.

9.12 **Governing Law.** This Agreement shall be construed and enforced in accordance with the laws of the State of California, without regard to its conflicts of law provisions.

9.13 **Captions.** The captions contained herein are for reference purposes only and shall not affect the meaning of this Agreement.

9.14 **Entire Agreement.** This Agreement, including the Exhibits attached hereto, contains the entire agreement of the Parties and as of the Effective Date supersedes any prior contracts, agreements, negotiations, proposals, or understandings relating to the subject matter of this Agreement.

9.15 **Public Health Plan Requirements**. Provider understands and acknowledges that Health Plan is a local public entity of the State of California, which status requires Health Plan contractors to comply with specified requirements, including those requirements specific to its local jurisdiction of the City and County of San Francisco, as well as its status as a Medi-Cal managed care plan. Provider thus agrees to the additional terms and conditions set forth on Exhibit B, Compliance with Law (and any attachments thereto), attached hereto and incorporated herein by this reference.

9.16 **Assignment.** Neither Party shall assign, delegate, or transfer its rights, duties, or obligations under this Agreement without the prior written consent of the other Party and any Regulating Agencies, if applicable. Any subcontracts under this Agreement shall be in writing and shall

ensure that subcontractors comply with all applicable terms and conditions of this Agreement. Upon Health Plan's request, such written agreements between Provider and subcontractors, and any amendments thereto, shall be submitted to Health Plan for its review. Health Plan shall have the right to terminate a subcontractor's services at any time in the event subcontractor is not providing services in a manner that meets Health Plan's reasonable approval. Provider shall be responsible for conduct and performance of each approved subcontractor.

9.17 **Force Majeure**. No Party shall, at any time, be deemed to have breached any obligation under this Agreement, or be in default hereunder, or be liable for damages by reason of any circumstance or delay resulting from acts of nature (such as, but not limited to, fires, floods, explosions, earthquakes, hurricane, and drought); terrorism, war, hostilities, invasion, or acts of foreign enemies; rebellion, revolution, insurrection, or military or usurped power; contamination by radioactivity; vandalism, riot, or strikes; acts of governmental authority; or other events that are beyond the reasonable anticipation and control of the Party affected thereby.

9.18 **Compliance with Law**. Health Plan and Provider agree that each will comply with all applicable requirements of state and federal statutes and regulations, or any amendments or modifications thereto. This includes, without limitation, applicable requirements under the Knox-Keene Act (Health and Safety Code § 1340, *et seq*., and Title 28 of the California Code of Regulations ("CCR")), Medi-Cal (Title XIX of the Social Security Act and CCR, Title 22), Title VII of the Civil Rights Act of 1964, HIPAA, HITECH, safe harbor regulations (including Title 42, Section 1001.952(t) of the Code of Federal Regulations) and regulatory directives from applicable Regulating Agencies.

9.19 **Conflict of Interest**. The parties hereto and their respective employees or agents shall have no interest or obligation, and shall not acquire any interest or obligation, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

9.20 **Counterparts; Signatures**. This Agreement may be executed in separate counterparts, each of which shall be deemed an original, and all of which shall be deemed one and the same instrument. The parties' electronic or faxed signatures, and/or signatures scanned into PDF format, shall be effective to bind them to this Agreement.

9.21 **Survival**. Unless otherwise provided herein, the rights and obligations of any party which by their nature extend beyond the expiration or termination of this Agreement, shall continue in full force and effect, notwithstanding the expiration or termination of this Agreement.

9.22 **Interpretation of Agreement**. This Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of which party drafted the Agreement. Section headings are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

By their signatures below, each of the following represent that they have authority to execute this Agreement and to bind the Parties on whose behalf their execution is made.

SAN FRANCISCO HEALTH PLAN

Signature: DocuSigned by: Nina Maruyama 9D4617B1400D431...

Print Name: Nina Maruyama

Title: Chief Officer Compliance & Regulatory Affair

Date: 7/27/2023

CITY AND COUNTY OF SAN FRANCISCO, THROUGH THE HUMAN SERVICES AGENCY AND ITS SAN FRANCISCO DEPARTMENT OF DISABILITY AND AGING SERVICES

Signature: DocuSigned by: Trent Rhorer 9753A8870BB74EE...

Print Name: Trent Rhorer

Title: Executive Director

Date: 7/20/2023

Approved as to Form:
DAVID CHIU
City Attorney

By: DocuSigned by: 2833E4B81D244D9...

Date: 7/20/2023

Glenn M. Levy
Deputy City Attorney

EXHIBIT A
SERVICES, RATES AND LOCATIONS

1. SCOPE OF SERVICES.

Provider will render Enhanced Care Management ("ECM") services as defined and further described in Attachment A-1 to this Exhibit ("Enhanced Care Management Requirements") and the San Francisco Health Plan Enhanced Care Management Program Guide ("Program Guide") as amended periodically and available on SFHP's website at https://www.sfhp.org/. Both Attachment A-1 and the Program Guide are incorporated herein by reference.

Provider will render these services for Health Plan's Medi-Cal line of business only. ECM services shall be rendered in accordance with all requirements indicated in the attachments noted above, and those of the Agreement herein.

2. RATES.

Provider will accept the following rates as payment in full for Authorized ECM Covered Services for all ECM-eligible Members:

$300.00 per ECM service/ visit

$50.00 per outreach

Provider agrees to submit compete encounter data documenting all services provided to Members.

