

SERVICE AGREEMENT

This Agreement is entered into by and between the San Mateo Health Commission, Health Plan of San Mateo (“HPSM”) and the County of San Mateo, Health System, Family Health Services Division (FHS), as of April 1, 2013 (“Effective Date”) and through October 31, 2015.

RECITALS

- A. WHEREAS, HPSM is a County Organized Health System formed pursuant to Welfare and Institutions Code section 14087.51 and Sections 2.68.010, 2.68.030 of the San Mateo County Ordinance Code;
- B. WHEREAS, HPSM contracts directly with the California Department of Health Care Services (DHCS) to provide health care services to eligible enrollees of California Children’s Services (CCS);
- C. WHEREAS, HPSM has contracted with DHCS to arrange and pay for family centered and whole child health care services to eligible Medi-Cal recipients under the CCS Demonstration Project as defined in the contents of Agreement Number 11-88291;
- D. WHEREAS, HPSM is to ensure and monitor appropriate and timely access of enrollees with CCS eligible medical conditions to a CCS approved Provider;
- E. WHEREAS, FHS has developed expertise in arranging for and managing delivery of services provided to eligible enrollees of CCS and FHS has operated the CCS Program for HPSM beneficiaries for over 25 years.
- F. WHEREAS, the parties hereto desire to enter in this Agreement to identify their respective rights and responsibilities in connection with the provision of CCS benefits to eligible enrollees by a CCS PROVIDER during the term hereof.
- G. NOW THEREFORE, in consideration of the mutual promises and agreement hereinafter contained, HPSM and FHS hereby agree as follows:

ARTICLE I

DEFINITIONS

- A. Care Coordination** means the assessment, linkage, and/or review of provided and needed medical treatment and ancillary services.
- B. California Children Services (CCS) Eligible Conditions** means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR) Section 41800.
- C. California Children Services (CCS) Program** means the public health program that assures delivery of specialized diagnosis, treatment and therapy services to financially and medically eligible children under the age of twenty one (21) years of age who have CCS eligible conditions.
- D. Confidential Information** means specific facts or documents identified as “confidential” by any law, regulations or contractual language.
- E. Contracting Providers** means a Physician, Nurse, technician, hospital, home health agency, nursing home, or any other individual or institution that contracts with HPSM to provide medical services to Members.
- F. County Organized Health System (COHS)** means a health plan that contracts with the State Department of Health Care Services to arrange and pay for comprehensive health care to all eligible CCS beneficiaries and other eligible beneficiaries residing in the county, and that is operated directly by a public entity established by a county government pursuant to Welfare and Institutions (W&I) Code, Section 14087.51 or 14087.54, or H&S Code, Chapter 3 (commencing with Section 101675) of Part 4 of Division 101.
- G. Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
- H. Demonstration Project (DP)** means the CCS pilot program awarded to HPSM through the California Department of Health Care Services (DHCS) under Section 1115 of the Social Security Act.
- I. Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Federal Medicaid (referred to Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP) Child Health and Disability Prevention Program (CHDP) and other health related programs.

- J. Department of Managed Health Care (DMHC)** means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
- K. Eligible Beneficiary** means any CCS beneficiary who has a county code in HPSM's Service Area.
- L. Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in HPSM during the date of service. It includes, but is not limited to, all services for which HPSM incurred any financial liability.
- M. Enrollment** means the process by which an Eligible Beneficiary becomes a Member of HPSM.
- N. Fraud** means an intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (Title 42 CFR 455.2; W&I Code 14043.1(i)).
- O. Grievance** means an oral or written expression of dissatisfaction made by a Member or Provider about any matter other than a Notice of Action. Examples of grievances are complaints related to quality of care, access problems, or provider interactions.
- P. Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administered by the DMHC (H&S Code 1340).
- Q. Member** means any Eligible Beneficiary who is enrolled with HPSM. For the purposes of this Agreement, "Enrollee" shall have the same meaning as "Member".
- R. Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner, certified nurse midwife, or a physician assistant authorized to provide Primary Care under Physician supervision.
- S. Notice of Action** means a formal letter informing a Member's family of any action taken to deny, defer, or modify authorization of a requested medical service by a Provider.
- T. Nurse** (or a "Participant") means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).
- U. Physician** means a person duly licensed as a Physician by the Medical Board of California.

- V. Timely Access** means compliance with the California regulations that establish specific, time-elapse standards regarding the maximum time period a patient has to wait to receive health care services, in accordance with 28 CCR 1300.67.2.
- W. Urgent Care** means an episodic physical or mental condition perceived by a managed care beneficiary as a serious but not life threatening that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.
- X. Vaccines for Children (VFC) Program** means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age eighteen (18) or younger and distributes immunization updates and related information to participating providers. Providers contracting with HPSM are eligible to participate in this program.

