MSO INC. SOUTHERN CALIFORNIA

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MSO, INC. OF SOUTHERN CALIFORNIA

COMPREHENSIVE MSO SERVICES CATALOG

Management Services Organization (MSO) Services for IPAs and Medical Groups

Service Selection Worksheet

☐ Instructions: Place a check mark in the box beside each service you would like MSO, Inc. to retain and provide. Leave the box blank for any service you do not wish to include. Use the notes lines at the end of each section, or the margins, to add comments.

Prospective Client Information

Name of Prospective IPA / Medical Group Client: _____

Name of Person Completing List: _____ Title: _____

Signature: _____ Date: _____

1. Utilization Management (UM)

- ☐ Receive, review, and process automatic authorizations for primary care and ancillary services per UM criteria
- ☐ Conduct outpatient pre-authorization review for specialist, ancillary, and diagnostic services within applicable regulatory turnaround times
- ☐ Conduct inpatient concurrent review with health plans, hospitals, and facilities to confirm medical necessity and appropriate level of care
- ☐ Communicate daily with Network Medical Directors to review and disposition pre-authorization requests
- ☐ Communicate daily with requesting providers to obtain clinical information and supporting documentation
- ☐ Notify members verbally and in writing of authorization decisions; distribute copies to PCPs and specialty/ancillary providers
- ☐ Maintain UM program description, criteria (e.g., MCG/InterQual), and policies; track inter-rater reliability
- ☐ Refer adverse determinations to the Medical Director and coordinate the appeals/IMR pathway with the Quality and Compliance functions

2. Case Management, Care Coordination & Population Health

Case Management / Transition of Care

- ☐ Conduct case management for members with chronic, complex, and serious conditions, coordinating with members, families, health plans, PCPs, specialists, and ancillary providers
- ☐ Coordinate transition of care and post-discharge follow-up to reduce avoidable readmissions

Population Health

- ☐ Perform risk stratification to identify high-risk and rising-risk members

- ☐ Operate chronic disease management programs (e.g., diabetes, CHF, COPD, CKD)
- ☐ Conduct Social Determinants of Health (SDOH) screening and connect members to community resources
- ☐ Coordinate preventive care and wellness outreach (e.g., Medicare Annual Wellness Visits)
- ☐ Report population health metrics to Client and health plans

3. Quality Management (QM) & HEDIS / Stars

Quality Management

- ☐ Receive, confirm, and respond to member and provider grievances; coordinate with providers, members, health plans, and regulators
- ☐ Investigate potential quality-of-care and quality-of-service issues; coordinate responses
- ☐ Support the Quality Management Committee with peer review cases (agenda, documents, minutes, notifications)
- ☐ Maintain the QM Program description and annual work plan; conduct the annual program evaluation

HEDIS / Stars Performance Management

- ☐ Track HEDIS measures and identify care gaps using MSO clinical data systems
- ☐ Coordinate member outreach for care-gap closure (preventive screenings, chronic-disease monitoring)
- ☐ Support HEDIS medical record retrieval and submission
- ☐ Generate Stars performance trend reports and coordinate with health plan Stars/bonus reconciliation

Note: "Send HEDIS gap reports to Client" remains a base service; chart abstraction/medical-record review for HEDIS may remain an additional-cost item (see final section).

4. Risk Adjustment / HCC Coding

- ☐ Identify and prioritize HCC/RAF gaps using retrospective claims data
- ☐ Coordinate retrospective and prospective chart review for accurate, compliant HCC documentation
- ☐ Support Risk Adjustment Data Submission (RADS) to health plans
- ☐ Provide provider education on appropriate HCC coding standards

Note: provider risk-adjustment coding training and chart-review abstraction may be structured as additional-cost services (see final section).

5. Credentialing

- ☐ Collect and review credentialing/re-credentialing applications and supporting documents
- ☐ Verify application accuracy and currency of licensure and other required documents
- ☐ Conduct Primary Source Verification and follow up on items needing clarification
- ☐ Present provider files to the Credentialing Committee (agenda, documents, minutes)

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- [ ] Notify providers of Credentialing Committee decisions
- [ ] Maintain the credentialing program, policies, and provider rights process consistent with NCQA/health plan delegation standards

6. Provider Network Operations & Relations

- [ ] Conduct provider office orientations and follow-up meetings
- [ ] Submit provider changes to health plans
- [ ] Reconcile the provider network with health plans quarterly
- [ ] Administer the provider grievance process within MSO responsibility
- [ ] Operate a dedicated provider inquiry line (authorization, claims, and general questions)
- [ ] Set up and train providers and office staff on the provider web portal
- [ ] Prepare and distribute the Provider Manual and updates
- [ ] Maintain MSO and network contact information with all health plans

