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AMERICAN MEDICAL RESPONSE WEST

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN MATEO

AMERICAN MEDICAL RESPONSE WEST, a California corporation,

Plaintiff,

v.

SAN MATEO HEALTH COMMISSION, a public entity; HEALTH PLAN OF SAN MATEO, a county organized health system; and DOES 1-20, Inclusive,

Defendants.

Case No. 20-CIV-03366

COMPLAINT FOR DAMAGES AND DECLARATORY RELIEF

American Medical Response West, through its counsel of record, hereby complains and alleges as follows:

PARTIES

1. American Medical Response West ("AMR") is a corporation duly organized and existing under the laws of the State of California, with its principal executive office in the State of Colorado. For several years prior to the date of this action, AMR provided emergency medical transportation services to Medi-Cal beneficiaries enrolled in a health plan managed and administered by Defendants.

2. On information and belief, Defendant San Mateo Health Commission (the "Commission") is the governing board for Defendant Health Plan of San Mateo. The Commission is a local public agency and political subdivision of the State of California, created by San Mateo County Ordinance No. 03067 and amended by Ordinance No. 04422, consisting of Sections 2.23.020 of Chapter 2.23 of Title 2 of the San Mateo County Ordinance Code, pursuant to authority for such creation conferred by California Welfare and Institutional Code, Section 14087.51.

3. On information and belief, Defendant San Mateo Health Plan (the "Plan") is a local community-based health plan covering approximately 130,000 San Mateo County residents. The Plan currently runs the following programs for San Mateo County residents: (i) Medi-Cal (state and federally funded health insurance program for low-income individuals and families); (ii) Care Advantage (health insurance program for those enrolled in both Medicare and Medi-Cal); (iii) Whole Child Model (services to kids with complex medical conditions); (iv) HealthWorks HMO (insurance for in-home services and support providers and eligible city employees); and (v) ACE (insurance for low-income adults who do not qualify for other health insurance).

4. The true names and capacities of Defendants sued herein as DOES l through 20, inclusive (hereinafter, the "Does" or the ''Doe Defendants"), are unknown to Plaintiff at this time, and therefore are sued by such fictitious names. AMR will amend this Complaint to allege the true names and capacities of these Does when they have been ascertained. AMR is informed and believes that each of the Defendants designated as a Doe is responsible in some manner for the events and happenings herein alleged, as well as for the damages alleged.

5. The Commission, the Plan, and the Doe Defendants are collectively referred to herein alternately as "Defendants."

6. AMR is informed and believes that each of the Defendants were, at all times relevant hereto, the agent, employee, alter ego or representative of the remaining Defendants, and were acting at least in part within the course and scope of such relationship. All actions of each of the Defendants herein alleged were ratified and/or approved by the officers, directors or managing agents of every other defendant.

JURISTICTION AND VENUE

7. The Court has jurisdiction over this proceeding pursuant to Code of Civil Procedure sections 410.10. The Court has jurisdiction to grant declaratory relief on behalf of AMR pursuant to Code of Civil Procedure section 1060.

8. The acts, the transactions and occurrences giving rise to this action occurred in substantial part in the County of San Mateo, in the State of California.

GENERAL ALLEGATIONS

A. The Parties Agree to a Medi-Cal-Based Reimbursement Methodology

9. On or about March 16, 2016, AMR, on the one hand, and the Commission (on behalf of the Plan), on the other hand, entered into three separate medical transport agreements covering three programs Defendants administered (the three agreements will collectively be referred to herein as the "Agreements"). Attached hereto as **Exhibit "A**" is a true and correct copy of the parties' March 16, 2016 agreement covering Defendants' Medi-Cal program. Attached hereto as **Exhibit "B**" is a true and correct copy of the parties' March 16, 2016 agreement covering Defendants' "Healthy Kids" program. Attached hereto as **Exhibit "C**" is a true and correct copy of the parties' March 16, 2016 agreement covering Defendants' "Healthworx" program.

10. Relevant to this action, the parties adopted the Medi-Cal reimbursement methodology in their Agreements. The parties, for instance, could have agreed to "case rates" for services rendered, meaning a set sum for each type of transportation. The parties, however, specifically agreed to utilize the Medi-Cal reimbursement methodology. In that regard, the Agreements require Defendants to reimburse AMR "at the prevailing reimbursement rates in effect

for the Medi-Cal Program using the Plan payment rate in effect for the State Medi-Cal Program or the PLAN payment rate, whichever is higher." *See* **Exhibit "A"** at ¶ 6.3.2, **Exhibit "B"** at ¶ 6.3, **Exhibit "C"** at ¶ 6.3.2.

B. The Legislature Increases Medi-Cal Reimbursements.

11. The Medicaid Act, 42 U.S.C. § 1396, *et seq*., authorizes federal financial support to states for medical assistance provided to certain low-income persons. (*Orthopaedic Hospital v. Belshe* (9th Cir. 1997) 103 F.3d 1491, 1493.) The program is jointly financed by the federal and state governments and administered by the states. (*Ibid*.; 42 C.F.R. § 430.0.) In order to receive matching federal financial participation, states must agree to comply with the applicable federal Medicaid law and regulations. (*See Alexander v. Choate* (1985) 469 U.S. 287, 289, fn. 1.)

12. Medi-Cal is administered by the Department of Health Care Service ("DHCS"). (*See* Cal. Code Regs., tit. 22, § 50004.) The Medi-Cal program is responsible for establishing and complying with a state Medicaid plan (the "State Plan") that, in turn, must comply with the provisions of the applicable federal Medicaid law. (42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 430.10 and 431.10.) The State Plan must be approved by the federal Centers for Medicare and Medicaid Services ("CMS") and describe the policies and methods to be used to set payment rates for each type of service included in the State Plan. (42 C.F.R. §§ 430.10 and 447.201(b).)

13. One way DHCS administers Medi-Cal is through the fee-for-service ("FFS") program, under which the State pays providers for Medi-Cal covered services. Another way DHCS administers Medi-Cal is by contracting with various managed care plans, such as the Defendants. DHCS pays Defendants "a fixed, prospective, monthly payment for each beneficiary enrolled," called a capitated rate. (*See Keffeler v. P'ship Healthplan of California*, 224 Cal. App. 4th 322, 329 (2014).) These capitation rates are required to be actuarially sound, *i.e*., "projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract… for the time period and the population covered under the terms of the contract[.]" (42 C.F.R. § 438.4(a).)

14. In 2017, the Legislature enacted Senate Bill ("SB") 523, which established a ground emergency medical transport ("GEMT") provider quality assurance fee ("QAF") program. SB 523

increased the rates paid by Medi-Cal to GEMT providers such as AMR. Specifically, Welfare and Institutions Code section 14129.3 states that

> "[c]ommencing July 1, 2018, and for each state fiscal year thereafter for which this article is operative, reimbursement to emergency medical transport providers for emergency medical transports shall be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule…. The resulting fee-for-service payment schedule amounts after the application of this section shall be equal to the sum of the Medi-Cal fee-for-service payment schedule amount for the 2015-16 state fiscal year and the add-on increase."

(Emphasis added.)

15. SB 523 required that DHCS request federal approval of the add-on to Medi-Cal rates. (Welf. & Inst. Code § 14129.6.) DHCS requested approval of a State Plan amendment to implement SB 523 on July 11, 2018 for an add-on of $220.80 (the "SB 523 add-on"). In February 2019, CMS approved an add-on of $220.80 to the Medi-Cal payments for GEMT services, effective July 1, 2018. The amended State Plan states that "[t]he resulting payment amount of $339.00 [base fee-for-service payment plus add-on] is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective." Even though AMR, on the one hand, and Defendants, on the other, were contracted during the relevant time period, Defendants are required to pay the add-on for AMR's services because the parties adopted the Medi-Cal reimbursement methodology in their Agreement. Indeed, any other interpretation would lead to an absurd result, i.e., a non-contracted provider performing services on Medi-Cal members would receive higher reimbursement than a contracted provider.

16. On June 14, 2019, DHCS issued an All Plan Letter to Medi-Cal managed care health plans, called All Plan Letter 19-007. AMR is informed and believes that Defendants are required in their contracts with the Department to comply with all Department All Plan Letters. All Plan Letter 19-007 directed that all Medi-Cal managed care plans, including Defendants, "reimbursing non-contracting GEMT providers for [emergency ambulance transport services] must pay a 'Rogers Rate' for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 [July 1, 2018 – June30, 2019] and billed with the specified CPT

codes." The All Plan Letter clarifies that "[t]he projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates."

17. On January 31, 2020, the DHCS issued an All Plan Letter to Medi-Cal managed care health plans, called All Plan Letter 20-002. All Plan Letter 20-002 directed Medi-Cal managed care plans, including Defendants, "[b]eginning on July 1, 2019, in addition to the FFS fee schedule base rate for GEMT services, emergency medical transport providers will be entitled to a fixed add-on amount of $220.80 for non-contracted GEMT services provided to MCP Members. The resulting payment amounts will be equal to the sum of the FFS fee schedule base rate and the add-on amount for each CPT Code. The resulting total payment amount for [certain specified] CPT codes … is $339.00 and, for [a certain other] CPT code ... is $400.72." All Plan Letter 20-002 further specified that "[t]he resulting total payment amount … for applicable CPT codes are the "Rogers Rates" that [Medi-Cal managed care plans] – or their delegated entities and Subcontractors – must pay non-contracted emergency medical transport providers pursuant to federal and state law for each SFY for which the FFS reimbursement rate add-on is effective." The All Plan Letter again clarified that "[t]he projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates." Again, even though the parties to this lawsuit were contracted, the All Plan Letters mandating the add-on amounts apply to Defendants' reimbursement obligations to AMR because the parties agreed to use the Medi-Cal reimbursement methodology.

18. AMR is informed and believes, and on that basis alleges, that DHCS has increased the capitation rates paid to Defendants and that Defendants have received increased capitation rates to account for the SB 523 add-on for the dates of service from July 1, 2018, when the QAF program began, to present.

19. For dates of services on or after July 1, 2018, to June 30, 2019, AMR provided GEMT services to Medi-Cal beneficiaries who were Defendants' members. During those dates, the parties' Agreements required Defendants to reimburse AMR pursuant to the Medi-Cal reimbursement methodology. As described above, the Medi-Cal methodology requires the SB 523 add-on payments. AMR submitted claims for such services in the ordinary course of its business, and Defendants have partially reimbursed AMR for such services. Defendants have failed to pay

AMR the full amounts due and owing by refusing to include the SB 523 add-on in their payments to AMR for dates of service on or after July 1, 2018.

20. Between July 1, 2018 and June 30, 2019 alone, AMR performed thousands of GEMTs for Defendants' members pursuant to the parties' agreement. AMR estimates that Defendants underpaid AMR more than $1.3 million in damages (excluding interest) during that time period.[1]

21. To the extent Defendants contend that they are public entities for purposes of the claims presentation requirements of the Government Tort Claims Act (Government Code sections 900, *et seq.*), AMR timely met all such requirements. Specifically, on February 6, 2020, AMR, through counsel, notified Defendants of their failure to pay the contractually-mandated add-on amounts. Attached hereto as **Exhibit "D"** is a true and correct copy of that letter. While Defendants have represented that they will issue further add-on payments to AMR for any GEMT *non-contracted* services, they have refused to reimburse AMR for claims made pursuant to the parties' Agreement.

FIRST CAUSE OF ACTION

Declaratory Relief

(Against all Defendants)

22. AMR re-alleges each and every allegation set forth in paragraphs 1 through 21, above, and incorporates them herein by this reference.

23. A real and immediate dispute exists between AMR, on the one hand, and Defendants, on the other hand, relating to the legal rights and obligation of the respective parties, *to wit*, whether, Defendants are obligated to pay AMIR the Medi-Cal fee-for-service payment amount inclusive of the SB 532 add-on during the time when the parties had agreed to apply the Medi-Cal reimbursement methodology for GEMT services to Defendants' Medi-Cal beneficiaries.

///

[1] AMR will provide Defendants a spreadsheet of underpaid claims. AMR cannot provide that documentation in this pleading as the spreadsheet would contain information protected from disclosure by the Health Insurance Portability and Accountability Act of 1996.

SECOND CAUSE OF ACTION

BREACH OF CONTRACT

(Against all Defendants)

24. AMR re-alleges each and every allegation set forth in paragraphs 1 through 21, above, and incorporates them herein by this reference.

25. On or about March 16, 2016, AMR, on the one hand, and Defendants, on the other hand entered into the Agreements.

26. AMR has performed all conditions, covenants, and promises required on its part to be performed in accordance with the terms and conditions of the Agreements, except those obligations that were waived by Defendants or which was excused or prevented from performing.

27. Defendants have breached the Agreements with AMR in the manners alleged in detail above.

28. After AMR learned of the contract violations by Defendants, AMR and its counsel have requested that Defendants perform their contractual obligations under the Agreements, as detailed above.

29. Despite these requests, Defendants have failed and refused to honor or perform their contractual obligations to AMR.

30. As a proximate result of Defendants' breach, as alleged herein, AMR has suffered damages in an amount to be proven at trial.

THIRD CAUSE OF ACTION

BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING

(Against all Defendants)

31. AMR alleges each and every allegation set forth in paragraphs 1 through 21, above, and incorporates them herein by this reference.

32. Every contract contains an implied covenant of good faith and fair dealing. Each party to a contract is thereby obligated to act in good faith at all times in performing the contract and refrain from doing anything to unfairly interfere with the right of the other party to receive the benefits of the contract.

33. Here, as alleged in detail above, Defendants have breached the covenant of good faith and fair dealing implied in the Agreements.

34. As a direct and proximate result of Defendants' breaches of the implied covenant of good faith and fair dealing, Plaintiff has suffered damages in an amount to be proven at trial which far exceeds the jurisdictional amount, plus statutory interest.

PRAYER FOR RELIEF

WHEREFORE, AMR pray for judgment against Defendants as follows:

1. For a declaration that Defendants are required to include the SB 523 add-on to payments to American Medical Response West for GEMT services;

2. For an award of compensatory damages to be proven at trial plus legally permissible interest;

3. For all attorneys' fees and costs incurred in bringing this action, to the extent recoverable by law; and

For such other relief as the Court deems just and appropriate.

DATED: August 10, 2020

DOLL AMIR & ELEY LLP

By:_____
MICHAEL M. AMIR
MARY TESH GLARUM
TED A. GEHRING
Attorneys for Plaintiff,
AMERICAN MEDICAL RESPONSE WEST

EXHIBIT A

Medi-Cal

Other Services Medical Transport Services Agreement
Between
San Mateo Health Commission
And
American Medical Response West

This Medical Transport Services Agreement ("Agreement") is entered into this **1st day of March 2016,** by and between **American Medical Response West,** a California corporation licensed in the State of California to provide medical transport (hereinafter referred to as "Provider" or "Other Services Provider") and certified to provide services under the State of California Medi-Cal Program, and the San Mateo Health Commission, a public entity (hereinafter referred to as "Commission" or "PLAN"). The parties agree as follows:

This Other Services Medical Transport Services Agreement in its entirety is comprised of the following:

Other Services Provider Medical Transport Services Agreement and
Attachment A - Case Management Protocol

The Provider has read and agrees to abide by the Agreement and all its Attachments, which are attached hereto and incorporated herein by reference.

The Provider shall participate as a Provider subject to the attached Terms and Conditions and Case Management Protocol.

The Provider agrees to be placed on a list of Other Services Providers to which Primary Care Physicians or Referral Providers may refer Members.