3. LOCATIONS.

Entities and locations covered by this Agreement and other relevant information:

Tax ID: 94-6000417
NPI: 1912615188
Address:Dept. of Disability & Aging Services, 1650 Mission Street, SF, CA 94103

ATTACHMENT A-1
ENHANCED CARE MANAGEMENT REQUIREMENTS

1. DEFINITIONS.

Community Supports means DHCS-approved services or settings that Health Plan offers in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives or settings under the State Plan.

Community Supports Provider means an individual or entity contracted with Health Plan to provide a Community Supports service approved by the DHCS.

Enhanced Care Management ("ECM") means 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.

ECM Provider means a Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM. For the purposes of this Attachment A-1, "ECM Provider" shall mean the same as "Provider" referenced in other areas of the Agreement.

Lead Care Manager means a Member's designated care manager for ECM, who works for the ECM Provider organization. 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.

Personal Information has the same meaning as the term "personal information" as defined in Information Practices Act at California Civil Code section 1798.3(a).

2. ECM PROVIDER REQUIREMENTS.

Provider Experience and Qualifications

a. ECM Provider shall be experienced in serving the ECM population(s) of focus it will serve, as assessed by and acceptable to Health Plan.

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

c. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS-Health Plan ECM and Community Supports contract and associated guidance. ECM Provider acknowledges additional requirements and guidance are available in the ECM Program Guide (hereafter "Program Guide"), as amended periodically, available on SFHP's website at https://www.sfhp.org/.

d. 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.

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

f. ECM Provider shall have processes and written agreements, such as a memorandum of understanding, 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.

g. 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).

Medicaid Enrollment/Vetting for ECM Providers

h. 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.

i. If APL 19-004 does not apply to an ECM Provider, the ECM Provider must comply with the Health 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.

Information Systems and Data Security

j. ECM Provider may utilize information technology ("IT") systems and platforms to provide the Covered Services listed herein. ECM Provider will be responsible for all costs related to use and maintenance of such information systems and other IT and communications systems. Systems and all data shall be monitored and safeguarded against physical and cybersecurity threats in accordance with industry best practices, compliant with HIPAA, California medical confidentiality laws, Health Plan's applicable government contracts (including but not limited to Health Plan's DHCS contract, Exhibit G), and any other applicable laws. ECM Provider shall furnish results of any third-party external information security assessments and copies of its information security policies to Health Plan upon request.

3. IDENTIFYING MEMBERS FOR ECM.

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

4. MEMBER ASSIGNMENT TO AN ECM PROVIDER.

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

b. ECM Provider shall immediately accept all Members assigned by Health 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. 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 notify Health Plan of Member's enrollment with ECM Provider for ECM on the next monthly enrollment report due to Health Plan, as outlined in the Program Guide. 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 to be initiated at any time.

   i. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.
   ii. ECM Provider shall notify Health Plan if the Member wishes to change ECM Providers.
   iii. Health Plan must implement any requested ECM Provider change within thirty 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, the DHCS-Health Plan ECM contract and any other related DHCS or Health Plan guidance.

b. ECM Provider shall submit regular capacity reports as outlined in the Program Guide.

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 the Program Guide.

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 and in compliance with applicable state and federal laws, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (a) mail, (b) email, (c) texts, (d) telephone calls, (e) telehealth.

d. 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 Personal Information and Protected Health Information between Health 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 obtain Member authorization for such data sharing and communicate back to Health Plan and maintain documentation of Member authorization in accordance with applicable laws.

d. ECM Provider shall notify Health Plan in a regular report, as outlined in the Program Guide, of its decision to discontinue ECM should the following circumstances apply to the Member:

   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.

8. <u>ECM REQUIREMENTS AND CORE SERVICE COMPONENTS OF ECM.</u>

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. ECM Provider shall participate in readiness and training activities facilitated by the Plan.

   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 and the DHCS-Health Plan ECM Community Supports contract.

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 Health 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 Health 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 Providers (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.

d. ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with DHCS ECM policies and procedures and the Program Guide, as follows:

   i. Outreach and Engagement of Health Plan Members into ECM, as described in this Attachment A-1 and the Program Guide.

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

      a. Engaging with each Member authorized to receive ECM primarily through in-person contact. 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.

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

c. Developing a comprehensive, individualized, person-centered care 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;

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

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

f. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight, and in accordance with Health Plan instructions in the Program Guide.

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

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

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

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

d. 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;

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

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

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

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

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

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

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

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

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

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

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

a. 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 Health Plan, as applicable;

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

c. 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);

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

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

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

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

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

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

9. TRAINING.

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

10. DATA SHARING TO SUPPORT ECM.

a. Health Plan will provide to ECM Provider the following data at the time of assignment and periodically thereafter, as outlined in the Program Guide, 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 and mutually agreed by Health Plan.

b. The Parties will ensure any such data sharing shall be in accordance with applicable laws and requirements of Regulatory Agencies for the protection of PHI and other confidential information.

11. CLAIMS SUBMISSION AND REPORTING.

a. ECM Provider shall submit claims for the provision of ECM-related services to Health Plan using the national standard specifications and code sets to be defined by DHCS, and as outlined in Exhibit A.

b. In the event ECM Provider is unable to submit claims to Health Plan for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to Health Plan with a minimum set of data elements (to be defined by DHCS) necessary for Health Plan to convert the invoice to an encounter for submission to DHCS. Invoices are to be submitted in accordance with the timely filing requirements applicable to claims outlined in the Claims Operations Manual. No payment shall be made for invoices that do not meet these standards.

