San Francisco Health Plan and
City and County of San Francisco
Enhanced Care Management
Fee For Service Provider Agreement

Amendment Number 3

THIS AMENDMENT (this "Amendment") is made as of May __, 2025, in San Francisco, California, by and between San Francisco Health Authority, a local governmental entity doing business as the San Francisco Health Plan (hereinafter referred to as "Health Plan" or "SFHP"), and the City and County of San Francisco, a municipal corporation (hereinafter referred to as "Community Supports Provider" or "City"), acting by and through its Executive Director of the Department on Disability and Aging Services.

Recitals

WHEREAS, City and SFHP have entered into the Agreement (as defined below) whereby City provides Enhanced Care Management ("ECM") services to Health Plan enrollees on a fee-for-service basis; and

WHEREAS, City and SFHP desire to modify the Agreement on the terms and conditions set forth herein to clarify the maximum anticipated revenues/reimbursement coming to the City pursuant to Article 7 of the Agreement, increase the total fiscal provisions of the Agreement, address other contractual language, and incorporate reimbursement for multidisciplinary team conference services; and

WHEREAS, this Amendment has been approved by the City's Board of Supervisors under Resolution No. _____ approved on May ___, 2025, in the amount listed below for the period commencing July 1, 2023, and ending June 30, 2025, with the option of up to three additional one-year term extensions through June 30, 2028.

Now, THEREFORE, the parties agree as follows:

1. Agreement. The term "Agreement" shall mean the Agreement titled "San Francisco Health Plan Enhanced Care Management Fee For Service Provider Agreement" and dated July 1, 2024, between SFHP and City including as previously modified by the First Amendment to the Agreement dated September 12, 2023, and the Second Amendment to the Agreement dated January 21, 2025.

2. Other Terms. Terms used and not defined in this Amendment shall have the meanings assigned to such terms in the Agreement.

3. Increase to Anticipated Revenue and Revenue Limit. Section 7.1.a) of the Agreement, "Anticipated Revenue and Revenue Limit," is hereby added to read as follows:

a) **Anticipated Revenue and Revenue Limit**. SFHP and Provider anticipate the total compensation to Provider under this Agreement will not exceed three million, nine-hundred forty-four thousand dollars ($3,944,000.00). In no event will the total compensation to Provider reach or exceed three million, nine-hundred forty-four thousand dollars ($3,944,000.00) without a written amendment to this Agreement as set

forth in the Agreement and also in compliance with Section 9.118 of the San Francisco Charter. Either Party may immediately terminate this Agreement without prior notice or compliance with other requirements listed in Article 2, above, if the total compensation amount reaches or exceeds the listed not-to-exceed limit.

4. Addition of Acts or Omissions Language. Section 8.4 of the Agreement, "Acts or Omissions," is hereby added to read as follows:

8.4. **Acts or Omissions**. The Plan and Provider are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in a contract with providers is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part of a plan, any entity contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.

5. Replacement of Exhibit A. Exhibit A, "Services, Rates and Locations," including any attachments to that Exhibit, is deleted and replaced with the attached Exhibit A, "Enhanced Care Management Provider Terms (effective April 1, 2024)", including any attachments to that replacement Exhibit.

6. Effective Date. Each of the modifications set forth above shall be effective on and after the date of this Amendment.

7. Legal Effect. Except as expressly modified by this Amendment, all of the terms and conditions of the Agreement shall remain unchanged and in full force and effect.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, Contractor and City have executed this Amendment as of the date first referenced above.

CITY

_____
Kelly Dearman
Executive Director
Department of Disability and Aging Services

Approved as to Form:

David Chiu
City Attorney

By: _____
Glenn M. Levy
Deputy City Attorney

SAN FRANCISCO HEALTH PLAN

_____
Jenn Moore
Chief Financial Officer

EXHIBIT A

ENHANCED CARE MANAGEMENT PROVIDER TERMS

1. SCOPE OF SERVICES.

Provider will render Enhanced Care Management ("ECM") Covered Services as defined and further described in Attachment A-1, "Enhanced Care Management Requirements," to this EXHIBIT A , and the ECM Provider Guide ("Provider Guide") as amended periodically and to be available on SFHP's website at https://www.sfhp.org/ - both incorporated herein by reference.

Health Plan may modify the Provider Guide from time to time by written notice to Provider at least sixty (60) calendar days prior to the effective date of the modification, unless a change in federal or state law or regulations or NCQA requirements requires a shorter timeframe for compliance. If Provider disagrees with the modification(s), then the parties will meet and in good faith negotiate a mutually acceptable modification to the update, including mutual agreement on the effective date of the update. If the parties are unable to negotiate a mutually acceptable modification, then either party will have the right to terminate this Amendment. A copy of the Provider Guide will be provided to Provider prior to the execution of this Amendment. Only with regard to ECM Covered Services, to the extent of any conflict between the Provider Guide and the Agreement, the terms of the Provider Guide shall govern.

Provider will render these services for Health Plan's Medi-Cal line of business only. ECM Covered Services shall be rendered in accordance with all requirements indicated in the documents 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

$200.00 per Multidisciplinary Team Conference (provided/ initiated by ECM Provider's clinical staff) per member per month

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

3. ENTITY INFORMATION.

Entities covered by this Agreement and other relevant information:

Tax ID: 94-6000417
NPI: 1912615188

ATTACHMENT A-1
ENHANCED CARE MANAGEMENT REQUIREMENTS

1. DEFINITIONS.

Community Supports means, pursuant to 42 CFR 438.3(e)(2), 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 Medi-Cal 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 Provider Guide (hereafter "Provider 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).

<u>Medicaid Enrollment/Vetting for ECM Providers</u>

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.

<u>Information Systems and Data Security</u>

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 Exhibit G of the Medi-Cal Agreement), 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 Provider 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 (10) 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 Health 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 Provider 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 (30) calendar 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 Community Supports contract and any other related DHCS or Health Plan guidance.

b. ECM Provider shall submit regular capacity reports as outlined in the Provider 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 Provider 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, and (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 Provider 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 Health 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 is assigned 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 instructions 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 the Provider Guide, as follows:

   i. Outreach and Engagement of Health Plan Members into ECM, as described in this Attachment A-1 and the Provider 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. Identifying 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 Provider 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, whose input is necessary for successful implementation of Member goals and needs;

c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, 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/or 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 been given 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. <u>TRAINING.</u>

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. <u>DATA SHARING TO SUPPORT ECM.</u>

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

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 Provider 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 V 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.