Other Services Provider
Executed by:

Signature

Brad White, General Manager
(Print Name and Title)

1510 Rollins Road, Burlingame, CA 94010
Address

September 3, 2015
Date

Tax ID#: 77-0324739
NPI#: 1659305902

Medicare#: ZZZ13822Z
Medicaid#: MTE00929F

Authority
Executed by:

Authorized Signature for
San Mateo Community Health Authority

701 Gateway Blvd., Suite 400
South San Francisco, 94080
Address

3/16/16
Date

MEDI-CAL
OTHER SERVICES PROVIDER
MEDICAL TRANSPORT SERVICES AGREEMENT

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TERMS AND CONDITIONS

Recitals:

A. The PLAN has entered into or will enter into and maintain contracts with the State of California under which San Mateo County Medi-Cal Members will receive, through the PLAN, all medical services hereinafter defined as "Covered Services."

B. The PLAN shall arrange such Covered Services under the case management of the Primary Care Provider chosen by or assigned to Members.

C. The Provider shall participate in providing Covered Services to Members and shall receive payment from the PLAN for the rendering of those Covered Services.

D. Both parties desire to demonstrate that effective and economical health care can be provided through a locally administered program.

NOW, THEREFORE, it is agreed that the above Recitals are true and correct and as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.1 "**Advanced Access"** shall mean the provision, by an individual physician, physician group or the medical group to which a Member is assigned, of appointments with a Other Services Provider, or other qualified primary care provider such as a nurse physician or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

1.2 "**Appointment Waiting Time**" shall mean the time from the initial request for health care services by a Member or the Member's Other Services Provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from HPSM or completing any other condition or requirement of HPSM.

1.3 **"Attending Provider"** shall mean (a) any Provider who is acting in the provision of Emergency Services to meet the medical needs of the Member or (b) any Provider who is, through delegation from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition.

1.4 **"Case Managed Members"** shall mean those Members who select or are assigned to a Primary Care Physician and are identified on the Primary Care Physician's Case Management list. The Primary Care Physician is responsible for delivering or arranging for delivery of all health services required by these Members under the conditions set forth in the Primary Care Physician Medical Services Agreement.

1.5 **"Case Management"** shall mean the coordination and follow up by the Primary Care Physician, of all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

1.6 **"Commission"** shall mean the San Mateo Health Commission.

1.7 **"Covered Services"** shall mean those health services set forth in Section 4 of this Agreement. Covered Services are subject to the limitations of Section 5.1.

1.8 **"Co-payment"** shall mean the portion of covered health care cost for which the Member has financial responsibility under Medi-Cal.

1.9 **"Correct Coding Initiative Edits"** shall mean the nationally recognized standards for editing claims for accurate coding and reporting of services.

1.10 **"Emergency Services"** shall mean those health care services required to relieve a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

i) placing the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
ii) serious impairment to bodily functions, or
iii) serious dysfunction of any bodily organ or part.

Emergency services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.

1.11 "**Evidence of Coverage"** shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the PLAN.

1.12 **"Excluded Services"** shall mean those health care services which are excluded as non-Covered Services in PLAN's Evidence of Coverage and for which the Member is financially responsible. These services may also be called "Non-Covered Services".

1.13 **"Fiscal Year of San Mateo Health Commission"** shall mean the twelve (12) months following the date the PLAN commences operations, and each twelve (12) months thereafter.

1.14 **"Health Plan of San Mateo" (HPSM)** shall mean the Health Plan governed by the San Mateo Health Commission.

1.15 **"Hospital"** shall mean any licensed acute general care hospital.

1.16 "**Identification Card"** shall mean a card which is issued by Medi-Cal to each covered person that bears the name and symbol of the PLAN and contains: Member's name and identification number, and the name of the Member's Primary Care Physician. The Identification Card is not proof of Member eligibility.

1.17 **"Interpreter"** shall mean a person fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language.

1.18 **"Limited English Proficient Member (LEP)"** shall mean Members who are limited-English speaking or non-English speaking including those who speak a language other than a threshold language.

1.19 **"Limited Services"** shall mean services rendered by a chiropractor, acupuncturist, podiatrist, or faith healer as covered under the Medi-Cal Program.

1.20 **"Medical Director"** shall mean the PLAN's Medical Director.

1.21 **"Medical Interpreter"** shall mean a person fluent in English and in the necessary second language, providing language services at medical points of contact with language proficiency related to clinical settings.

1.22 **"Medi-Cal Provider Manual"** shall mean the Allied Health or Vision Care Services Provider Manuals of the State Department of Health Services, issued by the Department's Fiscal Intermediary.

1.23 **"Medi-Cal Rates"** shall mean the schedule of Medi-Cal maximum allowances and rates of payment for physician and non-physician services in effect for California's Medi-Cal Program at the time the services were rendered.

1.24 **"Member"** shall mean any individual who is enrolled in the PLAN.

1.25 **"Non-Medical Interpreter"** shall mean a person fluent in English and the necessary second language, providing language services at non-medical points of contact with language proficiency related to the specific setting or circumstance.

1.26 **"Other Services"** shall mean Limited Services and other covered services including: chiropractic, acupuncture, family planning services, occupational therapy, speech pathology, audiology, podiatry, physical therapy, durable medical equipment, medical supplies, and, other Covered Services not otherwise covered under any other Agreement with PLAN.

1.27 **"Other Services Provider Advisory Committee"** shall mean the committee of Other Services Providers in San Mateo County chosen each year from among contracting Other Services Providers by the PLAN for the purpose of advising the PLAN.

1.28 **"Overpayments"** shall mean the amount of money Other Services Provider has received in excess of the amount due and payable under any federal, state, or other health care program requirements.

1.29 **"Participating Hospital"** shall mean a Hospital which has entered into an Agreement with the PLAN to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.30 **"PLAN"** shall mean the programs governed by the San Mateo Health Commission which serve San Mateo County Medi-Cal Members, also called Health Plan of San Mateo.

1.31 **"Preventive Care"** shall mean health care provided for prevention and early detection of disease, Illness, injury or other health condition.

1.32 **"Primary Care Physician" or "PCP"** shall mean a Physician or Physicians who have executed an Agreement with the PLAN, to provide the services of a Primary Care Physician.

1.33 **"Provider"** shall mean any health professional or institution certified by Medi-Cal to render services to Members and contracting with the PLAN.

1.34 "**Referral Authorization Form" or "RAF"** shall mean the form used by a Primary Care Physician to refer a patient to a Referral Provider, Other Services Provider or for hospitalization, and should accompany an approved Treatment Authorization Request (TAR) for those items or services requiring a TAR in the Medi-Cal Program.

1.35 **"Referral Provider"** shall mean any qualified Provider duly licensed in California and certified by the Medi-Cal Program who has executed an Agreement with the PLAN and is professionally qualified to practice his/her designated specialty and to whom the Primary Care Physician may refer any Member for consultation or treatment.

1.36 **"Referral Services"** shall mean any services which are not Primary Care Services and which are provided by Physicians or referral from the Primary Care Physician or by the Primary Care Physician.

1.37 **"San Mateo County"** shall also be referred to as "County".

1.38 **"Special Members"** shall include all beneficiaries determined by PLAN to be inappropriate for inclusion in the regular case management system. Special Members are those beneficiaries: (a) who are case-managed (either on a temporary or permanent basis) by the PLAN or a non-capitated Primary Care Physician and (b) eligible only for retroactive coverage of services.

1.39 **"Threshold Language"** shall mean primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible Members residing in a county. Additionally, languages spoken by a population of eligible LEP Members residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes, are also considered threshold languages for a county. Threshold languages in each county are designated by the Department of Health Services.

1.40 "**Treatment Authorization Request" or "TAR"** shall mean the form used to request those services which require approval by the PLAN's Medical Director. These requirements remain the same as those requirements in the Medi-Cal Program.

1.41 **"Triage" or "Screening"** shall mean the assessment of a Member's health concerns and symptoms via communication, with the physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to triage or screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

1.42 **"Triage or Screening Waiting Time"** shall mean the time waiting to speak by telephone with a physician, registered nurse or other qualified health professional acting within his or her scope of practice who is trained to screen or triage a Member who may need care.

1.43 **"Urgent Care"** shall mean health care for a condition which requires prompt attention.

1.44 **"Utilization Management (UM)"** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or medically necessary and which all Participating Providers must follow.

SECTION 2
QUALIFICATIONS

2.1 Other Services Provider

Any Other Services Provider duly licensed in the State of California may elect to serve Members hereunder as an Other Services Provider if that Provider meets the qualifications that may be set by the PLAN and:

2.1.1 Is or is in the process of being certified, and in good standing to provide services under the California Medi-Cal Program including those requirements contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations; and

2.1.2 Is an Other Services Provider within San Mateo County or has been specifically excepted from this requirement by the PLAN's Peer Review Committee.

SECTION 3
PROVIDER/PATIENT RELATIONSHIP

3.1 Listing

The PLAN will enter the name of each contracted Other Services Provider onto a list of Other Services Providers from which Primary Care and Referral Physicians may refer and Members may choose. Such a list shall contain the following information concerning the Other Services Provider:

- Name
- Telephone Number(s)
- Address(es)
- Language Capability
- Scope of Services (Specialty)
- Office Days and Hours

The PLAN may list Other Services Providers located outside the County on a separate list made available to Members on request.

3.2 **Eligibility**

Other Services Provider shall verify the eligibility of Members who present themselves at the time of service. Other Services Provider may make such verification by contacting the PLAN via the verification options as described in the Provider Manual.

SECTION 4
COVERED SERVICES

4.1 **Covered Services**

The Other Services Provider services are covered when provided by persons who meet the appropriate requirements to render services under the Medi-Cal Program; and these Covered Services are subject to the limitations set forth in the Medi-Cal Program, unless specifically excepted by PLAN.

4.2 **Prior Authorizations**

No prior authorizations from either the Primary Care Physician or the PLAN shall be required for Limited Services to the extent permitted by the Medi-Cal Program at the time services are rendered, however,

4.2.1 A Referral Authorization Form (RAF) shall be requested from the Primary Care Physician or the PLAN's Medical Director for those Limited Services (non-pharmacy) which require a prescription under the Medi-Cal Program, or

4.2.2 A Treatment Authorization Form (TAR) approved by the PLAN's Medical Director shall be obtained for services or goods which require a TAR in the Medi-Cal Program, or

4.2.3 A retroactive TAR shall be requested by the Provider from the PLAN's Medical Director for treatment of Emergency Medical Conditions.

4.3 **Imposition of Controls if Necessary**

In the interest of program integrity or the welfare of Members, the PLAN may introduce utilization controls as may be necessary at any time. In the event of such change, the change may take effect immediately upon receipt by the Other Services Provider of notice from the PLAN's Medical Director, but the Provider shall be entitled to appeal such action to the Grievance Review Committee, the Other Services Provider Advisory Committee and then to the Commission.

4.4 **Consultation with the PLAN's Medical Director**

The Other Services Provider or any other Provider may at any time seek consultation with the PLAN's Medical Director on any matter concerning the treatment of the Member.

4.5 Discrimination Prohibited

The Other Services Provider shall not discriminate on the basis of sex, race, creed, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, age, medical condition or mental status. In addition all Other Services Providers shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

4.6 Compliance with Commission Activities and Decisions

The Other Services Provider shall cooperate and participate with the PLAN in Quality Assessment and Improvement and Utilization Review programs, Grievance procedures, and all PLAN efforts undertaken as necessary for the PLAN to comply with federal and state regulatory and contractual requirements. The Provider shall also comply with all final determinations rendered by the PLAN and Commission decisions.

4.7 Linguistic Services

4.7.1 Interpreter Services for Limited English Proficient (LEP) Members

The Other Services Provider shall ensure equal access to health care services for all Limited English Proficient LEP Members through the utilization of qualified interpreter services at medical (advice, face to face, or telephone encounters), and non-medical (appointment services, reception) points of contact.

a) Quality Interpreter services shall be furnished during encounters with Providers (physicians, physician extenders, registered nurses, or other personnel) who provide medical or health care advice to Members, when identified by a Provider or requested by a Member.

b) Qualified Interpreter services may be obtained through the HPSM twenty-four (24) hour telephone interpreter service, on-site trained interpreters, bilingual or multilingual providers and/or staff or by contacting the PLAN's Member Services Department for assistance. NOTE: The use of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and only to be used if a Member insists on this after the provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

c) The PLAN contracts with a telephonic interpreter service vendor to assist Providers in complying with this Section. Providers are encouraged to use this service with HPSM members if there is no staff availability of language assistance to the member.

d) Provider must document the member's preferred language, the request/type of the interpreter services provided or refusal of language interpreter services by a Limited English Proficient (LEP) Member in the medical record.

d) Providers should utilize bilingual staff and/or the PLAN's interpreter services to ensure that LEP Members receive timely interpretation services at no charge and at all points of contact. This ensures that members are not subjected to unreasonable delays in receiving services.

4.7.2 Additional Linguistic Services for Threshold Language Members

Threshold languages in each county are designated by the Department of Health Services. These are primary languages spoken by the LEP population groups meeting a specific numeric threshold or concentration standard. The threshold language for San Mateo County effective 1/1/2000 is Spanish.

In addition to interpreter services for LEP Members, as stated in Section 4.7.1, the Other Services Provider shall provide the following services for Members whose language proficiency is in a threshold language.

a) Translated signage;
b) Translated written materials;
c) Referrals to culturally and linguistically appropriate community service programs; and
d) Information on how to file a grievance and the ability to file a grievance in non-English language

The Other Services Provider may request assistance from the PLAN in meeting these requirements.

SECTION 5
LIMITATIONS ON COVERED SERVICES

5.1 Medi-Cal Restrictions

5.1.2 Services provided shall be subject to the PLAN's most current Medi-Cal agreement with the State of California.

5.1.2 Services provided shall be subject to the limitations and procedures listed in the Medi-Cal Provider Manual unless the Provider is notified by the PLAN of modification in that policy. However, prior authorization shall be provided only through the Primary Care Physician, his/her on-call designee, or the PLAN's Medical Director.

5.1.3 Medi-Cal Members shall be entitled to a limited number of Covered Services per month. The Provider understands that in the event the Member has committed through appointment to seek the maximum number of Limited Services for the month of eligibility, no authorization for additional services will be granted by the PLAN, unless specifically approved by the PLAN's Medical Director through the approval of a Treatment Authorization Request (TAR).

5.2 Exceptions to Case Management Control

5.2.1 The Primary Care Physician authorization is not required for the PLAN payment to Providers of Limited Services. The provision of such services shall, however, be subject to the same utilization controls and payment limitations which are applied to these services under the Medi-Cal Program. Prior authorization where required may be granted by the PLAN's Medical Director.

5.2.2 Obstetrical and family planning services may be obtained on direct patient self-referral to qualified contracting Providers in accord with federal requirements Section 42 CFR 441.20.

5.2.3 The Primary Care Physician authorization is not required for Members designated as Special Members.

SECTION 6
PAYMENTS AND CLAIMS PROCESSING

6.1 Conditions for Payment

The PLAN will make reimbursement to the Provider for services provided to Members if the following conditions are met:

6.1.1 The Member was eligible for Medi-Cal at the time the service was provided by Provider; and

6.1.2 The service was a Covered Service under the Medi-Cal Program according to regulations in effect at that time; and

6.1.3 Prior authorization was received by the Provider from the PLAN or Primary Care Physician, except for emergency ambulance services rendered by Provider to a Member.

6.2 Billing for Services Provided

The Provider shall obtain and complete forms as are currently in use in the Medi-Cal Program for services rendered to Members and send all claims to the PLAN within time requirements contained in the PLAN's Provider Manual. Each claim shall contain the RAF and/or TAR number (if required) issued by the Primary Care Physician and/or PLAN.

6.3 Payments for Other Services Providers

6.3.1 Reimbursement for the Other Services Provider services shall be made at the prevailing reimbursement rates in effect for the Medi-Cal Program or the PLAN payment rate, whichever is higher, for services rendered by Other Services Providers for all properly documented Covered Services.