ARTICLE II

DUTIES OF HPSM

HPSM and FHS shall collaborate to fulfill the requirements of HPSM’s agreement with DHCS to be a Contractor under the CCS Demonstration Project. Exhibit A of the HPSM agreement with DHCS, “Scope of Work”, shall be incorporated and made a part of this agreement by this reference. Responsibilities specifically belonging to HPSM shall include:

- A. **Referrals** – HPSM’s Health Services and Member Services departments will facilitate the identification and referral of children to CCS who may be eligible for the CCS program and enrollment into the Demonstration Project (DP).
- B. **Care Coordination** – HPSM will partner with and provide oversight of FHS provision of specialized and well-managed, family centered care coordination for each Member. Utilizing an initial needs assessment, HPSM will determine the level and frequency of the care coordination required by each enrollee according to the family’s needs. HPSM will coordinate with the CCS Demonstration Project’s designated evaluator to obtain member and family feedback regarding their experiences of health care.
- C. **Utilization Management** – HPSM will partner with and provide oversight of FHS to develop, implement, and continuously update and improve a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary covered services. Through oversight, HPSM is responsible to ensure that the UM program includes:
- Qualified staff responsible for the UM program.

- Separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.
- Availability of qualified staff to enable separation of authorization and eligibility services.
- The ability to provide an avenue for a second opinion at no cost to HPSM Members.
- The utilization of evaluation criteria and standards to approve, modify, defer, or deny services
- HPSM will facilitate communication to Health Care Practitioner (HCP) of the procedures and services that require prior authorization and ensure that all contracting HCPs are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
- An established specialty referral system to track and monitor referrals requiring prior authorization. The system shall include authorized, denied, deferred or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.
- Consolidation of UM procedures and staff for both CCS and non-CCS conditions.

D. **Payment Obligation** – HPSM is the payor for all medically necessary CCS services, with the exception of those children and young adults in CCS who are not HPSM members. HPSM shall compensate all network Providers as HPSM and Provider negotiate and agree on compensation for services rendered.

E. **Medical Home** – HPSM will support the implementation of a medical home model.

F. **Cultural Competence** – HPSM shall ensure that all services, both clinical and non-clinical, are accessible to all CCS members and are provided in a culturally sensitive and competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds. This includes establishing methods for communicating effectively with members who have communication affecting conditions, including cognitive, vision or hearing impairments.

G. **Provider Relations** – HPSM will maintain and ensure an adequate network of CCS-approved health care providers and facilities. HPSM will conduct outreach to HPSM's Provider Network to explain policy and procedural changes of CCS Program. HPSM's network and provider relations personnel will ensure enrollees have:

- a. Timely access to CCS approved providers, including medically

- necessary specialty services;
 - b. Preventive care;
 - c. Primary care services twenty-four hours per day, seven days per week;
 - d. Emergency services and after-hours care; and
 - e. Physical access to provider offices and facilities;

- H. **Family Planning and Early Intervention** – HPSM will maintain a network where enrollees in the DP twelve (12) years of age or older will be able to access family planning services in a timely manner through an out-of-network Provider other than the PCP.,

- I. **Abuse Reporting** – HPSM staff with direct member contact acknowledge their status as mandated reporters and will adhere to all State of California abuse reporting requirements.

- J. **Behavioral Health Services** – HPSM will be responsible for payment for related outpatient laboratory services to treat a diagnosis of mental illness when the services are prescribed by contracting Providers or non-psychiatric, non-contracting Providers, as well as outpatient visits to a member’s PCP or network therapist for mild to moderate behavioral health conditions.

- K. **Demonstration Project Staff** –
 - 1. HPSM will provide a Medical Director for the Demonstration Project, who will review CCS cases for medical necessity and oversee any clinical quality improvement projects.
 - 2. HPSM will also provide a Director of the Demonstration Project who will oversee general operations of the project.
 - 3. Through Member Services, contracted translation services, and the Grievance and Appeals departments, HPSM will retain proper staffing levels and vendor relationships in order to address member requests or concerns in the language most appropriate for the client.
 - 4. HPSM shall ensure separation of medical decisions from fiscal and administrative management to assure medical decisions are not influenced by fiscal and administrative management.

- L. **Quality Improvement Project** – HPSM will provide support, data, and resources for quality improvement projects through the Quality

Improvement Department and through the provision of the Medical Director of the Demonstration Pilot and the Director of the Demonstration Project.