12. QUALITY AND OVERSIGHT.

a. ECM Provider acknowledges Health Plan will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with all requirements, which will include regular audits and corrective actions as outlined below.

b. ECM Provider shall respond to all Health Plan requests for information and documentation in a timely manner to permit ongoing monitoring of ECM, including all reports required by Health Plan and as further detailed in the Program Guide.

c. In the event ECM Provider's performance is found deficient in rendering the services outlined herein, Health Plan may at any time provide notice of corrective action and shall set forth the deficiencies in ECM Provider's performance. Upon receipt of the notice, ECM Provider shall submit a corrective action plan to Health Plan within thirty (30) calendar days, subject to approval

by Health Plan, to correct such deficiencies within a time period mutually agreed upon by the Parties and to the reasonable satisfaction of Health Plan. Health Plan shall perform any additional audits, as necessary, to verify the completion of corrective action plan(s). In the event such deficiencies are not corrected to the reasonable satisfaction of Health Plan, Health Plan reserves the right to exercise any and all remedies available to Health Plan under this Agreement, including but not limited to termination of provider's status as a participating ECM Provider, and termination of the Agreement.

13. PAYMENT FOR ECM.

a. Health Plan shall pay contracted ECM Providers for the provision of ECM in accordance with Article 7 and Exhibit A of the Agreement.

b. ECM Provider is eligible to receive payment when ECM is initiated for any eligible Member who has been duly enrolled with ECM Provider for ECM.

EXHIBIT B
COMPLIANCE WITH LAW

Health Plan and Provider agree that each will comply with all applicable requirements of local, state, and federal laws and regulations, whether or not contained in this Exhibit. The parties shall comply with the legal requirements stated in this Exhibit B, which shall supplement the Agreement between Provider and Health Plan, and further understand that this Exhibit is not exhaustive.

In the event of any conflict between the terms and conditions of this Exhibit B (including any attachments) and those contained in the Agreement, the terms and conditions of this Exhibit shall control. Notwithstanding the foregoing, if such conflict is in regard to a retention period, the provision calling for the longer retention period shall control.

1. **Health Plan Licensing Requirements**. Provider understands that as a subcontractor of Health Plan, Provider is subject to the requirements set forth under the Knox-Keene Health Care Service Plan Act of 1975 and related regulations promulgated by the California Department of Managed Health Care, as further described on Attachment I, Health Plan Licensing Requirements.

2. **Medi-Cal Program Requirements**. Provider understands that Health Plan is a Medi-Cal Managed Care Health Plan and subject to requirements under applicable laws and regulations, as well as the contractual obligations set forth under the Medi-Cal Agreement. As a subcontractor to Health Plan, Provider is likewise required to comply with the requirements of the Medi-Cal program, as further described on Attachment II, Medi-Cal Program Provisions.

3. **Immigration Compliance**. Provider warrants, represents and agrees that Covered Services will not be performed under the Agreement by any person who is an unauthorized alien under the Immigration and Reform and Control Act of 1986 (as the same has been or may be amended) or its implementing regulations. Provider shall ensure that each and every person performing Covered Services shall be a citizen or permanent resident of the United States, or have a valid United States visa authorizing employment in the United States, and shall be permitted to work for federal contractors, including but not limited to Medicare and Medicaid contractors.

4. **Export Regulations**. Provider acknowledges its obligations to control access to technical data under the U.S. Export Laws and Regulations and agrees to adhere to such laws and regulations with regard to any technical data received under this Agreement.

5. **Federal Equal Opportunity Requirements**

    a) **Discrimination**. 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 pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship.

    b) **Posting**. Provider shall 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, the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 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. Such notices shall state 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.

6. **Fraud and Abuse Prevention and Detection**. Provider shall comply with all fraud and abuse related laws and regulations as well as any and all Health Plan fraud and abuse prevention requirements. This shall include, but is not limited to, the following:

   a) Provide Health Plan with all data needed to investigate potential cases of fraud and abuse;

   b) Permit Health Plan access to Provider's (and Provider's subcontractors') books and records and facilities in order to complete any fraud investigations;

   c) Require Provider to represent and warrant that all claims, encounter data and other report represents truthful and accurate information; and

   d) Require disclosure of any sanctions for a health care related offense of Provider or its subcontractors.

Attachment I to Exhibit B
Health Plan Licensing Requirements

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void. In the event of any conflict between the terms and conditions of the Agreement, including those by amendment or attachment, and those contained in this Attachment I to Exhibit B, the terms and conditions of Attachment I to Exhibit B shall control.

DMHC Provisions

1) In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from a Member or subscriber any sums owed to Provider by the Health Plan. Provider, or agent, trustee, or assignee thereof, may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the Provider by Health Plan. (Health and Safety Code Section 1379)

2) To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)

3) Provider is responsible for coordinating the provision of health care services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))

4) Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))

5) Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))

6) To the extent Provider has any role in rendering emergency health care services, Provider shall make such emergency health care services available and accessible twenty-four (24) hours a day, seven days a week. (Rule 1300.67.2(c))

7) Provider shall participate in Health Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67.2(f))

8) Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Chapter 2.2 of Division 2 of the Health and Safety Code), and the Regulations promulgated hereunder (Chapter 2, Division 1 of Title 28 of the California Code of Regulations). Any provision of the aforementioned statutes or regulations that are required to be in this Agreement shall bind the Health Plan whether or not expressly set forth in this Agreement. (Rule 1300.67.4(a)(9))

9) Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code Section 1373.96) (Rule 1300.67.4(a)(10))

10) Any written communications to Members that concern a termination of this agreement shall comply with the notification requirements set forth in Health and Safety Code Section 1373.65(f)

11) Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least ten years; this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code Section 1381)

12) Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c)). If Provider has been delegated claims processing services, Provider shall also make available to Health Plan and DMHC all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes. Rule 1300.71(e)(4).

13) Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services. Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14) Upon Health Plan's request, provider shall report all co-payments paid by Members to provider. (Health and Safety Code Section 1385)

15) To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16) Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Claims Department, San Francisco Health Plan, P.O. Box 194247, San Francisco, CA 94119 Phone 415-547-7818 ext. 7115. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17) The written contract between Health Plan and Provider shall be prepared or arranged in a manner which permits confidential treatment by the Director of payment rendered or to be rendered to the provider without concealment or misunderstanding of other terms and provisions of the Agreement.

18) For any material revision to the Agreement or to the sub-delegation of duties by the parties, the parties shall receive prior authorization from the DMHC. (Rule 1300.52.4)

19) A description of the grievance procedure shall be readily available at each Provider facility. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68(b))

20) In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third-party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code Section 3040.

21) Provider is entitled to all protections afforded under the Health Care Providers' Bill of Rights. (Health & Safety Code Section 1375.7)

22) Health Plan and Provider shall comply with the provisions of Section 56.107 of the California Civil Code. Upon Health Plan's notification to Provider about a Member's request for confidential communication, as defined in California Civil Code § 56.107, Provider shall provide communications to Member in the form and format, or at alternative locations, as requested by Member. Health Plan and Provider shall not require a Protected Individual to obtain the policyholder, primary subscriber, or other enrollee's authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the Protected Individual has the right to consent to care. The terms "Protected Individual" and "Sensitive Services" shall have the meanings prescribed under California Civil Code Section 56.05. Health Plan and Provider shall direct all communications regarding a Protected Individual's receipt of Sensitive Services directly to the Protected Individual in the form and format, or at alternative locations, as requested by the Protected Individual and in compliance with Section 56.107, subsections (a)(3) and (b)(1) of the California Civil Code. Health Plan and Provider recognize the right of a Protected Individual to exclusively exercise rights granted under Section 56.107 regarding medical information related to Sensitive Services, and neither Health Plan nor Provider shall disclose medical information related to Sensitive Services provided to a Protected Individual to the policyholder, primary subscriber, or any Health Plan enrollee other than the Protected Individual receiving care, absent an express written authorization. Health Plan shall not condition enrollment or coverage on the waiver of rights provided in this Section. (Health & Safety Code § 1348.5; California Civil Code §§ 56.107, 56.05, and 56.35)

23) Health Plan and Provider agree that there are no monetary or other incentives to induce Provider or its Participating Providers to: (i) provide care to a Member in a manner inconsistent with the coverage requirements; nor to (ii) deny, reduce, limit, or delay specific, medically necessary,

and appropriate services provided with respect to a specific Member or groups of Members with similar medical conditions. (Health & Safety Code §§ 1367.62(a)(3) and 1348.6).

24) Where Provider's or Provider personnel's licensure or certification is required by law, Provider and/or its personnel shall be licensed or certified by its respective board or agency. If Provider's equipment is required to be licensed or registered by law, it shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law. (Health & Safety Code § 1367(b) and (c)).

25) In the event Provider has been delegated claims processing services, Provider shall be obligated to accept and adjudicate claims for health care services provided to Members, and establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes, in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations. (28 CCR 1300.71(e)).

Attachment II to Exhibit B
Medi-Cal Program Provisions

Provider understands that Health Plan is a Medi-Cal Managed Care Health Plan and subject to requirements under applicable laws, regulations, and contractual obligations set forth under the contract between Health Plan and the California Department of Health Care Services (the "Medi-Cal Agreement"). This Exhibit sets forth requirements pursuant to DHCS APL 17-004 and the Medi-Cal Agreement, and applies to contracts with any individual or entity who is classified as a "subcontractor" of Health Plan, as that term is defined in 42 C.F.R. § 438.2. In the event of any conflict between the terms and conditions of the Agreement, including those by amendment or attachment, and those contained in this Attachment II to Exhibit B, the terms and conditions of Attachment II to Exhibit B shall control.

Provider has been identified as a subcontractor of Health Plan and subject to the requirements below.

1. **Compliance with Legal and Regulatory Requirements and the Medi-Cal Managed Care Program**. Provider agrees to comply with all applicable state and federal Medicaid laws and regulations, including applicable sub regulatory guidance, contractual requirements set forth under the Medi-Cal Agreement, and the applicable requirements of the Medi-Cal Managed Care Program. Provider further understands and agrees that this Agreement is governed by and construed in accordance with all laws and applicable regulations governing the contract between Health Plan and DHCS. (22 C.C.R. § 53250(c)(2); Exhibit A, Attachment 6, Provisions 14.B.2 and 14.B.21 of the Medi-Cal Agreement)

2. **Approval by DHCS**. Provider understands that the Agreement is effective upon written approval by DHCS, or by operation of law where DHCS has acknowledged receipt and has failed to approve or disapprove the Agreement within 60 days of receipt. Amendments shall be submitted to DHCS for prior approval, at least 30 days before the effective date of any proposed changes governing compensation, services, or terms. Proposed changes, which are neither approved nor disapproved by DHCS, shall become effective by operation of law thirty (30) calendar days after DHCS has acknowledged receipt, or upon the date specified in the amendment, whichever is later. (22 C.C.R. § 53250(c)(3); Exhibit A, Attachment 6, Provision 14.B.3 of the Medi-Cal Agreement)

3. **Emergency Services**. In the event that Provider is delegated risk for non-contracting emergency services, Provider shall provide the services in compliance with applicable State and Federal law as well as applicable sections of the Medi-Cal Agreement (including but not limited to, 22 CCR § 53855 and Exhibit A, Attachment 8, Provision 13 of the Medi-Cal Agreement). (Exhibit A, Attachment 6, Provision 14.B.5 of the Medi-Cal Agreement)

