AMENDMENT NUMBER TWO
TO THE
FEE FOR SERVICE AGREEMENT
BETWEEN
SAN FRANCISCO HEALTH PLAN
AND
SAN FRANCISCO DEPARTMENT OF DISABILITY AND AGING SERVICES

This Amendment Number Two ("Amendment") to the Fee For Service Agreement ("Agreement") between San Francisco Health Authority, a governmental entity doing business as the **San Francisco Health Plan** ("Health Plan"), and **CITY AND COUNTY OF SAN FRANCISCO acting by and THROUGH THE San Francisco Department of Disability and Aging Services** ("Provider"), is effective January 1, 2024.

RECITALS

WHEREAS, Provider provides health care services to Health Plan enrollees on a Fee For Service basis under the Agreement; and

WHEREAS, Health Plan wishes to update the regulatory requirements to include the 2024 requirements set forth by DHCS and DMHC; and

WHEREAS, Health Plan and Provider wish to update language in the Agreement to include specific terms for the purposes of compliance with DHCS and DMHC requirements; and

WHEREAS, the parties wish to amend the Agreement to reflect these changes.

NOW, THEREFORE the parties agree as follows:

1. **Section 7.3 *Payment*** is deleted in its entirety and replaced with the following language:

   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. The Plan will provide written notice of overpayment which

includes 1) clear identification of the claim, 2) the name of the patient, 3) the date of service, and 4) a clear explanation of the basis upon which the plan believes the amount paid on the claim was in excess of the amount due including any interest and penalties on the claim. Provider may contest the Plan's notice of reimbursement of an overpayment of a claim prior to deduction in accordance with the Plan's Provider Dispute Resolution process as set forth in the Claims Manual. Payment will only be offset when the provider fails to reimburse the Plan within 30 working days for an uncontested payment, or when the Provider has entered into a written contract specifically authorizing the Plan to offset an uncontested notice of overpayment.

2. **Section 7.7 *Provider Dispute Resolution*** is deleted in its entirety and replaced with the following language:

   7.7 Provider Dispute Resolution Mechanism. Provider may have complaints, concerns, or differences such as denials of authorization or payment or other adverse actions, that arise as a provider for Health Plan. These complaints, concerns or differences may be appealed or resolved through Health Plan's Provider Dispute Resolution Mechanism, set forth in the Claims Operations Manual and Provider Manual. Provider and Health Plan shall be bound by the resolutions of such issues that emerge from the Provider Dispute Resolution Mechanism except as otherwise provided by law. Health Plan's dispute resolution process shall be fast, fair, cost-effective, and in compliance with the timeframes set forth in Health & Safety Code Sections 1371 and 1371.35.

3. **Exhibit B, *Compliance with Law*** and its attachments are deleted in their entirety and replaced with the attached **Exhibit B, *Compliance with Law*.**

[continued on next page]

IN WITNESS WHEREOF, the Parties have executed this Amendment as of the dates listed below. Except as modified above, all terms and conditions of the Agreement, as previously amended, shall remain the same.

SAN FRANCISCO HEALTH PLAN

DocuSigned by:
Jenn Moore
1CDB68C0E64A4B9...

Signature _____

Print Name Jenn Moore

Title Chief Operating Officer

Date 1/21/2025

SAN FRANCISCO DEPARTMENT OF DISABILITY AND AGING SERVICES

DocuSigned by:
Kelly Dearman
1848251CBC914C2...

Signature _____

Print Name _____

Title _____

Date 12/20/2024

Approved as to Form
David Chiu
City Attorney

DocuSigned by:
2833E4B81D244D9...

By _____
Glenn M. Levy,
Deputy City Attorney

Date 12/20/2024

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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 herein, 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 (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. **San Francisco Municipal Codes**. Provider agrees to comply with all applicable requirements of the City and County of San Francisco now or hereinafter in force and effect, including without limitation, the provisions and implementing guidelines and rules as further described on Attachment I, San Francisco Municipal Codes.

2. **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 Act and related regulations promulgated by the California Department of Managed Health Care, as further described on Attachment II, Health Plan Licensing Requirements.

3. **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 III, Medi-Cal Program Provisions.

4. **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.

5. **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.

6. **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.

7. **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.

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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 II to Exhibit B, the terms and conditions of Attachment II to Exhibit B shall control. (Note that references to "Rules" below are references to various sections found in Article 7 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations—for example, "Rule 1300.51" is a reference to 28 C.C.R. § 1300.51.)