- M. **Demonstration Project Advisory Committee** – HPSM will establish a Demonstration Project Advisory Committee consisting of community stakeholders and parents of children with CCS eligible conditions for the purposes of quality improvement and guidance related to the development of family-centered care processes.
- N. **Information Technology/MIS** – HPSM will maintain an accurate CCS claiming process as well as the technology infrastructure to enable efficient authorization and payment for Demonstration Project services. HPSM shall maintain technology infrastructure to ensure the capability to capture, edit, and utilize data elements for internal management use, as well as meet the data quality and timeliness requirements of DHCS' encounter data submission. In addition, the technology infrastructure shall provide data on member eligibility, medical home assignments and needs assessments, services authorizations, provider claims, encounter data, provider network capacity, and financial information. HPSM shall have processes that support compatible, efficient and successful interactions amongst those data elements as well as between those data elements and quality management/improvement functions. The technology infrastructure shall also have the capacity for report generation.

ARTICLE III

DUTIES OF FAMILY HEALTH SERVICES

HPSM and FHS shall collaborate to fulfill the requirements of HPSM's agreement with DHCS to be a Contractor under the CCS program. Exhibit A of the HPSM agreement with DHCS, "Scope of Work", shall be incorporated and made a part of this agreement by this reference.

Responsibilities specifically belonging to FHS shall include:

- A. **Family Centered Care** – FHS shall ensure that delivery of medically necessary health care is done in ways that supports the development of trusting relationships between Providers and family members. Consideration must be given to factors such as promoting continuity of Providers and allowing adequate time at visits to encourage Provider-family dialogue and the management of care coordination issues. FHS may not prohibit, or otherwise restrict, Health Care Practitioners acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient. FHS shall ensure that the list of core elements of family-centered care are integrated into Provider practices:

1. Respect and dignity: HCPs listen to and honor patient and family perspectives and choices.
2. Information sharing: HCPs communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
3. Participation: Patients and families are encouraged and supported in participating in care and decision-making at all levels.
4. Collaboration: HCPs collaborate with patients and families at all levels of health care, including: Care of an individual child; program development, implementation and evaluation; and policy formation.

B. **Care Transition** – Prepared in conjunction with the enrollees and their families, FHS will work toward preparing and completing transition plans on an annual basis beginning at fourteen (14) years of age, and ensure that all enrollees, with a medical condition expected to last beyond the twenty first (21st) birthday, receive the services necessary to make transitions to adult health care.

C. **Care Coordination** –FHS staff will be primarily responsible for specialized care coordination, in partnership with HPSM. FHS' care coordination for enrollees shall include both face-to-face and telephone contacts. Duties related to care coordination include, but are not necessarily limited to:

- Assessment of an enrollee's medical, behavioral, psychosocial, and functional needs and assessment of the family's functional needs.
- Facilitating meetings or team conferences with the family, enrollee and appropriate Providers.
- An initial needs assessment by the Care Coordinator initiated within thirty (30) days of enrollment for all new enrollees in the Demonstration Project. Subsequent assessments shall be performed on an annual basis and/or at a frequency determined by any changes in the level of service intensity.
- Development, implementation and ongoing monitoring of individualized family-centered care plans and family support plans in collaboration with the family and medical home Provider.
- Monitoring developmentally and medically appropriate immunization status.

- Utilization of the ICP and an initial comprehensive assessment of the enrollee's and the family's needs to determine the level and frequency of the care coordination required.
- Performing annual assessments and re-assessments at a frequency determined by tiering status or enrollment anniversaries.
- Coordination with the member's primary care physician and any ancillary service providers, to implement care plans and facilitate meetings or conferences.
- Make referrals and ensuring authorization of services.
- Referral into disease and chronic care management programs, ongoing monitoring of the enrollee's status in these programs and coordination and linkage with or to other appropriate Providers or resources.
- Informing Members that EPSDT services are available for Members under twenty-one (21) years of age.
- Transition planning.
- While FHS may not be financially responsible for a range of special services, such as those provided through Regional Centers, HCBS waiver, behavioral health, residential and institutional care services and dental services, FHS will be responsible for ensuring coordination of all the care the enrollee receives.
- Out-of-Plan Case Management and Coordination of Care: FHS shall implement procedures to identify individuals who may need or who are receiving services from out-of-plan Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management for services. To this end, FHS shall implement protocols and procedures for the exchange of medical records information, including procedures for maintaining the confidentiality of medical records. FHS shall also implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.
- Member education and advocacy, including:
 1. linkage to resources and services,
 2. ensuring that members understand their right to file a grievance or appeal in a modality appropriate for that client to have full understanding of their rights, and

3. informing members that EPSDT services are available for members under twenty-one years of age.