4. **Reports**. Provider agrees to submit any reports required by Health Plan, in a form acceptable to Health Plan. (22 C.C.R. § 53250(c)(5); Exhibit A, Attachment 6, Provision 14.B.6 of the Medi-Cal Agreement)

5. **Monitoring Rights**. Provider shall comply with all monitoring provisions of the Medi-Cal Agreement and any monitoring requests by DHCS. Provider understands that authorized State and Federal agencies have the right to monitor all aspects of Health Plan's operation for proper compliance, including, the inspection and auditing of Provider, which can be announced or unannounced. Provider is required to provide reasonable facilities, cooperation, and assistance to such agency representatives in the performance of their duties. (42 C.F.R. § 438.3(h); Exhibit A, Attachment 6, Provision 14.B.7 of the Medi-Cal Agreement)

6. **Audit and Inspection**. 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 the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20 of the Medi-Cal Agreement:

    a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees.

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

    c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

    d) For a term of at least ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

    e) Including all Encounter Data, as applicable, for a period of at least 10 years.

    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 Provider at any time.

    g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal program; seek recovery of payments made to Provider; impose other sanctions provided under the State Plan, and direct Health Plan to terminate the Agreement due to fraud.

    (42 C.F.R. § 438.3(h); 22 C.C.R. § 53250(e)(1); Exhibit A, Attachment 6, Provision 14.B.8 of the Medi-Cal Agreement)

7. **Policies and Procedures**. Provider shall implement and maintain policies and procedures that are designed to detect and prevent fraud, waste, and abuse. (DHCS All Plan Letter 17-004)

8. **Provider Subcontracts**. Provider agrees to maintain and make available to DHCS, upon request, copies of all subcontracts and to ensure that all subcontracts are in writing and require that the subcontractor:

    a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to the Agreement , 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.

b) Retain all records and documents for a minimum of ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

(22 C.C.R. § 53250(e)(3); Exhibit A, Attachment 6, Provision 14.B.10 of the Medi-Cal Agreement)

9. **Transfer of Care**. In the event the Medi-Cal Agreement between Health Plan and DHCS is terminated, Provider shall assist Health Plan in the orderly transfer of Members and medical care, as required by the Medi-Cal Agreement; including but not limited to, making available to DHCS copies of medical records, patient files, and any other pertinent information, necessary for efficient case management of Members. Provider further agrees to assist Health Plan in the orderly transfer of care in the event the contract between Provider and a subcontractor is terminated. (Exhibit A, Attachment 6, Provisions 14.B.11 and 14.B.12 of the Medi-Cal Agreement)

10. **Notice to DHCS**. Health Plan agrees to notify DHCS on behalf of Provider and Health Plan in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the U.S. Postal Service as first-class registered mail, postage attached. (22 C.C.R. § 53250(e)(4); Exhibit A, Attachment 6, Provision 14.B.13 of the Medi-Cal Agreement)

11. **Assignment and Delegation**. Provider agrees that assignment or delegation of this Agreement is void unless prior written approval is obtained from DHCS in those instances where prior approval by DHCS is required. (22 C.C.R. § 53250(e)(5); Exhibit A, Attachment 6, Provision 14.B.14 of the Medi-Cal Agreement)

12. **Hold Harmless**. Provider agrees to hold harmless both the State and Members in the event Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. Provider shall further ensure that any subcontracts contain this requirement. (22 C.C.R. § 53250(e)(6); Exhibit A, Attachment 6, Provision 14.B.15 of the Medi-Cal Agreement)

13. **Records Related to Litigation**. Provider agrees to timely gather, preserve, and provide to Health Plan and/or DHCS, any records in Provider's possession, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Provider's possession relating to threatened or pending litigation by or against DHCS related to this Agreement. Provider agrees to use all reasonable efforts to immediately notify Health Plan and DHCS of any subpoenas, document production requests, or requests for records, received by Provider related to this Agreement. Provider shall further ensure that any subcontracts contain this requirement. (Exhibit A, Attachment 6, Provision 14.B.16 of the Medi-Cal Agreement)

14. **Interpreter Services**. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites. (Exhibit A, Attachment 6, Provision 14.B.17 of the Medi-Cal Agreement)

15. **Provider Grievances**. Provider understands that it has a right to submit a grievance to Health Plan, which includes any complaint, dispute, request for consideration, or appeal, in accordance with Health Plan's process to resolve provider grievances. (Exhibit A, Attachment 6, Provision 14.B.18 of the Medi-Cal Agreement)

16. **Quality Improvement System**. Provider agrees to participate and cooperate in Health Plan's Quality Improvement System. If Health Plan has delegated Quality Improvement activities to Provider, the Agreement shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6 (Delegation of Quality Improvement Activities). The Agreement shall include, at minimum:

    a. Quality improvement responsibilities, and specific delegated functions and activities of the Health Plan and Provider.

    b. Health Plan's oversight, monitoring, and evaluation processes and Provider's agreement to such processes.

    c. Health Plan's reporting requirements and approval processes, and Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

    d. Health Plan's actions/remedies if Provider's obligations are not met.