6.3.2 The Medi-Cal Program's maximum reimbursement rates are referenced in the Medi-Cal Provider Manual.

6.4 **Co-payments**

The Provider may collect any co-payments from Members as are authorized under the Medi-Cal Program.

6.5 **Member Liability**

Unless the Member has other health insurance coverage under Medicare, CHAMPUS, Kaiser Permanente, Blue Cross, Blue Shield, or known insurance carrier or health plan, the Provider shall look only to the PLAN for compensation for Covered Services and, with the exception of authorized co-payments, and/or non-covered services, shall at no time seek compensation from Members or the State.

6.6 **No Reimbursement From State**

The Provider shall hold harmless the State of California and Members in the event the PLAN cannot or will not pay for services performed by the Provider pursuant to the terms of this Agreement.

6.7 **Correct Coding Initiative (CCI) Edits**

PLAN will utilize current CCI edits unless superseded by existing Medi-Cal payment methodologies.

6.8 **Overpayments**

Other Services Provider shall furnish and be paid for Covered Services provided to Members in a manner consistent with and in compliance with all applicable laws, regulations, and guidance, including the contractual obligations of HPSM under federal, state, or county health care programs, and with HPSM policies and procedures.

Other Services Provider shall promptly notify PLAN of any Overpayment or other incorrect payment of which Other Services Provider becomes aware and shall refund to PLAN, within 30 days after identification, any amount paid to Other Services Provider in excess of that to which Other Services Provider is entitled under this Agreement. It is Other Services Provider's responsibility to maintain an effective billing and reconciliation system to prevent, detect in a timely fashion, and take proper corrective action for program Overpayments.

An Overpayment may be the result of non-adherence to federal, state, or county health care program requirements, errors by PLAN personnel, payment processing errors by PLAN or designated payors, or erroneous or incomplete information provided by Other Services Provider to PLAN. PLAN shall recover Overpayments, amounts paid to Other Services Provider for services that do not meet the applicable benefit or medical necessity criteria established by PLAN, services not documented in Other Services Provider's records, any services not received by Member, non-Covered Services, or for services furnished when Other Services Provider's license was lapsed, restricted, revoked, or suspended.

PLAN shall recover in accordance with applicable law any Overpayment or other incorrect payment made under this Agreement by offset of the excess amount paid to Other Services Provider against current or future amounts due Other Services Provider, or by request of an immediate refund by Other Services Provider. The Fraud Enforcement and Recovery Act of 2009 (FERA) and the Patient Protection and Affordable Care Act of 2010 (PPACA) make an Overpayment which is retained for over 60 days after its identification an obligation which is sufficient for liability under the False Claims Act. False Claims Act liability includes triple damages and significant fines. PPACA also makes unpaid Overpayments grounds for Medicaid/Medi-Cal program exclusion.

In the event the PLAN determines that it has overpaid a claim, the PLAN shall notify the Other Services Provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the PLAN believes the amount paid on the claim was in excess of the amount due.

If the Other Services Provider does not contest the PLAN's notice of Overpayment, the Other Services Provider shall have 30 working days from the receipt of the notice to reimburse the PLAN the amount of the Overpayment. If the Other Services Provider contests the PLAN's notice of Overpayment, the Other Services Provider shall have 30 working days from the receipt of the notice to send written notice to the PLAN stating the basis upon which the Other Services Provider believes that the claim was not overpaid. The PLAN will receive and process the contested notice of Overpayment of a claim as a provider dispute under the PLAN's provider dispute processes.

If the Other Services Provider does not contest the Overpayment and does not reimburse the PLAN according to the above timelines, then the PLAN may offset the uncontested Overpayment against payments made to the Other Services Provider's current or future claim submissions. In the event that an Overpayment of a claim or claims is offset against Other Services Provider's current or future claim or claims, the PLAN shall provide the Other Services Provider a detailed written explanation identifying the specific Overpayment or payments that have been offset against the specific claim or claims.

PLAN shall take corrective action on Overpayments. Other Services Provider shall take remedial steps to correct the underlying cause of the Overpayment within 60 days of identification of the Overpayment or within such additional time as may be agreed to by PLAN. The corrective action shall include correcting the underlying cause of the Overpayment and taking remedial action to prevent the Overpayment from recurring.

Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by PLAN shall be handled in accordance with such policies and procedures.

SECTION 7
TERM, TERMINATION, AND AMENDMENT

7.1 Effective Date

This Agreement shall become effective on the date specified on the Other Services Provider Medical Services Agreement, or on the date for which the PLAN first assumes responsibility for insuring and arranging and paying for the care of Medi-Cal Members, whichever is later.

7.2 Term

This Agreement shall be for a term of one (1) year from the date it becomes effective and shall be automatically renewed for subsequent terms of one (1) year each. This Agreement may be terminated or amended as hereinafter provided.

7.3 Termination

This Agreement may be terminated by either party as follows:

7.3.1 If terminated by the Provider, termination shall require sixty (60) days advance written notice of such intent to terminate, transmitted by the Provider to the PLAN by Certified U.S. Mail, Return Receipt Requested, addressed to the office of the PLAN, as provided in Section 12.5.1. A copy of the written notice shall also be mailed as first-class registered mail to State Department of Health Services, Capitated Health Systems Division, 714/744 "P" Street, Sacramento, CA 95814.

7.3.2 The Provider may terminate this Agreement upon thirty (30) days written notice if in response to an Agreement amendment instituted according to the provision of Section 7.6, the Provider notifies the PLAN in writing of termination within sixty (60) days of notice said amendment.

7.3.3 If termination is initiated by the PLAN, the date of such termination shall be set by consideration for the welfare of Members and necessary allowance for notification of Physicians and Members, and the Provider shall be notified as hereinafter provided. The PLAN may terminate this Agreement at any time and for any reason upon thirty (30) days written notice.

7.3.4 Conditions for Termination by the PLAN

7.3.4.1 The PLAN shall terminate this Agreement effective immediately in the following situations: loss of licensure by Provider; loss by the Provider of Medi-Cal Provider certification.

7.3.4.2 The PLAN may terminate this Agreement effective immediately in the following situations: charges to Members by the Provider other than authorized co-payment charges for Covered Services and the Provider's failure to comply with the PLAN's utilization control procedures; Provider's failure to abide by Grievance or Quality Assessment and Improvement Committee decisions; the Provider's failure to

maintain adequate levels of insurance as specified in Section 10; the Provider's failure to meet the PLAN qualification criteria.

7.3.5 This Agreement shall terminate automatically on the date of the termination of the PLAN's contract with the State of California. The PLAN shall notify the Provider as soon as is practical upon receiving or sending such notice of termination.

7.4 Assignment

This Agreement is a personal service agreement and shall not be transferred or assigned to any other Provider or entity.

7.5 Amendment

7.5.1 Amendment by Mutual Agreement

This Agreement may be amended at any time upon written agreement of both parties subject to Section 11.9.

7.5.2 Amendment by the PLAN

This Agreement may be amended by the PLAN upon thirty (30) days written notice to the Provider. If the Provider does not give written notice of termination within thirty (30) days, as authorized by Section 7.3.2, the Provider agrees that any such amendment by the PLAN shall be a part of the Agreement. However, the provisions of Section 7.6.2 may not be invoked to amend any portion of Section 7 of this Agreement.

7.5.3 Knox-Keene Amendments

The terms of this Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended, and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind the PLAN and the Other Services Provider as appropriate, whether or not provided herein. If the Director of the Department of Managed Health Care or his/her successor requires further amendments to this Agreement, the PLAN shall notify the Other Services Provider in writing of such amendments. The Other Services Provider will have thirty (30) days from the date of the PLAN's notice to reject the proposed amendments by written notice of rejection to the PLAN. If the PLAN does not receive such written notice of rejection within the thirty (30) day period, the amendments shall be deemed accepted by and binding upon the Other Services Provider. Amendments for this purpose shall include, but not be limited to, material changes to the PLAN's Utilization Management, Quality Assessment and Improvement and Grievance programs and procedures and to the health care services covered by this Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and the duties of the parties herein shall be governed by California law.

7.6 **Continuity of Care**

Upon termination of this Agreement for any reason, the Provider shall ensure an orderly transition of care for Case Managed Members, including but not limited to the transfer of medical records. The costs to the Provider of photocopying such records will be reimbursed by the PLAN at a cost not to exceed $.25 per page.

SECTION 8
RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 **Records**

The Other Services Provider shall maintain for each Member who has received Covered Services, a legible record of services rendered, kept in detail consistent with appropriate professional practice. The Provider shall maintain such records for at least five (5) years from the close of the State's fiscal year in which this Agreement was in effect.

8.2 **Inspection Rights**

The Provider shall make all books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:

8.2.1 By the PLAN, the State, the Department of Managed Health Care, and all applicable State and Federal agencies and self-regulating agencies.

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

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

8.2.4 For a term of at least five (5) years from the close of the State Department of Health Services' fiscal year in which this Agreement was in effect.

8.3 **Confidentiality of Members Information**

For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by the Provider and its staff from unauthorized disclosure as required by Medi-Cal and any applicable laws.

8.4 **Subcontracts**

The Provider shall maintain and make available to the PLAN, the State, the Department of Managed Health Care, and upon request all subcontracts and shall ensure that all subcontracts are in writing and require that the subcontractor:

8.4.1 Make all books and records pertaining to the goods and services furnished under the

terms of the Agreement available at all reasonable times for inspection, examination, or copying by the PLAN, the State, the Department of Managed Health Care, and all applicable State and Federal agencies and self-regulating agencies; and

8.4.2 Retain such books and records for a term of at least five (5) years from the close of the State's fiscal year in which the subcontract is in effect.

8.5 Other Insurance Coverage

8.5.1 Medicare Recoveries

The Medi-Cal Provider Manual specifies that certain other health insurance programs (including Medicare) must be billed and recoveries made prior to billing the Medi-Cal Program for those Members who are entitled to both Medicare and Medi-Cal. Such rules shall also apply to the PLAN's administration of the Medi-Cal Program. The PLAN shall return claims to Provider if he/she has failed to first make recoveries from these other Programs.

8.5.2 Health Insurance Other Than Medicare

The Providers shall inform the PLAN of all potential third party insurance recoveries. The Provider shall notify the PLAN that health insurance or another health Program may cover any Covered Services provided by the Provider whenever the Provider discovers this potential coverage. The requirements concerning notification and recoveries in the current Medi-Cal Provider Manual shall apply. The Provider also shall cooperate with and assist the PLAN in obtaining such recoveries.

8.6 Member's Potential Tort, Casualty, or Worker's Compensation Awards

The Provider shall notify the PLAN that a potential tort, casualty insurance, or Worker's Compensation award may reimburse the Provider for any Covered Services provided by the Provider whenever the Provider discovers such potential awards.

SECTION 9
INSURANCE AND INDEMNIFICATION

9.1 Liability Insurance

Each Provider covered by this Agreement shall carry at its sole expense liability insurance of at least ONE MILLION DOLLARS ($1,000,000) per person per occurrence, insuring against professional errors and omissions (malpractice) in providing medical services under the terms of this Agreement and for the protection of the interests and property of Provider, its Members and employees, and the PLAN's Members.

9.2 Other Insurance Coverage

The Provider shall carry at its sole expense at least THREE HUNDRED THOUSAND DOLLARS ($300,000) per person per occurrence of the following insurance for the protection of the interest and property of the Provider, its members and employees, the PLAN's Members, the PLAN and

third parties; namely, personal injury on or about the premises of the Provider, general liability, employer's liability and Workers' Compensation to the extent said Workers' Compensation is required by law.

9.3 **Certificates of Insurance**

The Provider at its sole expense, if any, shall provide to the PLAN certificates of insurance or verifications of required coverage, and shall notify the PLAN of any notice of cancellation for any and all coverage required by this Agreement, and for subsequent renewals of all required coverage.

9.4 **Automatic Notice of Termination**

The Provider shall direct the insurance carrier to have automatic notification of insurance coverage termination given to the PLAN.

SECTION 10
GRIEVANCES, APPEALS, AND PROVIDER DISPUTES

10.1 **Grievances, Appeals and Provider Disputes**

It is understood that the Provider may have Grievances, Appeals and Provider Disputes which may arise as a health care provider under contract with the PLAN. These Grievances, Appeals and Provider Disputes shall be resolved through the mechanisms set out in Section 10.2. The Other Services Provider and the PLAN shall be bound by the decisions of the PLAN's Grievance, Appeals and Provider Disputes mechanisms.

10.2 **PLAN Member/Provider Initiated Grievances, Appeals and Provider Disputes Procedure**

10.2.1 Responsibility

The PLAN's Chief Executive Officer has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance, Appeals and Provider Disputes review systems. The Chief Executive Officer shall be assisted by the PLAN'S Director of Compliance and Regulatory Affairs, the Director of Health and Provider Services and the Medical Director, or their designees.

10.2.2 Resolution of Member and Provider-Initiated Grievances, Appeals and Provider Disputes

The Other Services Provider agrees that all disputes or disagreements between the Provider and the PLAN or the Member, shall be resolved in accordance with such Grievance, Appeals or Provider Disputes resolution processes, as set forth in the PLAN's Provider Manual. The PLAN may establish, and amend these processes from time to time. To the extent permitted by law, in accordance with applicable provisions of the Knox-Keene Health Service Plan Act of 1975, as amended, and the regulations promulgated hereunder by the Department of Managed Health Care, the Other Services Provider shall permit the PLAN to inspect and make copies of any and all records pertaining to any such dispute or disagreement, and shall provide copies of such records to the PLAN upon request.

The Other Services Provider may submit Grievances, Appeals or Provider Disputes to PLAN at the address provided in Section 11.5.1, or by calling PLAN's Grievance and Appeals Coordinator at 650-616-2850 or Provider Disputes Unit at 650-616-2836.

The Other Services Provider shall display in a prominent place at their place of service, notice informing Members how to contact the PLAN and file a complaint.

The Other Services Provider shall provide the telephone number of the PLAN to any Member wishing to file a complaint.

SECTION 11
GENERAL PROVISIONS

11.1 In the event any part of this Agreement is found to be unlawful or legislation modifies the entitlement of Members or other provision hereunder, the Agreement shall automatically and without prior notice be modified to reflect that which is lawful and all other provisions shall remain in full force and effect.

11.2 Within constraints of applicable State and Federal statutes, the PLAN shall inform Members regarding the Provider's willingness to undertake service to them.

11.3 Unless specifically excepted by the PLAN in this Agreement, in amendments to this Agreement, or in the PLAN's Formulary or Utilization Review procedures, the Provider shall follow the regulations of the Medi-Cal Program.

11.4 The waiver by the PLAN of any one or more defaults, if any, on the part of the Provider hereunder, shall not be construed to operate as a waiver by the PLAN of any other or future default in the same obligation or any other obligation in this Agreement.

11.5 Whenever it shall become necessary for either party to amend or terminate this Agreement, such notice shall be in writing and shall be served by Registered or Certified Mail, Return Receipt Requested, addressed as follows:

11.5.1 If served on the PLAN, it shall be addressed to:

Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

11.5.2 If served on the Provider, it shall be addressed to the Provider at the address which appears on the Other Services Provider Medical Services Agreement. Any such notice so mailed shall be deemed to have been served upon and received by the addressee forty-eight (48) hours after the same has been deposited in Registered or Certified United States mail, Return Receipt Requested. Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any changes of address.

11.6 This Agreement shall not be modified, altered or changed in any manner, except as provided in Sections 7.5.1, 7.5.2, and 11.9.

11.7 Throughout this Agreement the singular shall include the plural, and the plural the singular; the masculine shall include the neuter and feminine, and the neuter the masculine and feminine.

11.8 None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employer or the representative of the other.

11.9 This Agreement and any amendment to it shall become effective only after written approval by the State Department of Health Services of the form of the Agreement or amendment

SECTION 12
PROVIDER MANUAL

PLAN offers, via the PLAN's website and upon request, the Other Services Provider with a Provider Manual that contains those PLAN policies and procedures necessary for the proper operation of the Other Services Provider as it relates to Members and which describes all benefits plans, including limitations and exclusions offered by the PLAN. Other Services Provider agrees to comply with PLAN standards and policies outlined in the Provider Manual.

SECTION 13
OTHER SERVICES PROVIDER RELATIONSHIP TO PLAN

13.1 PLAN designates Other Services Provider as a primary provider of emergency and non-emergent transportation services. PLAN and Provider acknowledge this primary provider relationship is based on the Parties agreeing such a relationship: (1) is in full compliance with all State and federal guidelines regarding the patients' right to select a service provider, (2) is in expectation this preferred provider relationship will improve care coordination and further PLAN's goal of providing the right level of care at the right time for any patient requiring Provider's services, (3) that all fees paid by PLAN to Other Services Provider are based upon currently applicable Medicare and/or Medi-Cal fees as described above in Section 6 Payments, and without a pre-set expectation of patient referral volume, and (4) that this Agreement is not structured as any type of joint venture arrangement.

13.2 Other Services Provider shall respect the rights of any Member to select an alternate ambulance or non-ambulance services provider based on personal preference, insurance payor preference, or any other criteria as set forth under federal and State regulation.

13.3 All Other Services Provider services shall be requested from a ten-digit toll-free telephone number linked to Other Services Provider Call Center.

EXHIBIT B

HEALTHY KIDS

Other Services Medical Transport Services Agreement
Between
San Mateo County Community Health Authority
And
American Medical Response West

This Medical Services Agreement ("Agreement") is entered into this **1st day of March 2016,** by and between **American Medical Response West**, a California corporation, licensed in the State of California to provide medical transport (hereinafter referred to as "Provider" or "Other Services Provider") and duly licensed to operate in the State of California, and the San Mateo Community Health Authority, a public corporation (hereinafter referred to as "Authority" or "PLAN"). The parties agree as follows:

This Other Services Medical Transport Services Agreement in its entirety is comprised of the following:

Other Services Medical Transport Services Agreement
Attachment A -- Case Management Protocol
Attachment B -- Healthy Kids Program Summary of Benefits

The Provider has read and agrees to abide by the Agreement and all its Attachments, which are attached hereto and incorporated herein by reference.

The Provider shall participate as a Provider subject to the attached Terms and Conditions and Case Management Protocol.

The Provider agrees to be placed onto a list of Other Services Providers to which Primary Care Physicians and Referral Providers may refer Members.

Other Services Provider
Executed by:

Signature

Brad White, General Manager
(Print Name and Title)

1510 Rollins Road, Burlingame, CA 94010
Address

September 3, 2015
Date

Tax ID#: 77-0324739
NPI#: 1659305902
Medicare#: ZZZ13822Z
Medicaid#: MTE00929F

Authority
Executed by:

Authorized Signature for
San Mateo Community Health Authority

701 Gateway Blvd., Suite 400
South San Francisco, 94080
Address

3/16/16
Date

HEALTHY KIDS

OTHER SERVICES PROVIDER
MEDICAL TRANSPORT SERVICES AGREEMENT

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TERMS AND CONDITIONS

Recitals:

A. The PLAN has entered into or will enter into and maintain contracts with Children and Families First Commission, Peninsula Community Foundation, and the County of San Mateo pursuant to which individuals who subscribe and are enrolled under the Healthy Kids Program will receive, through the PLAN, health services hereinafter defined as "Covered Services".

B. The PLAN shall arrange such Covered Services under the Case Management of Primary Care Physicians chosen by or assigned to Members.

C. The Provider shall participate in providing Covered Services to Members and shall receive payment from the PLAN for the rendering of those Covered Services.

NOW, THEREFORE, it is agreed that the above Recitals are true and correct and as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.1 **'Advanced Access"** shall mean the provision, by an individual physician, physician group or the medical group to which a Member is assigned, of appointments with a PCP, or other qualified primary care provider such as a nurse physician or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the Member prefers not to accept the appointment offered within the same or next business day

1.2 "**Appointment Waiting Time**" shall mean the time from the initial request for health care services by a Member or the Member's provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from HPSM or completing any other condition or requirement of HPSM.

1.3 **"Attending Physician"** shall mean (a) any Physician who is acting in the provision of Emergency Services to meet the medical needs of the Member or (b) any Physician who is, through delegation from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition.

1.4 **"Authority"** shall mean the San Mateo Community Health Authority.

1.5 **"Case Managed Members"** shall mean those Members who select or are assigned to a Primary Care Physician and are identified on the Primary Care Physician's Case Management list. The Primary Care Physician is responsible for delivering or arranging for delivery of all health services required by these Members under the conditions set forth in the Primary Care Physician Medical Services Agreement.

1.6 **"Case Management"** shall mean the coordination and follow up by the Primary Care Physician, of all services deemed necessary to provide the Member with a plan of medically necessary and appropriate health care.

1.7 **"Children's Health Initiative (CHI) Coalition"** is the decision-making body established by the San Mateo Board of Supervisors for the planning and development of the Healthy Kids Program. The Coalition consists of representatives from the San Mateo Hospital Consortium, Children and Families First Commission, San Mateo Central Labor Council, Peninsula Community Foundation, Health Plan of San Mateo, and the San Mateo County Health Services and Human Services Agencies.

1.6 **"Co-payment"** shall mean the portion of covered health care cost for which the Member has financial responsibility under the Healthy Kids Program.

1.7 **"Correct Coding Initiative Edits"** shall mean the nationally recognized standards for editing claims for accurate coding and reporting of services.

1.8 **"Covered Services"** shall mean those health care services and supplies which a Member is entitled to receive under the Healthy Kids Program and which are set forth in the Healthy Kids Program Evidence of Coverage (Attachment B).

1.9 **"Emergency Services"** shall mean those health care services required to relieve a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

i) placing the health of an individual (or, in case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
ii) serious impairment of bodily function, or
iii) serious dysfunction of any bodily organ or part.

Emergency services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within scope of their licensure and privileges.

1.10 **"Evidence of Coverage"** shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the Healthy Kids Program.

1.11 **"Excluded Services"** shall mean those health care services which are excluded as Non-Covered Services in the Healthy Kids Program Evidence of Coverage (Attachment B), and not required by the Knox-Keene Act, for which the PLAN will not provide benefit payments. These services may also be referred to as "Non-Covered Services".

1.12 **"Health Plan of San Mateo" (HPSM)** shall mean the health plan governed by the San Mateo Community Health Authority.

1.13 **"Healthy Kids Program"** shall mean the health insurance created by the Children's Health Initiative Coalition for children through age 18 in families with incomes up to 400% of the federal poverty level residing in San Mateo County who are ineligible for Healthy Families and full scope Medi-Cal.

1.14 **"Hospital"** shall mean any licensed general acute care hospital.

1.15 **"Identification Card"** shall mean a card which is issued by the PLAN to each covered person that bears the name and symbol of the PLAN and contains: Member's name and identification number, Member's Primary Care Physician, and other identifying data. The identification card is not proof of Member eligibility.

1.16 **"Interpreter"** shall mean a person fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language.

1.17 **"Limited English Proficient Member (LEP)"** shall mean Members who are limited- English speaking or non-English speaking including those who speak a language other than a threshold language.

1.18 **"Limited Services"** shall mean those Covered Services rendered by a Chiropractor, Acupuncturist, Podiatrist, or Faith Healer as covered under the Healthy Kids Program.

1.19 **"Medical Director"** shall mean the PLAN's Medical Director.

1.20 **"Medical Interpreter"** shall mean an Interpreter providing language services at medical points of contact with language proficiency related to clinical settings.

1.21 **"Medi-Cal Provider Manual"** shall mean the Medical Services Provider Manual of the Department of Health Services, issued by the Department's Fiscal Intermediary.

1.22 **"Medi-Cal Rates"** shall mean the schedule of Medi-Cal maximum allowances and rates of payment for Physician and Non-Physician services in effect for California's Medi-Cal Program at the time the services were rendered.

1.23 **"Member"** shall mean an individual who is enrolled in good standing with the Healthy Kids Program.

1.24 **"Non-Medical Interpreter"** shall mean an Interpreter providing language services at non-medical points of contact with language proficiency related to the specific setting or circumstance.

1.25 **"Other Services"** shall mean: Limited Services and other Covered Services not included in the Specialty Care and Inpatient Hospital Services, as described in Section 4.

1.26 **"Overpayments"** shall mean the amount of money Primary Care Physician has received in excess of the amount due and payable under any federal, state, or other health care program requirements.

1.27 **"Participating Hospital"** shall mean a Hospital which has entered into an agreement with the PLAN to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.28 **"Participating Provider"** shall mean a Provider who has entered into an agreement with the PLAN to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.29 **"Physician"** shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law.

1.30 **"Physician Advisory Group"** shall mean the committee of Physicians or Providers practicing in San Mateo County chosen each year from among Participating Physicians by the PLAN for the purpose of advising the PLAN.

1.31 **"Physician Patient Load Limitation"** shall mean that maximum number of Members for whom the Primary Care Physician has contracted to serve, and the limit accepted by the PLAN beyond which the PLAN agrees that additional Members shall not be permitted to select or be assigned to that Primary Care Physician. Such limit may be changed by mutual agreement of the parties.

1.32 **"PLAN"** shall mean the programs governed by the San Mateo Community Health Authority which serve San Mateo County Medi-Cal Members, and Members of the Healthy Families, HealthWorx, and Healthy Kids Programs, also called Health Plan of San Mateo.

1.33 **"Preventive Care"** shall mean health care provided for prevention and early detection of disease, Illness, injury or other health condition

1.34 **"Primary Care Physician" or "PCP"** shall mean a Participating Physician duly licensed in California and certified by the Medi-Cal Program and who has executed an Agreement with the PLAN to provide the services of a Primary Care Physician.

1.35 **"Primary Care Services"** shall mean those services defined in the Primary Care Physician Scope of Services (Attachment A of the Primary Care Physician Medical Services Agreement) and provided to Members by a Primary Care Physician.

1.36 **"Provider"** shall mean any health professional or institution certified to render services to Members and contracting with the PLAN under the Healthy Kids Program.

1.37 **"Quality Assessment"** shall mean those processes and procedures established by the PLAN and designed to review and analyze various aspects of desired health care.

1.38 **"Referral /Authorization"** shall mean the process by which Participating Physicians or Providers direct a Member to seek or obtain Covered Services from a health professional, hospital, or any other Provider of Covered Services in accordance with the PLAN's referral and authorization procedures.

1.39 **"Referral Authorization Form"** (RAFs) shall mean forms generated by the Primary Care Physician identifying needs based on Member's clinical status. RAFs are used by the Primary Care Physician to authorize referral to a Referral Provider.

1.40 **"Referral Provider"** shall mean any qualified Provider duly licensed in California and certified by the Medi-Cal Program who has executed an Agreement with the PLAN and is professionally qualified to practice his/her designated specialty and to whom the Primary Care Physician may refer any Member for consultation or treatment.

1.41 **"Referral Services"** shall mean any services which are not Primary Care Services and which are provided by Providers on referral from the Primary Care Physician or by the Primary Care Physician.

1.42 **"San Mateo County"** shall also be referred to as "County".

1.43 **"Threshold Language"** shall mean primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible Members residing in a county. Additionally, languages spoken by a population of eligible LEP Members residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county. Threshold languages in each county are designated by the California Department of Health Services.

1.44 **"Treatment Authorization Form" (TARs)** shall mean forms generated by Providers to request a service/treatment that requires prior authorization by the PLAN.

1.45 **"Triage" or "Screening"** shall mean the assessment of a Member's health concerns and symptoms via communication, with the physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to triage or screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

1.46 **"Triage or Screening Waiting Time"** shall mean the time waiting to speak by telephone with a physician, registered nurse or other qualified health professional acting within his or her scope of practice who is trained to screen or triage a Member who may need care.

1.47 **"Urgent Care"** shall mean health care for a condition which requires prompt attention.

1.48 **"Utilization Management (UM)"** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or medically necessary and which all Participating Providers must follow.

SECTION 2
QUALIFICATIONS

2.1 Other Services Provider

Any Other Services Provider duly licensed in the State of California may elect to serve Members hereunder as an Other Services Provider if that Provider meets the qualifications that may be set by the PLAN and:

2.1.1 Is or is in the process of being certified, and in good standing to provide services under the California Medi-Cal Program including those requirements contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations; and

2.1.2 Is an Other Services Provider within San Mateo County or has been specifically excepted from this requirement by the PLAN's Peer Review Committee.

SECTION 3
PROVIDER/PATIENT RELATIONSHIP

3.1 Member Designation

At the time of determining Healthy Kids eligibility, the PLAN will request that each person select a Primary Care Physician contracting with the PLAN through whom that Member will seek all medical services, except Emergency Services and Limited Services. If no selection is made, the PLAN shall assign Member to a Primary Care Physician.

3.2 Listing

The PLAN will enter the name of each Other Services Provider contracted onto a list of Other Services Providers from which Primary Care Physician and Referral Providers may refer and Members may choose. Such a list shall contain the following information concerning the Other Services Providers:

- o Name
- o Address(es)
- o Telephone Number(s)
- o Language Capability
- o Scope of Services (Specialty)
- o Office Days and Hours

The PLAN may list the Other Services Providers outside the County or not having privileges at a Participating Hospital on a separate list made available to Members upon request.

3.3 Eligibility Verification

Other Services Provider shall verify the eligibility of Members who present themselves at the time of service. Other Services Provider may make such verification by contacting the PLAN via the verification options as described in the Provider Manual.

SECTION 4
COVERED SERVICES

4.1 Covered Services

Other Services Provider services are covered when they are medically necessary and appropriate for the care of the Member and are provided by persons who meet the appropriate requirements to render services under the Healthy Kids Program Evidence of Coverage (Attachment B); unless specifically excepted by the PLAN. Covered Services include, but are not limited to:

4.1.1 Audiology, electro-biometry, physical therapy, occupational therapy, speech therapy, family planning services, adult day health care, and/or other therapeutic and diagnostic measures prescribed by the Primary Care Physician or the Referral Provider or the Attending Physician which are held to be medically necessary and appropriate to the process of prevention, diagnosis, the management or treatment of diagnosed health impairment, or rehabilitation of the Member.

4.1.2 Ambulance Services as the result of a "911" emergency response system request for assistance if either of the following conditions apply:

1) The request was made for an emergency medical condition and ambulance transport services were requested.

2) A Member reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

4.1.3 Other medically necessary durable equipment rental, medical supplies, and non-emergent medical transportation.

4.1.4 All services and goods required or provided hereunder shall be of quality consistent with nationally accepted standards of medical care.

4.2 Prior Authorizations

Prior authorization is required in accordance with the PLAN's Case Management Protocol (Attachment A) and the Healthy Kids Program Evidence of Coverage (Attachment B).

4.3 Utilization Controls

The Other Services Provider recognizes the possibility that the PLAN may be required to take action requiring consultation with the PLAN's Medical Director or with other Providers prior to authorization of services or supplies. In the interest of Program integrity or the welfare of the Members, the PLAN may introduce utilization controls as may be necessary at any time if necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. In the event of changes other than these, the Other Services Provider will be notified via the Amendment procedures described in Section 7.6.2. The Provider shall be entitled to appeal such action to the Grievance Review Committee, the Other Services Advisory Group and then to the PLAN.

4.4 Place of Service

All services are to be provided at a place which the Other Services Provider, Primary Care Physician, or Referral Provider determines is appropriate for the proper rendition thereof, within the constraints of the Healthy Kids Program Evidence of Coverage (Attachment B).

4.5 Consultation with the PLAN's Medical Director

The Other Services Provider or any other Provider may at any time seek consultation with the PLAN's Medical Director on any matter concerning the treatment of the Member.

4.6 Discrimination Prohibited

The Other Services Provider shall not discriminate on the basis of sex, race, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, age, medical condition or mental status. In addition all Other Services Providers shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

4.7 Compliance with Commission Activities and Decisions

The Other Services Provider shall cooperate and participate with the PLAN in Quality Assessment and Improvement and Utilization Review programs, Grievance procedures, and all PLAN efforts undertaken as necessary for the PLAN to comply with federal and state regulatory and contractual requirements. The Provider shall also comply with all final determinations rendered by the PLAN and Commission decisions.

4.8 Linguistic Services

4.8.1 Interpreter Services for Limited English Proficient (LEP) Member

The Other Services Provider shall ensure equal access to health care services for all LEP Members through the utilization of interpreter services at medical (advice, face-to-face or telephone encounters), and non-medical (appointment services, reception) points of contact.

a) Quality Interpreter services shall be furnished during encounters with Other Services Providers (physicians, physician extenders, registered nurses, or other personnel) who provide medical or health care advice to Members, when identified by a Provider or requested by a Member.

Qualified Interpreter services may be obtained through the HPSM (24) hour telephone interpreter service, on-site trained interpreters, bilingual or multilingual providers and/or staff or by contacting the PLAN's Member Services Department for assistance. NOTE: The use of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and I sonly to be used if a Member insists on this after the provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

The PLAN contracts with a telephonic interpreter service vendor to assist Other Services Providers in complying with this Section. Other Services Providers are encouraged to use this service with HPSM members if there is no staff availability of language assistance to the member.

b) Other Services Providers must document the member's preferred language, the request/type of the interpreter services provided or refusal of language interpreter services by a Limited English Proficient (LEP) Member in the medical record.

c) Other Services Providers should utilize bilingual staff and/or the PLAN's interpreter services to ensure that LEP Members receive timely interpretation services at no charge and at all points of contact. This ensures that members are not subjected to unreasonable delays in receiving services.

4.8.2 Additional Linguistic Services for Threshold Language of Members

Threshold languages in each county are designated by the Department of Health Services. These are primary languages spoken by the LEP population groups meeting a specific numeric threshold or concentration standard. The threshold language for San Mateo

County effective 1/1/2000 is Spanish.

In addition to interpreter services for LEP Members as stated in Section 3.8.1, the Provider shall provide the following services for Members whose language proficiency is in a threshold language.

a) Translated signage;
b) Translated written materials; and
c) Referrals to culturally and linguistically appropriate community service programs; and
d) Information on how to file a grievance and the ability to file a grievance in non-English language

The Other Services Provider may request assistance from the PLAN in meeting these requirements.

SECTION 5
EXCLUSIONS FROM AND LIMITATIONS ON COVERED SERVICES

5.1 Exclusions

In addition to those services not covered under the Healthy Kids Program as specified in the Evidence of Coverage (Attachment B), the PLAN shall not make payment for the following services if they are provided to Members:

5.1.1 Dental Benefits, unless these benefits are provided by dental providers who contract with the PLAN to provide services under this program.

5.1.2 Services which in the judgment of the Primary Care Physicians (for services requiring referral) and/or the PLAN's Medical Director (for services requiring prior authorization), are not medically necessary, or appropriate for the control of health related illness, disease, or disability.

5.1.3 Services covered by the California Children's Services Program (CCS).

5.1.4 Other services as may be determined by the PLAN, and as noticed to the Participating PrimaryCarePhysicians.

5.2 Healthy Kids Program Restrictions

5.2.1 Services provided shall be subject to the limitations and procedures listed in the Healthy Kids Program Evidence of Coverage (Attachment B) and the PLAN Provider Manual unless the Other Services Provider is notified of modification to that policy.

5.2.2 State and federal law specify certain restrictions and limitations with respect to abortion and sterilization. These services shall be subject to the limitations specified therein and in the Healthy Kids Program Evidence of Coverage (Attachment B).

5.3 Exceptions to Case Management Control

5.3.1 The Primary Care Physician authorization is not required from the PLAN payment to Providers of Limited Services. The provision of such services shall, however, be subject to the utilization controls and limitations which are in the Healthy Kids Program Evidence of Coverage (Attachment B). Prior authorization where required may be granted by the PLAN's Medical Director.

5.3.2 Obstetrical and Family Planning Services may be obtained on direct patient self-referral to contracting qualified Providers in accord with Federal requirements at 42 CFR 441.20 and the Knox-Keene Health Care Service Plan Act of 1975, Section 1367.695.

SECTION 6
PAYMENTS AND CLAIMS PROCESSING

6.1 Conditions for Payment

The PLAN will make reimbursement to the Provider for services provided to Members if the following conditions are met:

6.1.1 The Member was eligible for the Healthy Kids Program at the time the service was provided by the Provider; and

6.1.2 The service was a Covered Service under the Healthy Kids Program according to regulations in effect at that time; and

6.1.3 Prior authorization, if required, was received by the Provider from the PLAN or the Primary Care Physician.

6.2 Billing for Services Provided

The Other Services Provider shall complete the form(s) specified by the PLAN for all services rendered to Members. Such form(s) shall be submitted with the information and within the time requirements contained in the PLAN Provider Manual.

6.3 Payment for Other Services Providers

Reimbursement for the Other Services Provider services shall be made at the prevailing reimbursement rates in effect for the State Medi-Cal Program or the PLAN payment rate, whichever is higher, for all properly documented services, as found in the Healthy Kids Program Evidence of Coverage (Attachment B).

6.4 Co-payments

Other Services Provider may collect any co-payments from Members as are authorized under the Healthy Kids Program.

6.5 Member Liability

Other than co-payments, the Other Services Provider shall look only to the PLAN for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services, including but not limited to, nonpayment by the PLAN, the PLAN's insolvency, dissolution, bankruptcy or breach of this Agreement. The Other Services Provider shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against, or make any surcharge upon any Member or other person acting on a Member's behalf for Covered Services payable by the PLAN. If the PLAN receives notice of any surcharges upon any Member, it shall be empowered to take appropriate action. This provision shall not prohibit billing and collecting from Members for services which are not Covered Services. The Provider shall supply to the Member prior to treatment of a non-covered service, a written note informing them of their financial responsibility for such services.

The obligations set forth in this Section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between the Other Services Provider and the Member or any persons acting on their behalf.

6.6 No Reimbursement from State or Others

The Other Services Provider agrees to hold harmless the State of California, Children and Families First Commission, Peninsula Community Foundation, the County of San Mateo and Members in the event the PLAN cannot or will not pay for services performed by the Other Services Provider pursuant to the terms of the Agreement.

6.7 Correct Coding Initiative (CCI) Edits

PLAN will utilize current CCI edits unless superseded by existing Medi-Cal payment methodologies.

6.8 Overpayments

Other Services Provider shall furnish and be paid for Covered Services provided to Members in a manner consistent with and in compliance with all applicable laws, regulations, and guidance, including the contractual obligations of HPSM under federal, state, or county health care programs, and with HPSM policies and procedures.

Other Services Provider shall promptly notify PLAN of any Overpayment or other incorrect payment of which Other Services Provider becomes aware and shall refund to PLAN, within 30 days after identification, any amount paid to Other Services Provider in excess of that to which Other Services Provider is entitled under this Agreement. It is Other Services Provider's responsibility to maintain an effective billing and reconciliation system to prevent, detect in a timely fashion, and take proper corrective action for program Overpayments.

An Overpayment may be the result of non-adherence to federal, state, or county health care program requirements, errors by PLAN personnel, payment processing errors by PLAN or designated payors, or erroneous or incomplete information provided by Other Services Provider to PLAN. PLAN shall recover Overpayments, amounts paid to Provider for services that do not

meet the applicable benefit or medical necessity criteria established by PLAN, services not documented in Other Services Provider's records, any services not received by Member, non-Covered Services, or for services furnished when Other Services Provider's license was lapsed, restricted, revoked, or suspended.

PLAN shall recover in accordance with applicable law any Overpayment or other incorrect payment made under this Agreement by offset of the excess amount paid to Other Services Provider against current or future amounts due Other Services Provider, or by request of an immediate refund by Other Services Provider. The Fraud Enforcement and Recovery Act of 2009 (FERA) and the Patient Protection and Affordable Care Act of 2010 (PPACA) make an Overpayment which is retained for over 60 days after its identification an obligation which is sufficient for liability under the False Claims Act. False Claims Act liability includes triple damages and significant fines. PPACA also makes unpaid Overpayments grounds for Medicaid/Medi-Cal program exclusion.

In the event the PLAN determines that it has overpaid a claim, the PLAN shall notify the Other Services Provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the PLAN believes the amount paid on the claim was in excess of the amount due.

If the Other Services Provider does not contest the PLAN's notice of Overpayment, the Other Services Provider shall have 30 working days from the receipt of the notice to reimburse the PLAN the amount of the Overpayment. If the Other Services Provider contests the PLAN's notice of Overpayment, the Other Services Provider shall have 30 working days from the receipt of the notice to send written notice to the PLAN stating the basis upon which the Other Services Provider believes that the claim was not overpaid. The PLAN will receive and process the contested notice of Overpayment of a claim as a provider dispute under the PLAN's provider dispute processes.

If the Other Services Provider does not contest the Overpayment and does not reimburse the PLAN according to the above timelines, then the PLAN may offset the uncontested Overpayment against payments made to the Other Services Provider's current or future claim submissions. In the event that an Overpayment of a claim or claims is offset against Other Services Provider's current or future claim or claims, the PLAN shall provide the Other Services Provider a detailed written explanation identifying the specific Overpayment or payments that have been offset against the specific claim or claims.

PLAN shall take corrective action on Overpayments. Other Services Provider shall take remedial steps to correct the underlying cause of the Overpayment within 60 days of identification of the Overpayment or within such additional time as may be agreed to by PLAN. The corrective action shall include correcting the underlying cause of the Overpayment and taking remedial action to prevent the Overpayment from recurring.

Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by PLAN shall be handled in accordance with such policies and procedures.

SECTION 7
TERM, TERMINATION, AND MODIFICATION

7.1 Effective Date

This Agreement shall become effective on the date specified on the Other Services Provider Medical Services Agreement, or on the date which the PLAN first assumes responsibility for Members under the Healthy Kids Program, whichever is later.

7.2 Term

This Agreement shall be for a term of one (1) year from the date it becomes effective and shall be automatically renewed for subsequent terms of one (1) year each. This Agreement may be terminated or amended as hereinafter provided.

7.3 Termination

7.3.1 This Agreement may be terminated by either party as follows:

If terminated by the Provider, termination shall require sixty (60) days advance written notice of intent to terminate, transmitted by the Provider to the PLAN and shall be delivered or sent postage paid by certified, registered or express mail, courier services (Federal Express, UPS, etc.), or other means which can provide written proof of delivery, and shall be deemed given two (2) days after the date of mailing unless written proof indicates differently, and is to be addressed as follows:

If served on the PLAN, it shall be addressed to:

Health Plan of San Mateo
Attn: Provider Services
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

If served on Provider, it shall be addressed to Provider at the address which appears on this Other Services Provider Medical Transport Services Agreement.

Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

The Provider may terminate this Agreement upon less than sixty (60) days written notice if it is in response to a contract amendment proposed by the PLAN according to the provision of Section 7.5.2.

7.3.2 If termination is initiated by the PLAN, the date of such termination shall be set by consideration for the welfare of the Members and necessary allowance for notification of the Members, and the Provider shall be notified as hereinafter provided. The PLAN may terminate this Agreement at any time and for any reason upon thirty (30) days written notice.

7.3.3 Conditions for Termination by the PLAN

7.3.1.1 The PLAN shall terminate this Agreement effective immediately if the medical license (or applicable license) of the Other Services Provider is revoked or suspended or if the Other Services Provider is excluded from participating in federal or state health programs pursuant to Sections 1128, 1128A, 1156, or 1842(j) of the Social Security Act.

7.3.1.2 The PLAN may terminate this Agreement effective immediately in the following situations: charges to Members by the Provider other than authorized copayment charges for Covered Services and the Provider's failure to comply with the PLAN's utilization control procedures; the Provider's failure to abide by Grievance or Quality Assessment and Improvement Committee decisions; the Provider's failure to maintain adequate levels of insurance as specified in Section 10; failure by the Provider to meet the PLAN's qualification criteria.

7.3.4 This agreement shall terminate automatically upon the termination of the PLAN's contract(s) with Children and Families First Commission, Peninsula Community Foundation, and the County of San Mateo. The PLAN shall notify the Other Services Provider as soon as is practical upon receiving or sending such notice of termination.

7.4 Assignment

This Agreement is a personal service agreement and shall not be transferred or assigned to any other provider or entity.

7.5 Amendment

7.5.1 Amendment by Mutual Agreement

This Agreement may be amended at any time upon written agreement of both parties subject to Section 11.8.

7.5.2 Amendment by the PLAN

This Agreement may be amended by the PLAN upon forty-five (45) business days written notice to the Other Services Provider. The Other Services Provider has the right to negotiate and agree to the change. If the PLAN and the Other Services Provider cannot agree to the Amendment, the Provider has the right to terminate the contract prior to the effective date of the Amendment. The Other Services Provider is expected to provide written notice to the PLAN with as much advance warning as possible.

This Agreement may be amended by the PLAN upon less than forty-five (45) business days written notice to the Other Services Provider if a change in state or federal law or regulation or any accreditation requirements of a private sector accreditation organization require a shorter timeframe for compliance.

None of the provisions in this section shall be construed to prevent the parties from mutually agreeing to waive the forty-five (45) business day notice requirement nor to mutually agree to proposed changes at any time after the Other Services Provider has received notice of the Amendment.

7.5.3 Knox-Keene Amendments

The terms of this Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended, and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind the PLAN and the Other Services Provider as appropriate, whether or not provided herein. If the Director of the Department of Managed Health Care or his/her successor requires further amendments to this Agreement, the PLAN shall notify the Other Services Provider in writing of such amendments. The Other Services Provider will have thirty (30) days from the date of the PLAN's notice to reject the proposed amendments by written notice of rejection to the PLAN. If the PLAN does not receive such written notice of rejection within the thirty (30) day period, the amendments shall be deemed accepted by and binding upon the Other Services Provider. Amendments for this purpose shall include, but not limited to, material changes to the PLAN's Utilization Management, Quality Assessment and Improvement and Grievance programs and procedures and to the health care services covered by this Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and the duties of the parties herein shall be governed by California law.

7.6 Continuity of Care

Upon termination of this Agreement for any reason, the Other Services Provider shall complete treatment in progress and/or shall assist in ensuring an orderly transition of care for Members, including but not limited to the transfer of Medical Records. The cost to the Provider of photocopying such records will be reimbursed by the PLAN at a cost not to exceed $.05 per page.

SECTION 8
RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 Record

The Other Services Provider shall maintain for each Member who has received Covered Services, a legible record of services rendered, kept in detail consistent with appropriate professional practice, which permits effective internal professional review and external medical audit process and which facilitates an adequate system for follow-up treatment. The Provider shall maintain such records for at least five (5) years from the close of the PLAN's fiscal year in which this Agreement was in effect.

8.2 Inspection Rights

The Other Services Provider shall make all books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination, or copying:

8.2.1 By the PLAN, the Department of Managed Health Care, the United States Department of Health and Human Services, and all applicable State and Federal agencies and self-regulatory agencies.

8.2.2 At all reasonable times at the Provider's normal place of business or at such other mutually-agreeable location in California.

8.2.3 In a form maintained in accordance with the general standards applicable to such book or recordkeeping.

8.2.4 For a term of at least five (5) years from the close of the PLAN's fiscal year in which this Agreement was in effect.

8.3 Confidentiality of Member Information

For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to the Members shall be protected by the Other Services Provider and his/her staff from unauthorized disclosure as required by the Healthy Kids Program and any applicable law, (i.e. the Health Insurance Portability and Accountability Act).

8.4 Subcontracts

The Provider shall maintain and make available to the PLAN, the State, the Department of Managed Health Care, and upon request all subcontracts and shall ensure that all subcontracts are in writing and require that the subcontractor:

8.4.1 Make all books and records pertaining to the goods and services furnished under the terms of the Agreement available at all reasonable times for inspection, examination, or copying by the PLAN, the State, the Department of Managed Health Care, and all applicable State and Federal agencies and self-regulating agencies; and

8.4.2 Retain such books and records for a term of at least five (5) years from the close of the State's fiscal year in which the subcontract is in effect.

8.5 Other Insurance Coverage

8.5.1 Health Insurance Other Than Medicare

Providers shall inform the PLAN of all potential third party insurance recoveries. The Other Services Provider agrees to notify the PLAN that health insurance or another health program other than Medicare may cover any Covered Services provided by the Other Services Provider whenever the Other Services Provider discovers this potential coverage. The Other Services Provider also shall cooperate with and assist the PLAN in obtaining such recoveries.

8.5.2 Medicare Recoveries

The Other Services Provider reimbursement rates for Members covered by Medicare requires that the Other Services Provider shall recover directly from Medicare for Medicare services rendered without going through the PLAN. Such Medicare recoveries belong to the Other Services Provider, but shall be reported to the PLAN on the form(s) specified by the PLAN.

8.6 Member's Potential Tort, Casualty, or Workers' Compensation Awards

The Other Services Provider shall notify the PLAN that a potential tort, casualty insurance, or Workers' Compensation award may reimburse Provider for any Covered Services provided by the Other Services Provider whenever the Provider discovers such potential awards.

SECTION 9
INSURANCE AND INDEMNIFICATION

9.1 Liability Insurance

Each participating Other Services Provider covered by this Agreement shall carry at its sole expense liability insurance of at least ONE MILLION DOLLARS ($1,000,000) per person per occurrence, insuring against professional errors and omissions (malpractice) in providing medical services under the terms of this Agreement and for the protection of the interests and property of the Provider, its members and employees, and the PLAN Members.

9.2 Other Insurance Coverage

The Other Services Provider shall carry at its sole expense at least THREE HUNDRED THOUSAND DOLLARS ($300,000) per person per occurrence of the following insurance for the protection of the interest and property of the Provider, its members and employees, PLAN Members, PLAN and third parties, namely, personal injury on or about the premises of the Provider, general liability, employer's liability and Workers' Compensation to the extent said Workers' Compensation is required by law.

9.3 Certificates of Insurance

The Provider at its sole expense, if any, shall provide to the PLAN certificates of insurance or verification of required coverage, and shall notify the PLAN of any notice of cancellation for any and all coverage required by this Agreement, and for subsequent renewals of all required coverage.

9.4 Automatic Notice of Termination

The Provider shall arrange with the insurance carrier to have automatic notification of insurance coverage termination given to the PLAN.

SECTION 10
GRIEVANCES, APPEALS, AND PROVIDER DISPUTES

10.1 Grievance, Appeals and Provider Disputes

It is understood that the Other Services Provider may have Grievances, Appeals and Provider Disputes which may arise as a health care provider under contract with the PLAN. These Grievances, Appeals and Provider Disputes shall be resolved through the mechanisms set out in Section 10.2. The Other Services Provider and the PLAN shall be bound by the decisions of the PLAN's Grievance, Appeals and Provider Disputes mechanisms.

10.2 PLAN Member/Provider Initiated Grievances, Appeals and Provider Disputes Procedure

10.2.1 Responsibility

The PLAN's Chief Executive Officer has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance, Appeals

and Provider Disputes review systems. The Chief Executive Officer shall be assisted by the PLAN'S Director of Compliance and Regulatory Affairs, the Director of Health and Provider Services and the Medical Director or their designees.

10.2.2 Resolution of Member and Provider-Initiated Grievances, Appeals and Provider Disputes

The Other Services Provider agrees that all disputes or disagreements between the Provider and the PLAN or the Member, shall be resolved in accordance with such Grievance, Appeals or Provider Disputes resolution processes, as set forth in the PLAN's Provider Manual. The PLAN may establish, and amend these processes from time to time. To the extent permitted by law, in accordance with applicable provisions of the Knox-Keene Health Service Plan Act of 1975, as amended, and the regulations promulgated hereunder by the Department of Managed Health Care, the Provider shall permit the PLAN to inspect and make copies of any and all records pertaining to any such dispute or disagreement, and shall provide copies of such records to the PLAN upon request.

The Other Services Provider may submit Grievances, Appeals or Provider Disputes to PLAN at the address provided in Section 11.4.1, or by calling PLAN's Grievance and Appeals Coordinator at 888-576-7227 or Provider Disputes Unit at 650-616-2836.

The Other Services Provider shall display in a prominent place at their place of service, notice informing Members how to contact the PLAN and file a complaint.

The Other Services Provider shall provide the telephone number of the PLAN to any Member wishing to file a complaint.

SECTION 11
GENERAL PROVISIONS

11.1 In the event any part of this Agreement is found to be unlawful or legislation modifies the entitlement of the Members or other provision hereunder, the Agreement shall automatically and without prior notice be modified to reflect that which is lawful and all other provisions shall remain in full force and effect.

11.2 Within constraints of applicable state and federal statutes, the PLAN shall inform the Members regarding the Other Services Providers willingness to undertake service to them.

11.3 The waiver by the PLAN of any one or more defaults, if any, on the part of the Other Services Provider hereunder, shall not be construed to operate as a waiver by the PLAN of any other or future default in the same obligation or any other obligation in this Agreement.

11.4 Whenever either party amends or terminates this Agreement, such notice shall be given in writing and shall be delivered or sent postage paid by certified, registered or express mail, courier services (Airborne, Federal Express, UPS, etc.), or other means which can provide written proof of delivery, and shall be deemed given two (2) days after the date of mailing unless written proof indicates differently, and is to be addressed as follows:

11.4.1 If served on the PLAN, it should be addressed to:

Health Plan of San Mateo
Attn: Provider Services
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080

11.4.2 If served on the Other Services Provider, it shall be addressed to the Provider at the address which appears on the Other Services Provider Medical Services Agreement.

Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

11.5 This Agreement shall not be modified, altered or changed in any manner, except as provided in Sections 7.5.1, 7.5.2, and 11.1.

11.6 None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee or the representative of the other.

11.7 Throughout this Agreement the singular shall include the plural, and the plural the singular; the masculine shall include the neuter and feminine, and the neuter the masculine and the feminine.

11.8 This Agreement and any amendment to it shall become effective only after approval by the Department of Managed Health Care of the form of the Agreement or amendment.

11.9 This Agreement contains provisions that require the Other Services Provider to comply with quality improvement, case management, and utilization management programs. By signing this Agreement, the Other Services Provider indicates that he/she has been given 15 business days in which to consider this Agreement. If he/she executes this Agreement within these 15 business days, he/she does so of his/her own free will.

SECTION 12
PROVIDER MANUAL

PLAN offers, via the PLAN's website and upon request, the Other Services Provider with a Provider Manual that contains those PLAN policies and procedures necessary for the proper operation of the Other Services Provider as it relates to Members and which describes all benefits plans, including limitations and exclusions offered by the PLAN. Other Services Provider agrees to comply with PLAN standards and policies outlined the Provider Manual.

SECTION 13
OTHER SERVICES PROVIDER RELATIONSHIP TO PLAN

13.1 PLAN designates Other Services Provider as a primary provider of emergency and non-emergent transportation services. PLAN and Provider acknowledge this primary provider relationship is based on the Parties agreeing such a relationship: (1) is in full compliance with all State and federal guidelines regarding the patients' right to select a service provider, (2) is in expectation

this preferred provider relationship will improve care coordination and further PLAN's goal of providing the right level of care at the right time for any patient requiring Provider's services, (3) that all fees paid by PLAN to Other Services Provider are based upon currently applicable Medicare and/or Medi-Cal fees as described above in Section 6 Payments, and without a pre-set expectation of patient referral volume, and (4) that this Agreement is not structured as any type of joint venture arrangement.

13.2 Other Services Provider shall respect the rights of any Member to select an alternate ambulance or non-ambulance services provider based on personal preference, insurance payor preference, or any other criteria as set forth under federal and State regulation.

13.3 All Other Services Provider services shall be requested from a ten-digit toll-free telephone number linked to Other Services Provider Call Center.

EXHIBIT C

HEALTHWORX

Other Services Medical Transport Services Agreement
Between
San Mateo Community Health Authority
And
American Medical Response West

This Medical Transport Services Agreement ("Agreement") is entered into this **1st day of March 2016,** by and between **American Medical Response West,** a California corporation licensed in the State of California to provide medical transport, (hereinafter referred to as "Provider" or "Other Services Provider") and certified to participate in the Medicare and State of California Medi-Cal programs, and the San Mateo Community Health Authority, a public corporation (hereinafter referred to as "Authority" or "PLAN"). The parties agree as follows:

This Other Services Medical Transport Services Agreement in its entirety is comprised of the following:

Other Services Medical Transport Service Agreement
Attachment A -- Case Management Protocol
Attachment B -- HealthWorx Program Summary of Benefits

The Provider has read and agrees to abide by the Agreement and all its Attachments, which are attached hereto and incorporated herein by reference.

The Provider shall participate as a Provider subject to the attached Terms and Conditions and Case Management Protocol.

The Provider agrees to be placed on a list of Other Services Providers to which Primary Care Physicians and Referral Providers may refer Members.

Other Services Provider
Executed by:

Signature

Brad White, General Manager
(Print Name and Title)

1510 Rollins Road, Burlingame, CA 94010
Address

September 3, 2015
Date

Authority
Executed by:

Authorized Signature for
San Mateo Community Health Authority

701 Gateway Blvd., Suite 400
South San Francisco, 94080
Address

3/16/16
Date

Tax ID#: 77-0324739
NPI#: 1659305902
Medicare#: ZZZ13822Z
Medicaid#: MTE00929F

HEALTHWORX

OTHER SERVICES PROVIDER
MEDICAL TRANSPORT SERVICES AGREEMENT

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TERMS AND CONDITIONS

Recitals

A. The PLAN has entered into or will enter into and maintain a contract with the San Mateo County Public Authority pursuant to which individuals who subscribe and are enrolled under the HealthWorx Program will receive, through the PLAN, health services hereinafter defined as "Covered Services".

B. The PLAN shall arrange such Covered Services under the Case Management of Primary Care Physicians chosen by or assigned to Members.

C. The Provider shall participate in providing Covered Services to Members and shall receive payment from the PLAN for the rendering of those Covered Services.

NOW, THEREFORE, it is agreed that the above Recitals are true and correct and as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

1.1 "**Advanced Access**" shall mean the provision, by an individual physician, physician group or the medical group to which a Member is assigned, of appointments with a PCP, or other qualified primary care provider such as a nurse physician or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the Member prefers not to accept the appointment offered within the same or next business day.

1.2 "**Appointment Waiting Time**" shall mean the time from the initial request for health care services by a Member or the Member's provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from HPSM or completing any other condition or requirement of HPSM.

1.3 **"Attending Physician"** shall mean (a) any Physician who is acting in the provision of Emergency Services to meet the medical needs of the Member or (b) any Physician who is, through delegation from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition.

1.4 **"Authority"** shall mean the San Mateo Community Health Authority.

1.5 **"Case Managed Members"** shall mean those Members who select or are assigned to a Primary Care Physician and are identified on the Primary Care Physician's Case Management list. The Primary Care Physician is responsible for delivering or arranging for delivery of all health services required by these Members under the conditions set forth in the Primary Care Physician Medical Services Agreement.

1.6 **"Case Management"** shall mean the coordination and follow up by the Primary Care Physician, of all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

1.7 **"Co-payment"** shall mean the portion of covered health care cost for which the Member has financial responsibility under the HealthWorx Program.

1.8 **"Correct Coding Initiative Edits"** shall mean the nationally recognized standards for editing claims for accurate coding and reporting of services.

1.9 **"Covered Services"** shall mean those health care services and supplies which a Member is entitled to receive under HealthWorx and which are set forth in the HealthWorx Evidence of Coverage (Attachment B) and in the PLAN's Provider Manual.

1.10 **"Emergency Services"** shall mean those health care services required to relieve a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

i) placing the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
ii) serious impairment of bodily functions, or
iii) serious dysfunction of any bodily organ or part.

Emergency services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.

1.11 **"Evidence of Coverage"** shall mean the document issued by PLAN to Members that describes Covered Services and Non-Covered Services in the HealthWorx Program.

1.12 **"Excluded Services"** shall mean specific conditions or circumstances listed in the Agreement or HealthWorx Evidence of Coverage (Attachment B), and not required by the Knox-Keene Act, for which the PLAN will not provide benefit payments. These services may also be referred to as "Non-Covered Services".

1.13 **"Health Plan of San Mateo"** (HPSM) shall mean the health plan governed by the San Mateo Community Health Authority.

1.14 **"HealthWorx "** shall mean the health insurance plan under Section 14087.51 of the California Welfare and Institution Code that is administered by the Health Plan of San Mateo for eligible In-Home Supportive Services (IHSS) workers whose employer of record is the San Mateo County Public Authority.

1.15 **"Identification Card"** shall mean a card issued by HealthWorx and/or PLAN to each covered person that bears the name and symbol of the PLAN and contains: Member's name and identification number, and the name of the Member's Primary Care Physician. The Identification Card is not proof of Member eligibility.

1.16 **"Interpreter"** shall mean a person fluent in English and in the necessary second language, who can accurately speak, read, and readily interpret the necessary second language, or person who can accurately sign and read sign language.

1.17 **"Limited English Proficient Member (LEP)"** shall mean Members who are limited-English speaking or non-English speaking including those who speak a language other than a threshold language.

1.18 **"Limited Services"** shall mean those Covered Services rendered by a chiropractor, acupuncturist, or podiatrist as covered under HealthWorx.

1.19 **"Limited Service Hospital"** shall mean hospital which is under contract to the PLAN, but not as a Participating Hospital.

1.20 **"Medical Director"** shall mean the PLAN's Medical Director.

1.21 **"Medical Interpreter"** shall mean a person fluent in English and the necessary second language, providing language services at medical points of contact with language proficiency related to clinical settings.

1.22 **"Medi-Cal Provider Manual"** shall mean the Medical Services Provider Manual of the Department of Health Services, issued by the Department's Fiscal Intermediary.

1.23 **"Member"** shall mean an individual who is enrolled in good standing with HealthWorx.

1.24 **"Non-Medical Interpreter"** shall mean a person fluent in English and the necessary second language, providing language services at non-medical points of contact with language proficiency related to the specific setting or circumstance.

1.25 **"Other Services"** shall mean: chiropractic, acupuncture, occupational therapy, speech pathology, audiology, podiatry, physical therapy, durable medical equipment, medical supplies, and, other Covered Services not otherwise covered under any other contract with HealthWorx.

1.26 **"Overpayments"** shall mean the amount of money Other Services Provider has received in excess of the amount due and payable under any federal, state, or other health care program requirements.

1.27 **"Other Services Provider Advisory Group"** shall mean the committee of Other Service Providers in San Mateo County chosen each year from among contracting Other Services Providers by PLAN for the purpose of advising PLAN.

1.28 **"Participating Hospital"** shall mean a Hospital which has entered into an Agreement with the PLAN to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.29 **"Participating Physician"** shall mean a Physician who has entered into an Agreement with the PLAN to provide Covered Services to Members. The term Participating and Contracting may be used interchangeably.

1.30 **"PLAN"** shall mean the programs governed by the San Mateo Community Health Authority which serve San Mateo County Medi-Cal Members and Members of Healthy Families and HealthWorx, also called Health Plan of San Mateo.

1.31 **"Preventive Care"** shall mean health care provided for prevention and early detection of disease, Illness, injury or other health condition.

1.32 **"Primary Care Physician" or "PCP"** shall mean Participating Physician duly licensed in California and certified by the Medi-Cal Program and who has executed an Agreement with the PLAN to provide the services of a Primary Care Physician.

1.33 **"Provider"** shall mean any health professional or institution certified to render services to Members and who has entered into a Service Agreement with the PLAN under HealthWorx.

1.34 **"Quality Assessment"** shall mean those processes and procedures established by the PLAN and designed to review and analyze various aspects of desired health care.

1.35 **"Referral/Authorization"** shall mean the process by which Participating Physicians or Providers direct a Member to seek or obtain Covered Services from a health professional, hospital or any other Provider of Covered Services in accordance with the PLAN's referral and authorization procedures.

1.36 **"Referral Provider"** shall mean any qualified Provider duly licensed in California and certified by the Medi-Cal Program who has executed an Agreement with the PLAN and is professionally qualified to practice his/her designated specialty and to whom the Primary Care Physician may refer any Member for consultation or treatment.

1.37 **"Referral Services"** shall mean any services which are not Primary Care Services and which are furnished by Providers on referral from the Primary Care Physician or by the Primary Care Physician.

1.38 **"San Mateo County"** shall also be referred to as "County".

1.39 **"Threshold Language"** shall mean primary languages spoken by LEP population groups meeting a numeric threshold of 3,000 eligible Members residing in a county. Additionally, languages spoken by a population of eligible LEP Members residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous, are also considered threshold languages for a county. Threshold languages in each county are designated by the California Department of Health Services.

1.40 **"Treatment Authorization Form" (TARs)** shall mean forms generated by Providers to request a service/treatment that requires prior authorization by the PLAN.

1.41 **"Triage" or "Screening"** shall mean the assessment of a Member's health concerns and symptoms via communication, with the physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to triage or screen a Member who may need care, for the purpose of determining the urgency of the Member's need for care.

1.42 **"Triage or Screening Waiting Time"** shall mean the time waiting to speak by telephone with a physician, registered nurse or other qualified health professional acting within his or her scope of practice who is trained to screen or triage a Member who may need care.

1.43 **"Urgent Care"** shall mean health care for a condition which requires prompt attention.

1.44 **"Utilization Management" (UM)** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or medically necessary and which all Participating Providers must follow.

SECTION 2
QUALIFICATIONS

2.1 Other Services Provider

Any Other Services Provider duly licensed in the State of California may elect to serve Members hereunder as an Other Services Provider if that Provider meets the qualifications that may be set by the PLAN and:

2.1.1 Is or is in the process of being certified, and in good standing to provide services under the California Medi-Cal program including those requirements contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Administrative Code; and

2.1.2 Is an Other Services Provider within San Mateo County or has been specifically excepted from this requirement by the Executive Director or his/her designee.

SECTION 3
PROVIDER/PATIENT RELATIONSHIP

3.1 Member Designation

At the time HealthWorx eligibility is confirmed, the PLAN will request that each person select a Primary Care Physician contracting with the PLAN through whom that Member will seek all medical services, except Emergency Services and Limited Services. If no selection is made, the PLAN shall assign Member to a Primary Care Physician.

3.2 Listing

The PLAN will enter the name of each Other Services Provider contracted onto a list of Other Services Providers from which Primary Care Physician and Referral Provider may refer and Members may choose. Such a list shall contain the following information concerning the Other Services Providers:

- o Name
- o Address(es)
- o Telephone Number(s)
- o Language Capability
- o Scope of Services (Specialty)
- o Office Days and Hours

The PLAN may list Other Services Providers outside the County or not having privileges at a Participating Hospital on a separate list made available to Members on request.

3.3 Eligibility Verification

Other Services Provider shall verify the eligibility of Members who present themselves at the time of service. Other Services Provider may make such verification by contacting the PLAN via the verification options as described in the Provider Manual.

SECTION 4
COVERED SERVICES

4.1 Covered Services

Other Services Provider services are covered when provided by persons who meet the appropriate requirement to render services under the HealthWorx Evidence of Coverage (Attachment B); and these Covered Services are subject to the limitations set forth in HealthWorx, unless specifically excepted by PLAN.

4.2 Prior Authorizations

Prior authorization is required in accordance with the PLAN's Utilization Management Protocol, and the HealthWorx Evidence of Coverage (Attachment B).

4.3 Imposition of Controls if Necessary

In the interest of program integrity or the welfare of Members, the PLAN may introduce utilization controls as may be necessary at any time. In the event of such change, the change may take effect immediately upon receipt by the Other Services Provider of notice from the PLAN's Medical Director, but the Provider shall be entitled to appeal such action to the Grievance Review Committee, the Other Services Advisory Group and then to the PLAN.

4.4 Place of Service

All services are to be provided at a place which the Other Services Provider or Referral Provider determines is appropriate for the proper rendition thereof, within the constraints of the HealthWorx Evidence of Coverage (Attachment B).

4.5 Consultation with PLAN's Medical Director

Other Services Provider or any other Provider may at any time seek consultation with the PLAN's Medical Director on any matter concerning the treatment to the Member.

4.6 Discrimination Prohibited

The Other Services Provider shall not discriminate on the basis of sex, race, creed, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), mental disability, age, medical condition or mental status. In addition all Primary Care Providers shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

4.7 Compliance with Commission Activities and Decisions

The Other Services Provider shall cooperate and participate with the PLAN in Quality Assessment and Improvement and Utilization Review programs, Grievance procedures, and all PLAN efforts undertaken as necessary for the PLAN to comply with federal and state regulatory and contractual requirements. The Provider shall also comply with all final determinations rendered by the PLAN and Commission decisions.

4.8 Linguistic Services

4.8.1 Interpreter Services for Limited English Proficient (LEP) Members

The Other Services Provider shall ensure equal access to health care services for all LEP Members through the utilization of qualified interpreter services at medical (advice, face to face, or telephone encounters), and non medical (appointment services, reception) points of contact.

a) Qualified Interpreter services shall be furnished during encounters with Providers (Provider extenders, registered nurses, or other personnel) who provide medical or health care advice to Members, when identified by a Provider or requested by a Member.

b) Qualified Interpreter services may be obtained through the HPSM (24) hour telephone language line service, on-site trained interpreters, bilingual or multilingual Providers. NOTE: The use of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and is only to be used if a Member insists on this after provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

c) The PLAN contracts with a qualified telephonic interpreter service to assist Providers in complying with this Section. Providers are encouraged to use this service with HPSM members if there is no staff availability of language assistance to the member.

d) Provider must document the patient's preferred language, the request/type of interpreter services provided or refusal of language interpreter services by a Limited English Proficient (LEP) Member in the medical record.

e) Providers should utilize bilingual staff and/or the PLAN's interpreter services to ensure that Limited English Proficient members receive timely interpretation services at no charge and at all points of contact. This ensures that members are not subjected to unreasonable delays in receiving services.

4.8.2 Additional Linguistic Services for Threshold Language Members

Threshold languages in each county are designated by the Department of Health Services. These are primary languages spoken by the LEP population groups meeting a specific numeric threshold or concentration standard. The threshold language for San Mateo County effective 1/1/2000 is Spanish.

In addition to interpreter services for LEP Members as stated in Section 4.8.1, the Provider shall provide the following services for Members whose language proficiency is in a threshold language.

a) Translated signage;
b) Translated written materials; and
c) Referrals to culturally and linguistically appropriate community service programs
d) Information on how to file a grievance and the ability to file a grievance in non-English language

The Other Services Provider may request assistance from the PLAN in meeting these requirements.

SECTION 5
LIMITATIONS ON COVERED SERVICES

5.1 HealthWorx Restrictions

5.1.1 Services provided shall be subject to the limitations and procedures listed in the HealthWorx Evidence of Coverage (Attachment B) and the PLAN's Provider Manual unless the Other Services Provider is notified of modification to that policy.

5.1.2 State and federal law specify certain restrictions and limitations with respect to abortion and sterilization. These services shall be subject to the limitations specified therein and in the PLAN's Provider Manual.

5.2 Exceptions to Case Management Control

5.2.1 Primary Care Physician authorization is not required for PLAN payment to providers of Limited Services. The provision of such services shall, however, be subject to the utilization controls and limitations which are in the HealthWorx Evidence of Coverage (Attachment B).

5.2.2 Obstetrical and Family Planning Services may be obtained on direct patient self-referral to contracting qualified Providers in accord with Federal requirements at 42 CFR 441.20.and the Knox-Keene Health Care Services Plan Act of 1975, Section 1367.695.

SECTION 6
PAYMENTS AND CLAIMS PROCESSING

6.1 Conditions for Payment

The PLAN will make reimbursement to the Provider for services provided to Members if the following conditions are met:

6.1.1 The Member was eligible for HealthWorx at the time the service was provided by the Provider; and

6.1.2 The service was a Covered Service under HealthWorx according to regulations in effect at that time; and

6.1.3 Prior authorization, if required, was received by the Provider from the PLAN or Primary Care Physician, except for emergency ambulance services rendered by Provider to a Member.

6.2 Billing for Services Provided

The Other Services Provider shall complete the form(s) specified by the PLAN for all services rendered to Members. Such form(s) shall be submitted with the information and within the time requirements contained in the PLAN's Provider Manual.

6.3 Payment for Other Services Providers

6.3.1 Reimbursement for the Other Services Provider services shall be made at the prevailing reimbursement rates in effect for the Medi-Cal Program using the PLAN payment rate in effect for the State Medi-Cal Program or the PLAN payment rate, whichever is higher, for all properly documented services as found in the HealthWorx Evidence of Coverage (Attachment B).

6.3.2 The Medi-Cal Program's maximum reimbursement rates are referenced in the Medi-Cal Provider Manual.

6.4 Co-payments

Provider may collect any copayments from Members as are authorized under HealthWorx.

6.5 Member Liability

Other than copayments, the Other Services Provider shall look only to the PLAN for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services, including but not limited to, nonpayment by the PLAN, the PLAN's insolvency, dissolution, bankruptcy or breach of this Agreement. The Other Services Provider shall not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against, or make any surcharge upon any Member or other persons acting on a Member's behalf for Covered Services payable by the PLAN. If the PLAN receives notice of any surcharges upon any Member, it shall be empowered to take appropriate action. This provision shall not prohibit billing and collecting from Members for services which are not Covered Services. The Provider shall supply to Member prior to treatment of a non-covered service, a written notice informing them of their financial responsibility for such services.

The obligations set forth in this Section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between the Other Services Provider and the Member or any persons acting on their behalf.

6.6 No Reimbursement From State

The Provider shall hold harmless the State of California, and Members in the event the PLAN cannot or will not pay for services performed by the Provider pursuant to the terms of this Agreement.

6.7 Correct Coding Initiative (CCI) Edits

PLAN will utilize current CCI edits unless superseded by existing Medi-Cal payment methodologies.

6.8 Overpayments

Other Services Provider shall furnish and be paid for Covered Services provided to Members in a manner consistent with and in compliance with all applicable laws, regulations, and guidance, including the contractual obligations of HPSM under federal, state, or county health care programs, and with HPSM policies and procedures.

Other Services Provider shall promptly notify PLAN of any Overpayment or other incorrect payment of which Other Services Provider becomes aware and shall refund to PLAN, within 30 days after identification, any amount paid to Other Services Provider in excess of that to which Other Services Provider is entitled under this Agreement. It is Other Services Provider's responsibility to maintain an effective billing and reconciliation system to prevent, detect in a timely fashion, and take proper corrective action for program Overpayments.

An Overpayment may be the result of non-adherence to federal, state, or county health care program requirements, errors by PLAN personnel, payment processing errors by PLAN or designated payors, or erroneous or incomplete information provided by Other Services Provider to PLAN. PLAN shall recover Overpayments, amounts paid to Other Services Provider for services that do not meet the applicable benefit or medical necessity criteria established by PLAN, services not documented in Other Services Provider's records, any services not received by Member, non-Covered Services, or for services furnished when Other Services Provider's license was lapsed, restricted, revoked, or suspended.

PLAN shall recover in accordance with applicable law any Overpayment or other incorrect payment made under this Agreement by offset of the excess amount paid to Other Services Provider against current or future amounts due Other Services Provider, or by request of an immediate refund by Other Services Provider. The Fraud Enforcement and Recovery Act of 2009 (FERA) and the Patient Protection and Affordable Care Act of 2010 (PPACA) make an Overpayment which is retained for over 60 days after its identification an obligation which is sufficient for liability under the False Claims Act. False Claims Act liability includes triple damages and significant fines. PPACA also makes unpaid Overpayments grounds for Medicaid/Medi-Cal program exclusion.

In the event the PLAN determines that it has overpaid a claim, the PLAN shall notify the Other Services Provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the PLAN believes the amount paid on the claim was in excess of the amount due.

If the Other Services Provider does not contest the PLAN's notice of Overpayment, the Other Services Provider shall have 30 working days from the receipt of the notice to reimburse the PLAN the amount of the Overpayment. If the Other Services Provider contests the PLAN's notice of Overpayment, the Other Services Provider shall have 30 working days from the receipt of the notice to send written notice to the PLAN stating the basis upon which the Other Services Provider believes that the claim was not overpaid. The PLAN will receive and process the contested notice of Overpayment of a claim as a provider dispute under the PLAN's provider dispute processes.

If the Other Services Provider does not contest the Overpayment and does not reimburse the PLAN according to the above timelines, then the PLAN may offset the uncontested Overpayment against payments made to the Other Services Provider's current or future claim submissions. In the event that an Overpayment of a claim or claims is offset against any Other Services Provider's current or future claim or claims, the PLAN shall provide the Other Services Provider a detailed written explanation identifying the specific Overpayment or payments that have been offset against the specific claim or claims.

PLAN shall take corrective action on Overpayments. Other Services Provider shall take remedial steps to correct the underlying cause of the Overpayment within 60 days of identification of the Overpayment or within such additional time as may be agreed to by PLAN. The corrective action shall include correcting the underlying cause of the Overpayment and taking remedial action to prevent the Overpayment from recurring.

Notwithstanding the above, notification and repayment of any Overpayment amount that routinely is reconciled or adjusted pursuant to policies and procedures established by PLAN shall be handled in accordance with such policies and procedures.

SECTION 7
TERM, TERMINATION, AND AMENDMENT

7.1 Effective Date

This Agreement shall become effective on the date specified on the Other Services Provider Medical Services Agreement, or on the date which the PLAN first assumes responsibility for Members under HealthWorx, whichever is later.

7.2 Term

This Agreement shall be for a term of one (1) year from the date it becomes effective and shall be automatically renewed for subsequent terms of one (1) year each. This Agreement may be terminated or amended as hereinafter provided.

7.3 Termination

This Agreement may be terminated by either party as follows:

7.3.1 If terminated by the Provider, termination shall require sixty (60) days advance written notice of intent to terminate, transmitted by the Provider to the PLAN as provided in Section 12.4.1., addressed to the office of PLAN.

7.3.2 The Provider may terminate this Agreement upon thirty (30) days written notice if in response to a contract amendment instituted according to the provision of Section 8.6.2, the Provider notifies the PLAN in writing of termination within sixty (60) days of notice said amendment.

7.3.3 If termination is initiated by the PLAN, the date of such termination shall be set by consideration for the welfare of Members and necessary allowance for notification of Providers and Members, and the Provider shall be notified as hereinafter provided. The

PLAN may terminate this Agreement at any time and for any reason upon thirty (30) days prior written notice.