7. Contracting & Network Development

- [ ] Identify providers required to satisfy health plan network-adequacy requirements, including specialty gaps and geographic-access standards
- [ ] Negotiate and execute provider contracts; verify accuracy and completeness before provider signature
- [ ] Distribute fully executed contracts to providers
- [ ] Review and negotiate health plan contracts on behalf of Client
- [ ] Maintain fee-schedule and contract-configuration tables used by Claims and UM

8. Delegation Oversight & Health Plan Audit Support

- [ ] Conduct pre-delegation readiness assessments across all delegated functions
- [ ] Coordinate health plan pre-delegation, annual, and ad hoc audits
- [ ] Prepare mock audits and Corrective Action Plans (CAPs) for audit findings
- [ ] Maintain the delegation matrix and evidence-of-oversight documentation per health plan
- [ ] Support DMHC, CMS, and DHCS regulatory filing obligations

9. Member Services & Eligibility

Member Services / Call Center

- [ ] Operate an inbound member inquiry function (eligibility, benefits, PCP assignment, referral status)
- [ ] Administer member grievance intake
- [ ] Coordinate interpreter and language assistance per Health & Safety Code §1367.04
- [ ] Support member satisfaction (CAHPS) survey programs required by health plans

Membership / Eligibility Management

- ☐ Obtain benefit and eligibility files from Client or payor
- ☐ Reconcile eligibility data and load it into the MSO system (electronic or manual)
- ☐ Maintain the member eligibility database, including current and historical records for retroactive verification and adjustments
- ☐ Identify each member by plan identification number
- ☐ Maintain the benefit database (co-pays, co-insurance, deductibles, cost-sharing)
- ☐ Maintain and track covered-service eligibility per member and apply coverage limitations to claims
- ☐ Reconcile retroactive eligibility denials against the claims payment process
- ☐ Provide PCPs a periodic membership/E-list and track Initial Health Assessment requirements

10. Claims Management

- ☐ Receive paper or electronic UB-04 and CMS-1500 claims from providers
- ☐ Enter claims into the Management Information System (MIS)
- ☐ Adjudicate claims per Client instructions and payor contracts
- ☐ Match claims to authorizations; prohibit unauthorized adjudication per Client policy; re-adjudicate when authorization is obtained
- ☐ Validate diagnosis, procedure, and modifier coding
- ☐ Adjudicate cost-sharing, benefit limits, and coverage
- ☐ Calculate allowed payment per Client fee schedule(s); support multiple schedules and periodic adjustments
- ☐ Coordinate benefits and pursue third-party/COB recovery (TPL/COB), including TPL adjudication and secondary billing to collect additional reimbursement for insured and reinsured services
- ☐ Release payable claims in compliance with Plan, CMS, and DMHC timeliness requirements
- ☐ Maintain Client claims compliance with payor requirements
- ☐ Generate claim denial letters
- ☐ Generate EDI and paper CMS-1500/UB-04 encounter data submissions to payors
- ☐ Operate claims mailroom, scanning, and OCR intake; route paper claims for electronic in-loading
- ☐ Administer Provider Dispute Resolution (PDR) and claims recovery/overpayment processes
- ☐ Conduct claims audit and examiner quality review (professional, facility, ancillary, lab/radiology, and Rx lines)

11. Financial Operations

Capitation & Sub-Capitation

- ☐ Reconcile monthly capitation receipts against health plan eligibility files
- ☐ Calculate and distribute PCP sub-capitation per Client compensation schedules

- ☐ Track capitation withhold balances and release per agreement terms
- ☐ Process retroactive capitation adjustments for eligibility changes; generate capitation reports for Client and PCPs

Risk Pool Administration

- ☐ Track and report charges against risk pool(s)
- ☐ Verify accuracy of risk pool reports generated by payors or Clients
- ☐ Reconcile risk pool surpluses and deficits with payors and Clients
- ☐ Pursue timely recovery of surpluses and negotiate favorable terms on validated deficits
- ☐ Manage hospital/facility risk pool reconciliation separately from professional pools

Bookkeeping & Accounting

- ☐ Maintain a full-cycle accounting and bookkeeping system for Client managed care business
- ☐ Maintain an accounts payable system
- ☐ Prepare and submit payor-required reports and forms on Client's behalf
- ☐ Monitor cash flow and balance sheet for adequate risk reserves

Financial Analysis & Solvency

- ☐ Provide pro forma financial modeling as requested
- ☐ Recommend stop-loss/reinsurance coverage levels based on claims history and capitation exposure, with the Client's broker
- ☐ Coordinate stop-loss claim submission and recovery from reinsurers
- ☐ Prepare and submit quarterly DMHC financial survey reports for the Client RBO
- ☐ Monitor solvency metrics — tangible net equity (TNE), working capital, cash-to-claims ratio
- ☐ Document IBNR estimation methodology per 28 CCR §1300.77.2 and prepare CAP responses if thresholds are breached