    (Exhibit A, Attachment 6, Provisions 14.B.19 and 14.B.20 of the Medi-Cal Agreement; Exhibit A, Attachment 4, provision 6.A of the Medi-Cal Agreement)

17. **Revocation of Delegated Activities**. Provider agrees to allow revocation of delegated activities or obligations or specify other remedies in instances where DHCS or Health Plan determines that the Provider has not performed satisfactorily. (42 C.F.R. § 438.230(c)(iii); Exhibit A, Attachment 6, Provision 14.B.22 of the Medi-Cal Agreement)

18. **Data Sharing for Coordination of Care**. If Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use it as Provider is able for the purpose of Member care coordination. (42 C.F.R. § 438.208; Exhibit A, Attachment 6, Provision 14.B.23 of the Medi-Cal Agreement)

19. **Changes to DHCS Contract**. Health Plan agrees to inform Provider of prospective requirements added by DHCS to the contract between Health Plan and DHCS before the requirement would be effective, and Provider agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS and to the extent possible. (Exhibit A, Attachment 6, Provision 14.B.24 of the Medi-Cal Agreement)

20. **Disclosure Statement** . Provider understands that DHCS mandates specified information regarding ownership and control interests to be disclosed due to Provider's relationship to Health Plan. Provider shall complete the Disclosure Statement in compliance with DHCS requirements. (42 C.F.R. § 455.104; DHCS All Plan Letter 17-004)

21. **Recovery from Other Sources**. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. Provider shall report to the Health Plan and DHCS within ten (10) days after discovery of any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award. (Exhibit E, Attachment 2, Provision 24 of the Medi-Cal Agreement)

22. **Provider Data**. If applicable, Provider shall submit to Health Plan complete, accurate, reasonable, and timely provider data needed (and requested) by Health Plan in order to meet its provider data reporting requirements to DHCS. Such provider data may include, but not be

limited to, claims and payment data, health care services delivery Encounter Data, and network information as may be required by the Medi-Cal Agreement. (Exhibit A, Attachment 3, Provision 1 of the Medi-Cal Agreement; DHCS All Plan Letter 16-019)

23. **Encounter Data**. If applicable, Provider shall submit to Health Plan complete, accurate, reasonable, and timely Encounter Data needed by Health Plan in order for Health Plan to meet its encounter data reporting requirements to DHCS. (Exhibit A, Attachment 3, Provisions 2.C and 2.G of the Medi-Cal Agreement; DHCS All Plan Letter 14-019)

24. **Prohibition of Balance Billing.** Provider shall not collect reimbursement or balance bill a Medi-Cal member for the provision of covered services. (Exhibit A, Attachment 8, Provision 6 of the Medi-Cal Agreement)

25. **Provider Training**. Health Plan shall provide, and Provider shall participate in, cultural competency, sensitivity and diversity training. (Exhibit A, Attachment 9, Provision 13.E of the Medi-Cal Agreement)

26. **Protected Health Information (PHI)**. As a condition of obtaining access to records utilized/maintained by Health Plan for the Medi-Cal Program, Provider agrees not to divulge any information obtained in the course of performing services under this Agreement to unauthorized persons. Provider further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services, which would identify or make identifiable such persons. Provider acknowledges receipt of a copy of Exhibit G of the Medi-Cal Agreement, and agrees to the applicable restrictions and conditions therein with respect to such PHI. (Exhibit G, Provision III.E.1 of the Medi-Cal Agreement)

27. **Cultural & Linguistic Services**. Provider agrees to cooperate with Health Plan's language assistance program developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04.

EXHIBIT C

SAN FRANCISCO HEALTH PLAN
HIPAA PRIVACY AND SECURITY BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement, effective as of July 1, 2023 (the "Effective Date") is made by and between **San Francisco Health Authority doing business as San Francisco Health Plan ("Health Plan")** and the City and County of San Francisco acting by and through the **San Francisco Department of Disability and Aging Services ("Contractor")**, with reference to the following:

A. Health Plan and Provider are parties to the Enhanced Care Management Fee For Service Provider Agreement (the "Agreement") (executed or to be executed) pursuant to which Provider provides or will provide a service to, or performs a function on behalf of, Health Plan and, in connection therewith, uses, discloses or has access to Protected Health Information ("PHI"), which includes Electronic Protected Health Information ("EPHI"), that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the American Recovery and Reinvestment Act of 2009 ("ARRA"), the Health Information Technology for Economic and Clinical Health ("HITECH"), certain privacy and security regulations found at 45 CFR Parts 160 and 164 ("HIPAA Regulations"), and California Civil Code Section 56.107;

B. In preparation for the Agreement, the Parties have found it necessary to exchange data, including PHI, in electronic transactions;

C. Health Plan is a Covered Entity as that term is defined in the HIPAA Regulations. Provider, creates, receives or has access to PHI and/or EPHI from or on behalf of Health Plan and is, therefore, a Business Associate, as defined in the HIPAA Regulations;

D. Upon full execution of the Agreement, the Parties agree that this Business Associate Agreement shall be inserted as "Exhibit C" to the Agreement, and shall cover the preparatory phases of the Agreement, as well as the continued use, disclosure, and/or access of Health Plan PHI by Provider, as further detailed in the Agreement and this Business Associate Agreement;

E. Pursuant to the HIPAA Regulations, Provider, as a Business Associate of Health Plan, must agree in writing to certain mandatory provisions regarding the safeguarding, use and disclosure of PHI; and

F. The purpose of this Business Associate Agreement is to satisfy the Business Associate contract requirements as set forth at § 164.314(a) and § 164.504(e) of the HIPAA Regulations, as they may be amended from time-to-time.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. Definitions. Unless otherwise provided in this Business Associate Agreement, capitalized terms have the same meaning as set forth in the HIPAA Regulations. PHI, unless otherwise specifically stated, shall include both PHI and EPHI.