7.3.4 Condition for Termination by the PLAN

7.3.4.1 The PLAN shall terminate this Agreement effective immediately if the medical license of the Other Services Provider is revoked or suspended or if the Other Services Provider is excluded from participating in federal or state health programs pursuant to sections 1128, 1128A, 1156, or 1842(j) of the Social Security Act.

7.3.4.2 The PLAN may terminate this Agreement effective immediately in the following situations: charges to Members by the Provider other than authorized co-payment charges for Covered Services and the Provider's failure to comply with the PLAN's utilization control procedures; the Provider's failure to abide by Grievance or Quality Assessment and Improvement Committee decisions; the Provider's failure to maintain adequate levels of insurance as specified in Section 9; Provider's failure to meet the PLAN qualification criteria.

7.3.5 This Agreement shall terminate automatically on the date of the termination of the PLAN's contract with the State of California. The PLAN shall notify the Provider as soon as is practical upon receiving or sending such notice of termination.

7.4 Assignment

This Agreement is a personal service agreement and shall not be transferred or assigned to any other provider or entity.

7.5 Amendment

7.5.1 Amendment by Mutual Agreement

This Agreement may be amended at any time upon written agreement of both parties subject to Section 11.8.

7.5.2 Amendment by the PLAN

This Agreement may be amended by the PLAN upon thirty (30) days written notice to the Provider. If the Provider does not give written notice of termination within thirty (30) days, as authorized by the Section 8.3.2, Provider agrees that any such amendment by the PLAN shall be a part of the Agreement. However, the provisions of Section 8.6.2 may not be invoked to amend any portion of Section 7 of this Agreement.

7.5.3 Knox-Keene Amendments

The terms of this Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 the "Act"), as amended, and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind the PLAN and the Provider as appropriate, whether or not provided herein. If the Director of

the California Department of Managed Health Care or his/her successor requires further amendments to this Agreement, the PLAN shall notify the Provider in writing of such amendments. The Provider will have thirty (30) days from the date of the PLAN's notice to reject the proposed amendments by written notice of rejection to the PLAN. If the PLAN does not receive such written notice of rejection within the thirty (30) day period, the amendments shall be deemed accepted by and binding upon the Provider. Amendments for this purpose shall include, but not be limited to, material changes to the PLAN's Utilization Management, Quality Assessment and Improvement and Grievance programs and procedures and to the health care services covered by this Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and the duties of the parties herein shall be governed by California law.

7.6 Continuity of Care

Upon termination of this Agreement for any reason the Other Services Provider shall complete treatment in progress and/or shall assist in ensuring an orderly transition of care for Members, including but not limited to the transfer of Medical Records. The cost to the Provider of photocopying said records will be reimbursed by PLAN at a cost not to exceed $.25 per page.

SECTION 8
RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 Records

The Provider shall maintain for each Member who has received Covered Services, a legible record of services rendered, kept in detail consistent with appropriate professional practice. The Provider shall maintain such records for at least five (5) years from the close of the PLAN's fiscal year in which this Agreement was in effect.

8.2 Inspection Rights

The Provider shall make all books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination, or copying:

8.2.1 By the PLAN, the State, the Department of Managed Health Care, and all applicable State and Federal agencies and self regulating agencies.

8.2.2 At all reasonable times at the Provider's normal place of business or at such other mutually-agreeable location in California.

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

8.2.4 For a term of at least five (5) years from the close of the PLAN's fiscal year in which this Agreement was in effect.

8.3 Confidentiality of Member Information

For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by the Provider and its staff from unauthorized disclosure as required by HealthWorx and any applicable laws.

8.4 Subcontracts

The Provider shall maintain and make available to the PLAN, the State, the Department of Managed Health Care, and upon request all subcontracts and shall ensure that all subcontracts are in writing and require that the subcontractor:

8.4.1 Make all books and records pertaining to the goods and services furnished under the terms of the Agreement available at all reasonable times for inspection, examination, or copying by the PLAN, the State, the Department of Managed Health Care, and all applicable State and Federal agencies and self-regulating agencies; and

8.4.2 Retain such books and records for a term of at least five (5) years from the close of the State's fiscal year in which the subcontract is in effect.

8.5 Other Insurance Coverage

8.5.1 Health Insurance Other Than Medicare

Providers shall inform the PLAN of all potential third party insurance recoveries. The Other Services Provider agrees to notify the PLAN that health insurance or another health program other than Medicare may cover any Covered Services provided by the Other Services Provider whenever the Other Services Provider discovers this potential coverage. The Other Services Provider also shall cooperate with and assist the PLAN in obtaining such recoveries.

8.5.2 Medicare Recoveries

The Other Services Provider reimbursement rate for Members covered by Medicare requires that the Other Services Provider shall recover directly from Medicare for Medicare services rendered without going through the PLAN. Such Medicare recoveries belong to the Other Services Provider, but shall be reported to the PLAN on the form(s) specified by the PLAN.

8.6 Member's Potential Tort, Casualty, or Worker's Compensation Awards

The Other Services Provider shall notify the PLAN that a potential tort, casualty insurance, or Worker's Compensation award may reimburse provider for any Covered Services provided by the Other Services Provider whenever the Provider discovers such potential awards.

SECTION 9
INSURANCE AND INDEMNIFICATION

9.1 Liability Insurance

Each participating Provider covered by this Agreement shall carry at its sole expense liability insurance of at least ONE MILLION DOLLARS ($1,000,000) per person per occurrence, insuring against professional errors and omissions (malpractice) in providing medical services under the terms of this Agreement and for the protection of the interests and property of the Provider, its members and employees, and the PLAN Members.

9.2 Other Insurance Coverage

The Provider shall carry at its sole expense at least THREE HUNDRED THOUSAND DOLLARS ($300,000) per person per occurrence of the following insurance for the protection of the interest and property of the Provider, its members and employees, PLAN Members, PLAN and third parties, namely, personal injury on or about the premises of the Provider, general liability, employer's liability and Workers' Compensation to the extent said Workers' Compensation is required by law.

9.3 Certificates of Insurance

The Provider at its sole expense, if any, shall provide to the PLAN certificates of insurance or verifications of required coverage, and shall notify the PLAN of any notice of cancellation of any and all coverage required by this Agreement, and for subsequent renewals of all required coverage.

9.4 Automatic Notice of Termination

The Provider shall direct the insurance carrier to have automatic notification of insurance coverage termination given to the PLAN.

SECTION 10
GRIEVANCES, APPEALS, AND PROVIDER DISPUTES

10.1 Grievances, Appeals and Provider Disputes

It is understood that the Provider may have Grievances, Appeals and Provider Disputes which may arise as a health care provider under contract with the PLAN. These Grievances, Appeals and Provider Disputes shall be resolved through the mechanisms set out in Section 10.2. The Provider and the PLAN shall be bound by the decisions of the PLAN's Grievance, Appeals and Provider Disputes mechanisms.

10.2 PLAN Member/Provider Initiated Grievances, Appeals and Provider Disputes Procedure

10.2.1 Responsibility

The PLAN's Chief Executive Officer has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance, Appeals

and Provider Disputes review systems. The Chief Executive Officer shall be assisted by the PLAN'S Director of Compliance and Regulatory Affairs, the Director of Health and Provider Services, and the Medical Director, or their designees.

10.2.2 Resolution of Member and Provider-Initiated Grievances, Appeals and Provider Disputes

The Provider agrees that all disputes or disagreements between the Provider and the PLAN or the Member, shall be resolved in accordance with such Grievance, Appeals or Provider Disputes resolution processes, as set forth in the PLAN's Provider Manual. The PLAN may establish, and amend these processes from time to time. To the extent permitted by law, in accordance with applicable provisions of the Knox-Keene Health Service Plan Act of 1975, as amended, and the regulations promulgated hereunder by the Department of Managed Health Care, the Provider shall permit the PLAN to inspect and make copies of any and all records pertaining to any such dispute or disagreement, and shall provide copies of such records to the PLAN upon request.

The Provider may submit Grievances, Appeals or Provider Disputes to PLAN at the address provided in Section 11.4.1, or by calling PLAN's Grievance and Appeals Coordinator at 888-576-7227 or Provider Disputes Unit at 650-616-2836.

The Provider shall display in a prominent place at their place of service, notice informing Members how to contact the PLAN and file a complaint.

The Provider shall provide the telephone number of the PLAN to any Member wishing to file a complaint.

SECTION 11
GENERAL PROVISIONS

11.1 In the event any part of this Agreement is found to be unlawful or legislation modifies the entitlement of Members or other provision hereunder, the Agreement shall automatically and without prior notice be modified to reflect that which is lawful and all other provisions shall remain in full force and effect.

11.2 Within constraints of applicable state and federal statutes, the PLAN shall inform Members regarding the Providers willingness to undertake service to them.

11.3 The waiver by the PLAN of any one or more defaults, if any, on the part of the Provider hereunder, shall not be construed to operate as a waiver by the PLAN of any other or future default in the same obligation or any other obligation in this Agreement.

11.4 Whenever it shall become necessary for either party to amend or terminate this Agreement, such notice shall be in writing and shall be delivered or sent postage paid by certified, registered or express mail, courier services (Airborne, Federal Express, UPS, etc.), or other means which can provide written proof of delivery, and is to be addressed as follows:

11.4.1 If served on the PLAN, it should be addressed to:

Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
Attn: Provider Services

11.4.2 If served on the Provider, it shall be addressed to the Provider at the address which appears on the Other Services Provider Medical Services Agreement. Any such notice so mailed shall be deemed to have been served upon and received by the addressee forty-eight (48) hours after the same has been deposited in Registered or Certified United States mail, Return Receipt Requested. Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

11.5 It is agreed by these parties that neither this Agreement in its entirety, nor any portion thereof, may be modified, altered or changed in any manner, except as provided in Sections 7.5.1 and 7.5.2.

11.6 None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee or the representative of the other.

11.7 Throughout this Agreement the singular shall include the plural, and the plural the singular; the masculine shall include the neuter and feminine, and the neuter the masculine and feminine.

11.8 This Agreement and any amendment to it shall become effective only after approval by the PLAN of the form of the Agreement or amendment as required by HealthWorx.

SECTION 12
PROVIDER MANUAL

PLAN offers, via the PLAN's website and upon request, the Other Services Provider with a Provider Manual that contains those PLAN policies and procedures necessary for the proper operation of the Other Services Provider as it relates to Members and which describes all benefits plans, including limitations and exclusions offered by the PLAN. Other Services Provider agrees to comply with PLAN standards and policies outlined the Provider Manual.

SECTION 13
OTHER SERVICES PROVIDER RELATIONSHIP TO PLAN

13.1 PLAN designates Other Services Provider as a primary provider of emergency and non-emergent transportation services. PLAN and Provider acknowledge this primary provider relationship is based on the Parties agreeing such a relationship: (1) is in full compliance with all State and federal guidelines regarding the patients' right to select a service provider, (2) is in expectation this primary provider relationship will improve care coordination and further PLAN's goal of providing the right level of care at the right time for any patient requiring Provider's services, (3) that all fees paid by PLAN to Other Services Provider are based upon currently applicable

Medicare and/or Medi-Cal fees as described above in Section 6 Payments, and without a pre-set expectation of patient referral volume, and (4) that this Agreement is not structured as any type of joint venture arrangement.

13.2 Other Services Provider shall respect the rights of any Member to select an alternate ambulance or non-ambulance services provider based on personal preference, insurance payor preference, or any other criteria as set forth under federal and State regulation.

13.3 All Other Services Provider services shall be requested from a ten-digit toll-free telephone number linked to Other Services Provider Call Center.

EXHIBIT D

dae doll amir eley

February 6, 2020

VIA OVERNIGHT MAIL AND FAX[1]
650-616-0060

Ms. Maya Altman
Chief Executive Officer
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

Re: Demand for Payment Regarding Underpayments to American Medical Response

Dear Ms. Altman:

On behalf of American Medical Response West (NPI Nos. 1134147150, 1316971518, 1356376057, 1386678605, 1659305902 and 1922391226) ("AMR"), we demand that Health Plan of San Mateo ("HPSM") comply with its legal and contractual obligations to include the add-on amount of $220.80 established by Senate Bill ("SB") 523 of 2017 to the payment for all ground emergency medical transports with dates of service on or after July 1, 2018. AMR asserts that the total overdue payments for dates of service on or after July 1, 2018, through and including September 12, 2019, are approximately $930,009.60 plus interest, as listed on the enclosed spreadsheet of claims.[2]

As you may be aware, in 2017, the Legislature enacted Senate Bill 523, which established a ground emergency medical transport ("GEMT") provider quality assurance fee ("QAF") program. Pursuant to that legislation, GEMT providers like AMR agreed to subject themselves to a provider fee to fund an increase of Medi-Cal fee-for-service rates. The collected QAF amounts paid by GEMT providers represent the state share of the capitation adjustment received by PAYOR and other Medi-Cal managed care plans.

The increase in Medi-Cal fee-for-service rates is codified in Welfare and Institutions Code section 14129.3, which states that:

> Commencing July 1, 2018, and for each state fiscal year thereafter for which this article is operative, reimbursement to emergency medical transport providers for emergency medical transports shall be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. … *The resulting fee-for-service payment schedule amounts after*

[1] The facsimile transmission does not include the spreadsheet.

[2] To the extent HPSM contends that a claim must be submitted pursuant to Government Code sections 900, *et seq.*, this letter timely meets such requirement.

> *the application of this section shall be equal to the sum of the Medi-Cal fee-for-service payment schedule amount for the 2015-16 state fiscal year and the add-on increase.*

(Emphasis added.)

The State Department of Health Care Services ("DHCS") has established the resulting fee-for-service payment schedule amount to be $339.00 ($118.20 + $220.80 add-on) for codes A0427, A0429 and A0433, effective July 1, 2018. (*See* All Plan Letter 19-007.)

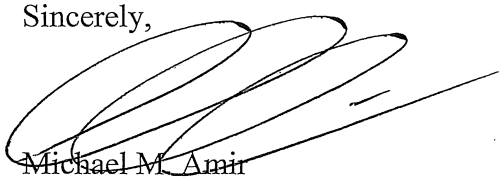
DHCS adjusted the capitation rates paid to Medi-Cal managed care plans associated with the implementation of SB 523 on or around April 10, 2019. Consequently, DHCS paid plans a capitation adjustment that was intended to account for the add-on fees that health plans have to pay to providers under the QAF program. We understand that DHCS does not distinguish between in-network or out-of-network transports when calculating the capitation adjustment. In any event, we are unaware of any guidance from DHCS to the contrary, especially as DHCS has no authority to intervene in the contractual relationship between a plan and a provider.

The claims at issue are subject to the agreements (and any amendments thereto) between HPSM and AMR (the "Agreements"). The Agreements' payment requirements are linked to Medi-Cal. Accordingly, HPSM is obligated to pay the add-on for transports provided by AMR between July 1, 2018, through and including June 30, 2019, and ongoing. AMR has prepared the attached spreadsheet of approximately 4,212 GEMTs during the July 1, 2018 to June 30, 2019 time period for which it did not receive the $220.80 add-on, amounting to an underpayment of approximately $930,009.60 exclusive of interest. For GEMTs provided by AMR, these underpayments violate the Agreement, which require payment at Medi-Cal rates, including the add-on fee.

On behalf of AMR, we invoke the dispute resolution provisions of the Agreements to address HPSM's failure to pay the add-on amount. To the extent that resolution of this dispute does not result in HPSM's payment of the total Medi-Cal fee-for-service payment per transport that includes the add-on amount, AMR will take appropriate steps to enforce its contractual and legal rights. By sending this letter, AMR does not waive and expressly reserves its rights to assert any and all claims, arguments or rights against HPSM described herein.

Please feel free to contact me at if you have any questions or would like to discuss this matter further. Thank you for your immediate attention to this matter.

Sincerely,



Michael M. Amir

Enclosure
Cc: Joe Don Ridgell (by e-mail only without attachment)