12. Compliance & Governance

- ☐ Deliver Compliance and Code of Conduct training annually and upon new provider/staff onboarding (FWA, HIPAA, CMS Model of Care)
- ☐ Investigate compliance breaches; manage reporting and resolution per regulatory requirements
- ☐ Update policies and procedures as required by law, regulation, or health plan
- ☐ Participate in and coordinate Client responses to health plan and regulatory audits across all operational areas
- ☐ Maintain the compliance program and serve as / support the Compliance Officer function, including grievance & appeals oversight and systems control audits

13. Cultural & Linguistic Services and Health Education

- ☐ Administer Cultural & Linguistic (C&L) program and threshold-language requirements

- [ ] Develop and distribute member health education materials and coordinate health education programs
- [ ] Support HEDIS/QI member education and outreach campaigns

14. Technology, Data & Provider Portal

Management Information System (Infrastructure)

- [ ] Maintain MIS databases: eligibility, provider/MSO records, vendor files, authorizations, claims, fee schedules, benefit tables, and adjustment/support tables
- [ ] Provide role-based data security restricting access by user, classification, and Client authorization
- [ ] Comply with HIPAA transaction, privacy, and security rules
- [ ] Demonstrate physical security at all facilities housing Client data
- [ ] Provide and maintain phone/communications infrastructure for the Service Center
- [ ] Conduct disaster recovery testing; maintain hardware/software inventory and ongoing maintenance
- [ ] Operate help desk, encounter-data submission, and eligibility/claims in-load systems and server management

Client- and Provider-Facing Technology

- [ ] Provide a provider web portal for authorization submission/status, claims status, eligibility verification, and report downloads
- [ ] Maintain EDI clearinghouse connectivity and enrollment
- [ ] Provide a management analytics/reporting dashboard of key operational and financial metrics
- [ ] Maintain clinical data systems supporting UM, Quality, and Risk Adjustment
- [ ] (Optional) Deploy AI-enabled tools for care-gap closure, prior authorization, or denial management

15. General Administration & Board Support

- [ ] Supervise and coordinate all managed care operations under Client risk contracts — contract performance monitoring, financial-metric tracking, and operational oversight
- [ ] Serve as primary point of contact with health plans, providers, and regulators
- [ ] Report to the assigned Client contact; attend Board meetings
- [ ] Prepare Board packets, agendas, and minutes
- [ ] Manage production and distribution of Client-branded member and provider communications (print and digital)

16. Reporting

- [ ] Quarterly and YTD balance sheet, income statement, and cash flow (cash and accrual)
- [ ] Quarterly and YTD accounts receivable and accounts payable aging
- [ ] Periodic claims lag study and quarterly claims status (open, payable, IBNR)

- ☐ Stop-loss submission and recovery reports by claim, by member, and in aggregate (quarterly and annually)
- ☐ Financial reports for finance committee meetings
- ☐ Support audited financial statements (third-party auditors) with all required data
- ☐ Generate and mail IRS Form 1099 to each provider paid through the MSO
- ☐ Prepare and submit all reports required by health plans and regulators across all operational areas (claims, credentialing, C&L, financial, health education, information systems, provider network operations, quality management, and utilization management) monthly, quarterly, and annually

17. IPA Formation & Development Consulting

- ☐ Provide consulting and development services to physician groups forming or expanding an IPA — organizational structure, health plan contract negotiation support, credentialing program setup, and operational readiness assessment

18. Services Typically Available at Additional Cost

These items are commonly scoped as add-on / additional-cost services rather than base services. Several are carried from the original Exhibit B; others are flagged here for a pricing decision.

- ☐ Recalculation/editing of already-processed claims due to a Board declaration or change in Client claims parameters
- ☐ Preparation of tax documents, legal fees, express mail, Client document printing, or duplicate record copying beyond plan-required minimums
- ☐ Provider risk-adjustment coding training
- ☐ Medical record review/abstraction for risk-adjustment coding and HEDIS (sending HEDIS gap reports to Client remains a base service)
- ☐ Claims processing and financial reporting for periods outside the Agreement's effective dates
- ☐ Additional costs from materially increased requirements mandated by a Participating Plan after commencement (subject to mutual agreement)
- ☐ Other items mutually agreed by Client and MSO not previously provided under the Agreement
- ☐ IPA formation / new-group development consulting (priced by engagement)

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Acknowledgment & Authorization

The undersigned, on behalf of the prospective Client named above, has reviewed this catalog and selected the services indicated by the checked boxes for MSO, Inc. of Southern California to retain and provide.

Prospective Client

Signature: _____ Date: _____

Printed Name: _____ Title: _____

MSO, Inc. of Southern California

Signature: _____ Date: _____

Lan Phan, Chief Executive Officer, MSO, Inc. of Southern California