2. Scope of Use and Disclosure of PHI. Except as otherwise limited in this Business Associate Agreement:

a. Provider shall use and disclose PHI solely to provide the services, or perform the functions, described in the Agreement, provided that such use or disclosure would not violate the HIPAA Regulations if so used or disclosed by Health Plan.
b. Provider may use or disclose PHI for the proper management and administration of Provider or to provide Data Aggregation services to Health Plan, provided that such use or disclosure is required by law, or Provider obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Provider of any instances of which it is aware in which the confidentiality of the information has been breached. When using or disclosing PHI, Provider shall limit PHI to a limited data set as defined at 45 CFR 164.514(3)(2) and to the minimum data necessary to accomplish the intended purpose of using or disclosing the PHI.

3. Obligations of Provider. Provider shall:
   a. Not use or disclose PHI other than as permitted or required by the Agreement or as Required by Law. As required by §164.502(b) of the HIPAA Regulations, when using or disclosing PHI, or requesting PHI from Health Plan, Provider shall make reasonable efforts to limit the PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request
   b. Use reasonable and appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 to prevent use or disclosure of the PHI other than as provided for by this Business Associate Agreement. Provider further acknowledges that it is subject to the requirements of 45 CFR 164.308, 164.310, 164.312, and 164.316 to the same extent such requirements are applicable.
   c. Mitigate, to the extent practicable, any harmful effect that is known to Provider of a use or disclosure of PHI by Provider in violation of the requirements of this Business Associate Agreement.
      1. With respect to PHI in computerized form (EPHI) involving Medi-Cal beneficiaries, report to Health Plan any breach or Security Incident of which Provider becomes aware, within 24 hours of discovery of the Incident, including after hours, weekends, and holidays.
   d. With respect to breaches or security incidents that impact non-Medi-Cal beneficiaries, Provider agrees to notify Health Plan of any Breach of Unsecured PHI in accordance with 45 CFR 164.410. Such notification shall be made in as expeditious a manner as possible and in no event later than 30 calendar days after discovery.
   e. Report to Health Plan uses or disclosures of the PHI not provided for by this Business Associate Agreement of which Provider becomes aware, which do not meet the low probability requirement that demonstrates that there is a low probability that the protected health information has been compromised.
      1. To demonstrate that there is in fact a “low probability” that PHI has been compromised, the BA must perform a risk assessment of at least the following factors:
         - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
         - The unauthorized person who used the PHI or to whom the disclosure was made;
         - Whether the PHI was actually acquired or viewed; and
         - The extent to which the risk to PHI has been mitigated.
      2. The BA’s risk assessments shall be thorough and completed in good faith and for the conclusions reached to be reasonable.
      3. If an evaluation of the factors fails to demonstrate that there is a low probability that PHI has been compromised, breach notification is required.
   f. In accordance with 45 CFR 164.502(e)(1)(ii), require contractors, subcontractors, and/or agents to whom Provider provides PHI created or received by Provider on behalf of Health Plan to agree to the same restrictions, conditions, and requirements that apply to Provider with respect to such PHI under the Agreement.

g. If applicable, provide access, at the request of Health Plan, and in the time and manner as designated by Health Plan, to PHI in a Designated Record Set, to Health Plan in order to meet the requirements under § 164.524 of the HIPAA Regulations. If Health Plan and Provider mutually agree, Provider may provide such access directly to Individual, provided that such access is provided to the Individual in the time-frames set forth in § 164.524 of the HIPAA Regulations.
h. If applicable, make any amendment(s) to PHI in a Designated Record Set that the Health Plan directs or agrees to pursuant to § 164.526 of the HIPAA Regulations at the request of Health Plan in the time and manner as designated by the Health Plan
i. Make internal practices, books, and records, including, but not limited to, policies and procedures, relating to the use and disclosure of PHI created or received by Provider on behalf of Health Plan available to the Secretary, and to Health Plan, if requested, in a time and manner designated by the Secretary, for purposes of the Secretary determining Health Plan's compliance with the HIPAA Regulations.
j. Maintain for a period of six (6) years an accounting of all disclosures of PHI that are required to be maintained under § 164.528 of the HIPAA Regulations. Such accounting will include at a minimum the date of the disclosure, the name and address of the recipient, a description of PHI disclosed and the purpose of the disclosure that reasonably informs the Individual of the basis for the disclosure.
k. If applicable, provide to Health Plan in time and manner as directed by Health Plan, information collected in accordance with Section 3.k. of this Business Associate Agreement, to permit Health Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with § 164.528 of the HIPAA Regulations. If Health Plan and Provider mutually agree, Provider may provide such accounting directly to Individual, provided that such accounting is provided to the Individual in the time-frames set forth in § 164.528 of the HIPAA Regulations.
l. Make reasonable efforts to implement any restriction of the use or disclosure of PHI that Health Plan has agreed to under Section 4.c. of this Business Associate Agreement.
m. With respect to EPHI, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that Provider creates, receives, maintains, or transmits on behalf of Health Plan as required by 45 CFR Part 164, Subpart C.
n. With respect to EPHI, ensure that any agent, including a subcontractor, to whom Provider provides EPHI, agrees to implement reasonable and appropriate safeguards to protect the EPHI.
o. Provide Health Plan with a complete report of all breaches or security incidents in accordance with §164.410 of the HIPAA Regulations. Provider shall send the completed report to Health Plan without unreasonable delay and in no case later than forty-five (45) calendar days after Provider's discovery of the breach. Such breach report shall include at minimum the following, to the extent available to Provider:
    1. The identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, or disclosed during the breach.
    2. A brief description of what happened.
    3. A description of the types of unsecured PHI that were involved in the breach (e.g., name, social security number, date of birth, CPT, diagnosis, etc.).
    4. Steps the Individuals should take to protect themselves from harm resulting from the breach.
    5. A description of what is being done to investigate the Breach, to mitigate harm to Individuals, and to protect against further Breaches.
    6. Contact information for Individuals to obtain additional information.