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 and not removed without the prior written consent of the Director of DMHC. 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) (28 C.C.R. § 1300.67.8(b))

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 Provider without concealment or misunderstanding of other terms and provisions of the Agreement. (Rule 1300.67.8(a))

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)).

26) Except for applicable co-payments and deductibles, a provider shall not invoice, or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit. (28 CCR 1300.71(g)(4))

27) A) The Plan shall provide Provider with a minimum of 45 days prior written notice before instituting any changes, amendments, or modifications to information or fee schedules to the Agreement as required by Rule 1300.71(m).

B) If a change is made by amending a manual, policy, or procedure document referenced in the contract, the Plan shall provide 45 days notice to provider and the Provider shall have the right to negotiate and agree to this change. If the Plan and Provider cannot agree to the change, then either party has the right to terminate the contract (in accordance with Section 2.2 of this Agreement) before implementation of the change (Section 1375.7 (b)(1)(A)).

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Schedule A to Attachment I to Exhibit B

DMHC Requirements for Risk Bearing Organizations (Reserved)

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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 of 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 III to Exhibit B, the terms and conditions of Attachment III 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 30 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 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 at the subcontractor's place of business or at such other mutually agreeable location in California.

b) Retain all records and documents for a minimum of 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. 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. **Public Records; Disclosure Statement**. To the extent DHCS receives Health Plan's Agreement with Provider, subcontractor agreements, or downstream subcontractor agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the subcontractor or downstream subcontractor; stockholders owning more than 5 percent of the stock issued by the subcontractor or downstream subcontractor; and major creditors holding more than 5 percent of the debt of the subcontractor or downstream subcontractor must be attached to the Agreement or downstream subcontractor agreement at the time that agreement is submitted to DHCS. 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.

28. **Emergency Preparedness**. With regard to emergency preparedness, Provider shall: (i) annually submit evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859; (ii) advise Health Plan as part of its emergency plan; and (iii) notify Health Plan within 24 hours of an emergency if Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an emergency.

29. **Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Service (IHS) Facilities**. For FQHCs, RHCs, and other clinics, the Agreement and Provider's downstream subcontractor agreement and amendments thereto will become effective only as set forth in Exhibit A, Subsection 3.1.8 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor* Agreements) of the Medi-Cal Agreement.
    a. For FQHCs, RHCs, and other clinics, any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the covered services rendered to a Member.
    b. For IHS Facilities that qualify as a FQHC but are not a network provider, Health Plan or the appropriate financially responsible party shall reimburse such IHS Facilities as set forth in 42 CFR section 438.14(c)(1).
    c. For services provided to Members who are qualified to receive services from an IHS Facility pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, regardless of whether the IHS Facility is a network provider:
        i. Health Plan or the appropriate financially responsible party shall reimburse IHS Facility at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service in accordance with APL 17-020 and APL 21-008.

ii. Health Plan or the appropriate financially responsible party shall ensure compliance with any retroactive changes to the outpatient per visit rates published in the Federal Register by the Indian Health Service by appropriately reimbursing IHS Facilities in accordance therewith.

iii. Health Plan or the appropriate financially responsible party shall reimburse IHS Facilities at the Medi-Cal FFS Rate for services that, pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, are not eligible for the outpatient per-visit rate published in the Federal Register by the Indian Health Service.

d. The parties shall comply with all Medi-Cal requirements, including Exhibit A, Attachment III, Provision 3.3.7 of the Medi-Cal Agreement, with regard to FQHCs, RHCs and/or IHS Facilities. To the extent that an IHS Facility qualifies as an FQHC or RHC, the requirements of Provision 3.3.7 subsection (B) shall also apply to such contracted IHS Facility.

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Attachment III to Exhibit B
San Francisco Municipal Codes

Provider will ensure that any subcontractors comply with all applicable requirements of the City and County of San Francisco authorities and City and County of San Francisco statutes, regulations, and administrative codes now or hereinafter in force and effect to the extent that they directly bear upon the subject matter or services to be performed under this Agreement including, but not limited to, all provisions of the San Francisco Labor and Employment Code Article 111, the "Minimum Compensation Ordinance" ("MCO"), Labor and Employment Code Article 121, the "Health Care Accountability Ordinance" ("HCAO"), and Labor and Employment Code Article 142, the "City Contractor/Subcontractor Consideration of Criminal History in Hiring and Employment Decisions".

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