D. Utilization Management – FHS will develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of all medically necessary covered services, including CCS and non-CCS conditions. FHS is responsible to ensure that the UM program includes:

- Qualified staff responsible for the UM program.
- Provision of qualified staff to enable separation of authorization and eligibility services.
- The ability to provide an avenue for a second opinion at no cost to HPSM Members.
- Established criteria for approving, modifying, deferring, or denying requested services. FHS will utilize evaluation criteria and standards to approve, modify, defer, or deny services. FHS shall document the manner in which Providers are involved in the development and/or adoption of specific criteria used.
- FHS will communicate to HCPs the procedures and services that require prior authorization and ensure that all contracting HCPs are aware of the procedures and timeframes necessary to obtain prior authorization for these services.
- An established specialty referral system to track and monitor referrals requiring prior authorization. The system shall include authorized, denied, deferred or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.
- Consolidation of UM procedures and staff for both CCS and non-CCS conditions.

E. Timeframes for Medical Authorization – Medical authorizations will be completed within the following timeframes:

1. *Emergency care*: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
2. *Concurrent review of authorization for treatment already in place*: Within twenty-four (24) hours of the decision, consistent with urgency of the Member's medical condition and in accordance with H&S Code, Section 1367.01 (h)(3).
3. *Retrospective review*: Within thirty (30) calendar days in accordance with H&S Code Section 1367.01(h)(1).
4. *Pharmaceuticals*: Twenty-four (24) hours on all drugs that require prior authorization in accordance with W&I Code, Section 14185(a)(1).
5. *Routine authorizations*: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are

requests for specialty service, cost control purposes, out of network not otherwise exempt from prior authorization) in accordance with H&S Code, Section 1361.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendars days only where the Member or the Member's Provider requests an extension, or FHS can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

6. *Expedited authorizations:* For requests in which a Provider indicates, or FHS determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, FHS must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than three (3) working days after receipt of the request for services. FHS may extend the three (3) working days' time period by up to fourteen (14) calendar days if the Member requests an extension, or if FHS justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
7. *Post-stabilization:* Upon receipt of an authorization request from an emergency services Provider, FHS shall render a decision within thirty (30) minutes or the request is deemed approved, in accordance to 28 CCR 1300.71.4.
8. *Non-urgent care following an exam in the emergency room:* Response to the request within thirty (30) minutes or deemed approved.
9. *Therapeutic enteral formula for medical conditions in infants and children:* Timeframes for medical authorization of medically necessary therapeutic enteral formulas for infants and children and the equipment and supplies necessary for delivery of these special foods are set forth in Numbered Letter 22-0805, Enteral Nutrition Products as a CCS Benefit, W&I Code, Section 14103.6 and H&S Code, Section 1367.01.
10. *Hospice inpatient care:* Twenty-four (24) hour response.

F. .

- G. **Cultural Competence** – FHS shall ensure that all services, both clinical and non-clinical, are accessible to all CCS members and are provided in a culturally sensitive and competent manner, including those with limited English proficiency or reading skills and those with diverse cultural backgrounds. This includes establishing methods for communicating effectively with members who have

communication affecting conditions, including cognitive, vision or hearing impairments.

- H. **Provider Relations** – FHS will participate in HPSM provider outreach related to Pilot goals and any process changes that may affect CCS members of HPSM.
- I. **Care Management Team**– FHS will maintain qualified staffing at a level that is sufficient to provide comprehensive case management services for the CCS member population.
- J. **Care Plan** – FHS shall perform assessments and work with the CCS Member, family, HPSM, and others to develop a care plan covering the full range of required psycho-social and health services. The Care Management Team shall continue to work with the CCS Member to assure that she/he is receiving and benefiting from the services and to determine if modification of the care plan is required.
- K. **Information Technology (IT)** - FHS will provide IT services to support its staff, including, but not necessarily limited to, facilitating a secure data connection between HPSM and FHS, enabling secure email and file sharing. Additionally, FHS agrees that FHS staff will work with HPSM staff to transition to HPSM utilization management and care management systems. The timelines for these transitions shall be mutually agreed to by HPSM and FHS leadership.
- L. **Transition** - FHS agrees that PHN staff will continue to complete transition plans is prepared in conjunction with the members and their families.

FHS also agrees that all enrollees in CCS with a medical condition expected to last beyond his or her 21st birthday will receive the care coordination services necessary to make effective transitions to providers of adult health services.

- M. **Orientation** – FHS shall provide orientation of CCS policy and process changes to Providers and staff.
- N. **Family Planning and Early Intervention** – FHS staff will authorize the provision of FP services for Members under twenty-one (21) years of age, including those who have special health care needs, in accordance to 22 CCR 51340 and 51340.1.
- O. **Abuse Reporting** – FHS staff with direct client contact acknowledge their status as mandated reporters and will therefore adhere to all State of California abuse reporting requirements.

- P. **Behavioral Health Services** – FHS staff is responsible for authorizing appropriate mental health services within the scope of the DP, including medically necessary psychotherapeutic drugs, including those that may have been prescribed by out-of-plan psychiatrists.
- Q. **Family Advisory Subcommittee of the Demonstration Project Advisory Committee** – FHS will establish a Demonstration Project subcommittee consisting of parents of CCS enrollees or CCS consumers for the purposes of quality improvement, education and guidance related to the development of family-centered care processes. FHS will also participate in meetings of the Demonstration Project Advisory Committee.
- R. **Demonstration Project Staff** –
1. FHS' Medical Director will determine eligibility for the CCS program, will collaborate with the Demonstration Project Medical Director to ensure quality care and be responsible for clinical oversight of the CCS Medical Therapy Units.
 2. FHS will also provide a CCS Administrator, 50% of whose time will be dedicated to the DP, and who will supervise the Care Management Team and any FHS administrative staff. FHS will retain staffing that properly addresses the language needs of the population served.
 3. FHS will provide staff with experience working with enrollees with special health care needs to conduct the care management, utilization management, and other services for the DP, as described above.
 4. FHS will confer with HPSM about the hiring of any Demonstration Project staff.
- S. **Staff Training:** FHS will ensure that CCS staff completes training related to ethics, HIPAA and that staff licenses are in good standing.
- T. **Quality Improvement Project** – FHS will provide data and resources for quality improvement projects through the CCS nurses and administrative staff, and through the provision of the Medical Director of CCS and the CCS Administrator.

ARTICLE IV

PAYMENTS AND CLAIMS PROCESSING

Payment HPSM shall reimburse FHS for actual costs for providing all services as described above.

- a. Each quarter, FHS shall provide HPSM their claim and related back up billed to State DHCS in order for HPSM to accrue expected costs.

- b. FHS will invoice HPSM for HPSM's share when FHS receives the revised claim and payment from DHCS.
- c. HPSM will provide payment within 30 days of receiving FHS's invoice.

ARTICLE V

RECORDS AND REPORTS

Maintenance of Records. FHS shall maintain, and require any of its Downstream Entities, contractors, or subcontractors to maintain, documentation of all activity conducted under this Agreement, including Claims processed, for a minimum of seven (7) years from the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. Such documentation, including books and records, shall be in a format and media deemed appropriate by FHS and HPSM, and sufficient to accommodate periodic auditing of records to evaluate the quality, appropriateness, and timeliness of services performed by FHS under this Agreement. This shall include maintenance of encounter data for a period of at least seven (7) years.

Records pertaining to goods or services furnished under this agreement shall be accessible to HPSM upon thirty (30) days prior written notice for annual audits, or sooner if required by the circumstances or state or local oversight agencies.

Use of Information. FHS and HPSM may use, reproduce, or adapt information obtained in connection with this Agreement, including Claims data information and eligibility information, in any manner they deem appropriate, except that each party and its agents, employees, and contractors shall maintain the confidentiality of this information to the extent required by applicable Law, including the provisions of the Health Insurance Portability and Accountability Act of 1996, Subtitle F – Administrative Simplification, (referred to in this Agreement as "HIPAA"), and may not use the information in any way prohibited by Law. Each party shall be solely responsible for its own use of the information, and shall indemnify and hold the other party harmless for, from and against any and all costs, losses, and damages incurred by such other party as a result of such use.

Right to Audit Records. FHS agrees to permit access to, for inspection, examination or copying, by HPSM, the California Department of Managed Health Care, the California Department of Health Care Services, the California Department of Health and Human Services, or the California Department of

Justice, and or their designees, at all reasonable times, all records and documents maintained or utilized by FHS in the performance of this Agreement. HPSM and representatives of a regulatory or accreditation agency may each inspect and audit, at least once quarterly or as required, FHS' business records that directly relate to billings made to HPSM for Claims. FHS may inspect and audit, or cause to be inspected and audited, once annually, the books and records of HPSM directly relating to this Agreement, including the existence and number of Members. HPSM and FHS shall fully cooperate with and assist and provide information to representatives of each other, independent accountants hired by either party, and representatives of any regulatory or accreditation agency, to conduct any such inspection or audit. To the extent that HPSM and/or FHS have control of the following, such audits shall be at the auditing party's sole expense and shall only be made during normal business hours, following thirty (30) days written notice, without undue interference to the audited party's business activity, and in accordance with reasonable audit practices. Where a regulatory or accreditation agency imposes demands that do not meet the above standards for conducting an audit, HPSM and FHS will cooperate with the requirements of the auditing agency to the extent possible. An audit of FHS' records may be conducted at FHS's office where such records are located and shall be limited to transactions under the seven (7) year period preceding such audit unless the document retention period is extended according to applicable law. If a completed audit reveals a discrepancy in the results and the previous calculations of the audited party, then the auditing party shall deliver written notice setting forth in reasonable detail the basis of such discrepancy. The parties shall use reasonable efforts to resolve the discrepancy within thirty (30) days following delivery of the notice, and such resolution shall be final, binding, and conclusive upon the parties. Upon a final and conclusive determination of a discrepancy revealed by an audit procedure under this Agreement, the party that owes money shall pay such sums to the other party within thirty (30) days of the delivery of the conclusive audit findings.

Records Related to Recovery for Litigation. Upon request by DHCS, HPSM and FHS shall gather in a timely manner, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in HPSM or FHS' possession, relating to threatened or pending litigation by or against DHCS. HPSM or FHS retain and may assert that requested documents are privileged, by identifying such documents and stating the privilege that supports withholding them.

Reporting. Family Health Services will provide data to support HPSM's compliance with State regulatory agencies or private accreditation requirements. Specific reports or information, which may not be set forth in this Agreement, may be required of HPSM by State or federal regulatory agencies or private accreditation organizations from time to time. FHS shall provide such data or reports to HPSM in a mutually agreeable time and manner that enables HPSM to meet its obligations.

ARTICLE VI

TERM AND TERMINATION

Term. The term of this Agreement shall commence on April 1, 2013 and shall continue in full force and effect, subject to the following provisions for termination:

Termination Without Cause. FHS or HPSM may terminate this Agreement without cause upon providing the other party with sixty (60) days prior written notice.

Termination for Material Breach. Either party shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party if the party to whom such notice is given is in material default under this Agreement. The party claiming the right to terminate hereunder shall set forth in the notice of intended termination required hereby the effective date of such termination and the facts underlying its claim that the other party is in breach of this Agreement. If the COUNTY or the HPSM remedies such alleged breach within twenty (20) days of the receipt of such notice, the Agreement shall remain in effect for the remaining term and such termination notice shall no longer be in effect. Notwithstanding the other provisions of this paragraph, the HPSM may immediately suspend this Agreement pending completion of applicable termination procedures, if the HPSM makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

Both parties shall notify the State of California, in writing, thirty (30) days prior to termination of this Agreement.

Effect of Termination

1. As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect, and each of the parties shall be relieved and discharged from performance, except as specified in Paragraph 2 of this Section.
2. HPSM shall remain liable for payment of all CCS services rendered to HPSM's Member up to the termination of this Agreement.

ARTICLE VII

Grievances and Appeals Process

FHS shall utilize HPSM's Grievance and Appeals system when a HPSM member or provider is dissatisfied with his/her experience accessing or utilizing the CCS DP. HPSM will accept Grievances and Appeals in writing, by phone, or through email or other electronic means.

Appeals. Members shall have ninety (90) days from the date on a Notice of Action to file an appeal of the Notice of Action with FHS or HPSM. Members may simultaneously request a State fair hearing regarding the Notice of Action. During the appeal, the Member must have a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. The member must be given the opportunity before and during the appeals process to examine their case file, including medical records and any other documents and records considered during the appeals process. FHS differentiates between standard Appeals and expedited Appeals. FHS processes an Appeal on an expedited basis when the standard timeframe for processing an appeal could seriously jeopardize the member's life, health, or ability to regain maximum function.

Grievances. Members shall have one hundred and eighty (180) days from the date of the incident or action which caused the Member to be dissatisfied, to file a grievance.

Provider Grievances. FHS shall utilize HPSM's Grievance and Appeals system to accept, acknowledge and resolve Provider grievances. Provider grievances may concern the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member, or the processing of a payment or non-payment of a claim by HPSM.

FHS shall forward to HPSM all Appeals or Grievances received through CCS or through other avenues within FHS related to the CCS program within five (5) business days. Standard Appeals and Grievances shall be resolved within thirty (30) calendar days from the date of receipt. Expedited Appeals shall be resolved within seventy-two (72) hours from the time of receipt.

ARTICLE VIII

INSURANCE

HPSM shall obtain (to the extent not already possessed) and maintain, with respect to the activities in which HPSM engages pursuant to this Agreement, commercial general liability insurance of not less than \$1,000,000 per occurrence for bodily injury and property damage liability combined. The commercial general liability insurance policy shall include coverage for liabilities arising out of premises, operations, independent contractors, products, completed operations, personal and advertising injury, and liability assumed under the insured agreement.

ARTICLE IX

INDEMNITY

- A. FHS Indemnification-** FHS agrees to indemnify, defend and hold harmless HPSM, its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with any negligence in connection with FHS' operations or its services hereunder including the operations and services of FHS' affiliates, Subcontractors/Vendors and their respective employees and agents. This provision is not intended to, nor shall it be construed to, require FHS to indemnify HPSM for any HPSM liability independent of that of FHS, nor to cause FHS to be subject to any liability to any third party (either directly or as an indemnitor of HPSM or its agents, officers and employees) in any case where FHS liability would not otherwise exist. Rather, the purpose of this provision is to assure that HPSM and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against HPSM or such agents, officers, or employees resulting from the actions or other omissions of FHS, its affiliates, Subcontractors/Vendors and their respective employees and agents in connection with their operations and services relating to this Agreement
- B. HPSM Indemnification –** HPSM agrees to indemnify, defend and hold harmless FHS, Its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with any negligence in connection with HPSM's operations or its services hereunder including the operations and services of HPSM's affiliates, Subcontractors/Vendors and their respective agents. This provision is not intended to, nor shall it be construed to, require HPSM to indemnify FHS for any FHS liability independent of that of HPSM, nor to cause HPSM to be subject to any liability to any third party (either directly or as an indemnitor of FHS or its agents, officers employees) in any case where HPSM liability would not otherwise exist. Rather, the purpose of this provision is to assure that FHS and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against FHS or such agents, officers, or employees resulting from the actions or other omission of HPSM, its affiliates, subcontractors/vendors and their respective employees and agents in connection with their operations and services relating to this Agreement.
- C. Third Party Liability–** In the event that FHS renders services to Members for injuries or other conditions resulting from the acts of other parties, the HPSM will have the right to recover from any settlement, award or recovery from any responsible third party the value of all services which have been rendered by FHS pursuant to the terms of this Agreement.

ARTICLE X

MISCELLANEOUS

- A. Entire Agreement** – This Agreement (together with all Exhibits hereto) contains the entire Agreement between the parties relating to the rights herein granted and the obligations herein assumed. It is the express intention of the FHS and the HPSM that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the Effective Date hereunder.
- B. Amendments** – This Agreement and any Exhibits hereto may be amended only by an instrument in writing, duly executed by both parties in accordance with applicable provisions of State and Federal law and regulations.
- C. Notices** - Any notice required to be given pursuant to the terms and provisions of this Agreement, unless otherwise indicated in this Agreement, shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or courier service (Federal Express, UPS, etc.) or other means which can provide written proof of delivery, to HPSM at:

Maya Altman, Chief Executive Officer
Health Plan of San Mateo
701 Gateway Blvd, Suite 400
South San Francisco, CA 94080

and FHS at:

Jean Fraser, Chief
Health System
San Mateo County Health System
225 37th Avenue
San Mateo, CA 94403

- D. Waiver of Obligations** – No obligation under this Agreement or an Exhibit hereto may be waived by any party except by an instrument in writing, duly executed by the party waiving such obligations. All waivers shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the

extension of the waiver to any other provisions of this Agreement unless so specified in writing.

- E. Counterparts** – This Agreement may be executed in counterparts, each of which shall be considered to be an original; however, all such counterparts shall constitute but one and the same Agreement. This Agreement may be executed by facsimile or PDF signature, all of which taken together constitute a single agreement between the parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and PDF), will be considered as legally effective as an original signature.
- F. Headings** – The headings or titles of articles and sections contained in this Agreement are intended solely for the purpose of facilitating reference, are not a part of the Agreement and shall not affect in any way the meaning or interpretation of this Agreement.
- G. Governing Law** – This Agreement will be governed by and construed in accordance with the laws of the State of California, without regard to any conflict of law principles applied therein. Any suit or proceeding relating to this Agreement shall be brought only in the state or federal courts located in California, and all Parties hereby submit to the personal jurisdiction and venue of such courts will be the County of San Mateo.
- H. Confidentiality** - For the purposes of this Agreement, “Confidential Information” means any software, data, business, financial, operational, customer, or other information disclosed by one party to the other and not generally known by or disclosed to the public. Confidential Information shall include any and all Personal Information, defined as any information that is or includes personally identifiable information. Personal Information includes, but is not limited to, name, address and any unique personal identification number. Notwithstanding anything herein to the contrary, Confidential Information shall not include information that is: (a) already known to or otherwise in the possession of a party at the time of receipt from the other party, provided such knowledge or possession was not the result of a violation of any obligation of confidentiality; (b) publicly available or otherwise in the public domain prior to disclosure by a party; (c) rightfully obtained by a party from any third party having a right to disclose such information without breach of any confidentiality obligation by such third party; or (d) developed by a party independent of any disclosure hereunder, as evidenced by written records. Each party shall maintain all of the other party’s Confidential Information in strict confidence and will protect such information with the same degree of care that such party exercises with its own Confidential Information, but in no event less than a reasonable degree of care. If a party suffers any unauthorized disclosure, loss of, or inability to account for the Confidential Information of the other party, then the party to whom such Confidential Information was disclosed shall promptly notify and cooperate with the disclosing party and take such actions as may be necessary or

reasonably requested by the disclosing party to minimize the damage that may result therefrom. Except as provided in this Agreement, a party shall not use or disclose (or allow the use or disclosure of) any Confidential Information of the other party without the express prior written consent of such party. If a party is legally required to disclose the Confidential Information of the other party, the party required to disclose will, as soon as reasonably practicable, provide the other party with written notice of the applicable order or subpoena creating the obligation to disclose so that such other party may seek a protective order or other appropriate remedy. In any event, the party subject to such disclosure obligation will only disclose that Confidential Information which the party is advised by counsel as legally required to be disclosed. In addition, such party will exercise reasonable efforts to obtain assurance that confidential treatment will be accorded to such Confidential Information. Access to and use of any Confidential Information shall be restricted to those employees and persons within a party's organization who have a need to use the information to perform such party's obligations under this Agreement or, in the case of HPSM, to make use of the services, and are subject to a contractual or other obligation to keep such information confidential. A party's consultants and subcontractors may be included within the meaning of "persons within a party's organization," provided that such consultants and subcontractors have executed confidentiality agreements with provisions no less stringent than those contained in this section. Such signed agreements shall be made available to the other party upon its request. Additionally, HPSM, may, in response to a request, disclose FHS Confidential Information to a regulator or other governmental entity with oversight authority over HPSM, provided HPSM (i) first informs FHS of the request, and (ii) requests the recipient to keep such information confidential. All of a party's Confidential Information disclosed to the other party, and all copies thereof, are and shall remain the property of the disclosing party. All such Confidential Information and any and all copies and reproductions thereof shall, upon request of the disclosing party or the expiration or termination of this Agreement, be promptly returned to the disclosing party or destroyed (and removed from the party's computer systems and electronic media) at the disclosing party's direction, except that to the extent any Confidential Information is contained in a party's backup media, databases and email systems, then such party shall continue to maintain the confidentiality of such information and shall destroy it as soon as practicable and, in any event, no later than required by such party's record retention policy. In the event of any destruction hereunder, the party who destroyed such Confidential Information shall provide to the other party written certification of compliance therewith within fifteen (15) days after destruction.

- I. **Conflicts of Interest** – FHS shall ensure that its personnel do not have any conflicts of interest with respect to HPSM's "Conflict of Interest" policy including activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to HPSM or any Member or CCS Applicant, or the person's objectivity in performing the contract work is or might be otherwise impaired, or a person has an unfair competitive advantage.

- J. Inurement** - This Agreement shall be binding upon all assignees, heirs and successors-in-interest of either party.
- K. Assignment** – Neither HPSM nor FHS shall assign this Agreement without the written consent of the other party.
- L. Compliance with Laws** – Parties agree to comply with all applicable State and Federal laws, regulations, and directives by regulatory agencies. It is understood and acknowledged by FHS that HPSM is a public entity and subject to all applicable open meeting and record laws, including but not limited to the California Public Records Act and the Ralph M. Brown Act.
- M. Independent Contractor** - The relationship between HPSM and FHS is an independent contractor relationship. Neither FHS nor its employee(s) and/or agent(s) shall be considered to be an employee(s) and/or agent(s) of HPSM, and neither HPSM nor any employee(s) and/or agent(s) of HPSM shall be considered to be an employee(s) and/or agent(s) of FHS. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.
- N. Invalidity and Severability** - In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

Signatures on Following Page

By signing below, I affirm that I am the duly authorized representative of the signing party and have authority to execute and bind the party for which I affix my signature.

Health Plan of San Mateo

Signature	Name	Title
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Dated: _____

County of San Mateo, Health System, Family Health Services

Signature	Name	Title
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Dated: _____