p. Reports for Medi-Cal beneficiaries may require additional report elements, which the Health Plan will provide to Provider. Provider shall work with Health Plan to comply with the reporting requirements of the Medi-Cal program.

q. Provider shall also comply with all the requirements of a Business Associate under the HITECH Act and the requirements of 45 CFR Sections 164.308, 164.310, 164.312 and 164.316. The written policies and procedures and documentation required by 45 CFR Section 164.316 shall be made available to Health Plan, upon Health Plan's request. The additional requirements of the HITECH Act that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby are incorporated into this Business Associate Agreement.

r. Provider agrees that it is subject to and will abide by the restrictions and conditions contained in Exhibit G of Client's contract with DHCS, to which Provider confirms receipt.

s. Provider understands that under some circumstances Health Plan may be the Business Associate of other entities whose PHI may be in the possession of Health Plan, and that such PHI of other entities could be disclosed by Health Plan in connection with the Agreement. To the extent that any PHI of other entities is disclosed to Provider, and to the extent that Health Plan serves as a Business Associate of such other entities, Provider agrees to the Business Associate restrictions and requirements of any separate Business Associate agreement that Health Plan may have with such other entities concerning the PHI in question.

4. Obligations of Health Plan. Health Plan shall:
   a. Provide Provider with the notice of privacy practices that Health Plan furnishes to Individuals in accordance with § 164.520 of the HIPAA Regulations.
   b. Promptly notify Provider of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Provider's use or disclosure of PHI.
   c. Promptly notify Provider of any restriction to the use or disclosure of PHI that Health Plan has agreed to in accordance with § 164.522 of the HIPAA Regulations, to the extent that such restriction may affect Provider's use or disclosure of PHI.
   d. Not request Provider to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if so used or disclosed by Health Plan, unless such use or disclosure is necessary for the purposes of Data Aggregation or management and administrative activities of Provider under the Agreement.

5. Termination for Breach. Upon Health Plan's knowledge of a material breach of the terms of this Business Associate Agreement by Provider, Health Plan shall, in accordance with the notification requirement and cure period set forth in the Agreement, terminate such Agreement**.**

6. Future Confidentiality of PHI. Upon the expiration or earlier termination of the Agreement, for any reason, Provider shall return or destroy all PHI received from Health Plan, or created or received by Provider on behalf of Health Plan, and provide written certification that Provider retains no copies of such PHI; provided that Provider shall provide to Health Plan notification of any conditions that Provider believes make the return or destruction of PHI infeasible. If Health Plan agrees that return or destruction of PHI is infeasible, Provider shall extend the protections of this Business Associate Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Provider maintains such PHI.

7. Amendment. The parties agree to take such action to amend this Business Associate Agreement from time-to-time as is necessary for Health Plan to comply with the requirements of HIPAA and the HIPAA Regulations.

8. Survival. The respective rights and obligations of Provider under Section 6 of this Business Associate Agreement shall survive the termination of the Agreement.

9. Interpretation. Any ambiguity in this Business Associate Agreement shall be resolved to permit Health Plan to comply with the HIPAA Regulations.

10. Conflict of Terms. Whenever the terms of this Business Associate Agreement and the Agreement (or any attachments thereto) are in conflict, the terms of this Business Associate Agreement shall control.

11. Other Terms Remain in Force. Except as expressly modified by the terms of this Business Associate Agreement, all of the terms and conditions set forth in the Agreement shall remain in full force and effect.

12. Indemnification. Provider agrees to defend, indemnify and hold Health Plan harmless from and against any and all claims, losses, liabilities or expenses (including without limitation attorneys' fees and any fines, penalties, or other such applicable costs) which may arise, in whole or in part, out of a breach or violation by Provider of its obligations under this Agreement or applicable law.

13. Provider agrees that Health Plan shall be entitled, without waiving any additional rights or remedies otherwise available to Health Plan at law or in equity or by statute, to injunctive and other equitable relief in the event of a breach or intended or threatened breach by Provider of any of Provider's covenants set forth herein. In the event such equitable relief is sought in connection herewith, Provider agrees to waive any requirement for the securing or posting of any bond in connection with such remedy.

14. Disclaimer. Health Plan makes no warranty or representation that compliance by Provider with this Agreement is satisfactory for Provider to comply with any obligations it may have under the HIPAA Regulations or any other applicable law or regulation pertaining to the confidentiality, use or safeguarding of health information. Provider is solely responsible for all decisions it makes regarding the use, disclosure or safeguarding of PHI.

15. Encryption. Electronic PHI transmitted or otherwise transferred between the parties must be encrypted by a process that renders the Electronic PHI unusable, unreadable, or indecipherable to unauthorized individuals within the meaning of §13402 of the HITECH Act and any implementing guidance, including but not limited to 45 C.F.R. § 164.402.

16. Effective Date. This Business Associate Agreement shall be effective on the Effective Date, as defined in the introductory paragraph herein.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the parties have executed this Business Associate Agreement as of the date(s) set forth below.

Executed at San Francisco, CA

CITY AND COUNTY OF SAN FRANCISCO, THROUGH THE HUMAN SERVICES AGENCY AND ITS SAN FRANCISCO DEPARTMENT OF DISABILITY AND AGING SERVICES

DocuSigned by:
Trent Rhorer
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By

Printed: Trent Rhorer

Title: Executive Director

Date: 7/20/2023

SAN FRANCISCO HEALTH PLAN

DocuSigned by:
Nina Maruyama
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By:

Nina Maruyama
Printed:

Chief Officer Compliance & Regulatory Affair
Title:

7/27/2023
Date: