Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan Executive / Finance Committee Meeting

DATE: **Thursday,** October 4, 2012
TIME: 3:00 p.m.
PLACE: 2220 E. Gonzales Road, Suite 230, Oxnard, CA

AGENDA

Call to Order, Welcome and Roll Call

Public Comment / Correspondence

1. **Approve Minutes**
   a. August 24, 2012 Special Meeting Minutes
   b. September 6, 2012 Regular Meeting Minutes
   c. September 20, 2012 Special Meeting Minutes

2. **Consent Item**
   a. Ratification of Contract with the Law Firm of Wilke-Fleury for Specialized Legal Services for Managed Care Contracting

3. **Accept and File CEO Update** *(verbal)*

4. **Approval Items**
   a. Consideration of Adoption of Claims Procedure for Claims Against Gold Coast Health Plan and Recommendation to Commission
   b. Discussion of Bylaws and Meeting of the Executive / Finance Committee

5. **Accept and File Items**
   a. August Financials
   b. Plan-to-Plan Contract Template

Meeting Agenda available at http://www.goldcoasthealthplan.org

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ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMISSION AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE CLERK OF THE BOARD, 2220 E. GONZALES ROAD, SUITE 200, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT TRACI AT 805/981-5340. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING

Comments from Committee Members

Adjourn

Unless otherwise determined by the Commission, the next regular meeting of the Executive Finance Committee Meeting will be held on November 1, 2012 at 3:00 p.m. at 2240 E. Gonzales Road, Suite 280, Oxnard CA 93036

Meeting Agenda available at http://www.goldcoasthealthplan.org

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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Special Executive / Finance Committee Meeting Minutes August 24, 2012

(Not official until approved)

Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board's Office.

CALL TO ORDER

Vice-Chair Juarez called the Special meeting to order at 2:35 p.m. in Nordman Cormany Hair & Compton LLP - Conference Room on the 6th Floor, 1000 Town Center Drive, Oxnard, CA.

COMMITTEE MEMBERS PRESENT
Anil Chawla, Clinicas del Camino Real, Inc.
David Glyer, Private Hospitals / Healthcare System
Roberto Juarez, Clinicas del Camino Real, Inc.
Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT COMMITTEE MEMBERS
Robert Gonzalez, Ventura County Medical Health System

STAFF IN ATTENDANCE
Cassie Undlin, Interim CEO
Sonia DeMarta, Interim CFO
Nancy Kierstyn Schreiner, Legal Counsel
Steve Lalich, Communications Manager
Paula Cabral, Administrative Assistant

PUBLIC COMMENT

None.

1. CEO REPORT

Interim CEO Undlin reported that she held meetings with ACS, a request for a change of the individual that manages the ACS / GCHP account was made and weekly calls with the new manager have been scheduled. Concerns were reviewed to ensure that both sides understand the issues. It was noted that a lot of this should have been in place before Go-Live. Interim CEO Undlin is too busy with the RGS transition to handle the Specialty Contract so a new Project Manager will be in the office later in the week.

2. ACCEPT AND FILE FINANCIAL REPORT

a. Budget

Interim CFO DeMarta reviewed the assumptions that went into the budget. In terms of enrollment, minimal growth was assumed of approximately 0.3% (268 members). Beginning membership is 96,540 excluding retro members. The Plan expects CBAS implementation to bring an additional 1,000 members. Enrollment at the end of 2013 is estimated to be 97,808.

Interim CFO DeMarta stated that staff is estimating an increase of 3.9% in premiums; however, the rates have not been finalized therefore the number could change. She then reviewed the rate assumption being presented for 8 categories overall, an increase is expected from an average of $248.45 pmpm in 2011-12 to $264.82 pmpm 2012-13. Staff continues to reserve funds for the AB97 rate cut because the assembly bill has still not been adjudicated. The Plan will continue to reserve approximately 2.2% of gross premium.

Interim CFO DeMarta continued her report stating that staff estimates a slight increase in Healthcare Costs. Calculation is based on what IBNR and tangible equity needed to be at the end of the year. We do not anticipate a decrease in premiums because contracts are not being renegotiated, but expect increased efficiencies going forward and should see some reductions as the Plan is maturing. We budgeted for quite a bit of growth on the medical management side; there will be a focus on case management and authorizations and following the contracts received from the State and Providers.

Vice-Chair Juarez noted there was no rate increases for Providers. Interim CEO Undlin stated the Plan pays a lot of Providers at Medi-Cal rate schedules and the hospital side is experiencing some rate increases. The goal is to off-set by medical management activities.

Vice-Chair Juarez asked if the Adult / Family capitation rate of $8.38 is going to be increased because the Milliman report was originally higher. Interim CFO DeMarta said that a meeting is scheduled with Milliman within the next couple of weeks to begin discussions on what the capitation rate should be, but we have not asked them to reevaluate it.

Vice-Chair Juarez noted that there were fee increases for long-term care facilities and pharmacy but the Plan is not giving increases to fee for service when this is supposed to be a managed care plan, capitated plan. Interim CEO Undlin responded that it is unfortunate, the Plan needs consistency in paying claims and it needs to meet the TNE requirements, but we only have three years to meet TNE requirements.

Discussion was held regarding Provider incentives. Interim CEO Undlin noted that at this point the budget just funds the TNE. The State requirements have to be met and there needs to be consistency in pricing.

Interim CFO DeMarta reported that on January 1, 2013 primary care will need to be paid at the Medicare rate due to the Healthcare Reform Legislation; but this has not been budgeted. The PCP capitation rate will need to go up to reflect as if it were underfunded. Interim CFO DeMarta stated that we can revisit the numbers after we get our final rates. The State and the courts are still fighting so we are still reserving approximately 2.2% for AB97 for payment back to the State.

Committee Member Glyer asked what our goals are for where we want medical management to get to during the year for funding Providers in the future. Are there goals established in order to benchmark this area. Interim CEO Undlin stated that some programs have not been utilized as they should have been. We need to establish standards, targets and policies to see progress during the year. The systems are connected and are better.

Interim CFO DeMarta reviewed the staffing levels which are currently at 39 full time employees (FTE's) as of July 1, 2012 and 11 positions are scheduled to start within the next month. Recruitment is in process for an additional 5 positions which brings us to 55 budgeted; 7 additional staff positions are needed but are not currently budgeted.

Vice-Chair Juarez advised Interim CEO Undlin that a motion had been passed by the Commission that in order to increase staff proportion to the size of the budget or increase staff to be more than 10% above it would need to come to the Commission. CEO is allowed to do this outside of the budget as long as it is within 10% and doesn't result in an operating loss. We can't vote on something that goes against a motion and a policy the Commission already set.

Legal Counsel Kiersten Schreiner stated the motion was that the CEO could not do it, but the Commission by approving a budget that has a specific number of positions, you as a Commissioner, would be taking that action as long as it is in the budget, and authorize approved positions would be permitted and the prior motion would be the CEO still has during the budget year.

There was a discussion of reclassifying some Director positions to Managers. The positions of Chief Operating Officer and Health Services Director are not new. Care Coordination Managers are new (due to the size of the nursing staff). The Human Resources (HR) position is a function we previously had but this is something being added on because we will be doing Human Resources internally. There is also an HR Analyst and HR Technician but the end number will probably be two positions. The Quality Management (QM) positions are new over last year. Health Services have an Administrative position to support nurses.

Committee Member Rodriguez suggested putting two lines of justification next to the position. A review of the organization chart that was presented to the State and job classifications for each position was reviewed.

Interim CFO DeMarta explained that with regard to Facilities there was no change in the budget. Addressed as a separate operating budget item, expansion of approximately 1,600 feet has been freed up by the County for us to use by next week. It is not reflected in the budget.

Interim CFO DeMarta noted that under Administrative Expenses, AB97 is still an unknown. Utilization Rates - we do not have a full sense on our rates therefore we are making assumptions. Net income of $6 million is based on premium rates. We have a rate increase on September 7, 2012. In October we will receive the final numbers.

There is a high level of elderly in this community and there is a need to put some energy into that area this next year. Funding is very critical for long-term care. Issues with share of costs and payments. Elder care is higher than average and very difficult to manage. There is a need for someone to do assessments on the clients (i.e. nursing homes) to determine if that is the appropriate place; currently there is no staff available for this.

Committee Member Chawla noted there was a program for home support services from Medicare whereby you would pay for home services. Interim CEO Undlin stated that design should be given consideration and how other COHS handle these, but not all COHS do long-term care.

Interim CFO DeMarta explained that the Plan's total administrative costs are slightly up compared to what our actuals were due to staffing. Some vacancies have been filled with consultants which is more costly. ACS costs are expected to go down because of the PMPM (per member per month) basis due to membership declining.

Vice-Chair Juarez asked what makes up the 43% in benefits. Interim CFO DeMarta responded that staff is working on what the make-up of that is and noted that some comparisons will be done to similar organizations. Interim CEO Undlin stated that effective September 4, there will be a change in vacation days for new hires. It was noted that some benefits are quite generous.

Committee Member Rodriguez moved to approve the budget as presented but would be revisited when the new CEO arrives in September so that he can provide any adjustments. Any changes should be presented to the Commission again. Vice-Chair Juarez seconded. The motion carried. **Approved 4-0.**

Committee Member Rodriguez asked when the financial statements are due for audit. Interim CFO DeMarta stated they are due to the State on October 30th. We are waiting for audit comments from last year's audit.

The meeting adjourned at 3:45 pm.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Executive / Finance Committee Meeting Minutes
September 6, 2012
(Not official until approved)

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:03 pm at Nordman Cormany Hair & Compton LLP**,** 1000 Town Center Drive, Sixth Floor, Oxnard, California 93036.

ROLL CALL

COMMITTEE MEMBERS PRESENT
Anil Chawla, Clinicas del Camino Real, Inc. (Arrived at 3:22 p.m.)
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, Ventura County Medical Health System
Roberto Juarez, Clinicas del Camino Real, Inc.
Catherine Rodriguez, Ventura County Medical Health System (Arrived 3:22 p.m.)

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Sonia DeMarta, Interim CFO
Nancy Kierstyn Schreiner, Legal Counsel
Guillermo Gonzalez, Government Affairs Director
Steve Lalich, Communications Manager
Traci R. McGinley, Clerk of the Board
Paula Cabral, Administrative Assistant
Cassie Undlin, Consultant

1. APPROVE MINUTES

a. July 19, 2012 Regular Meeting Minutes

It was noted that Agenda Item 2, *Accept and File CEO Update,* should be corrected to read as follows "….the meeting with Margaret Tater from the Department of Health Services would be visiting the Plan on Friday, July 20, 2012..."

Committee Member Glyer moved to approve the Minutes as amended. Chair Gonzalez seconded. The motion carried. **Approved 3-0.**

PUBLIC COMMENT

Christina Velasco, Clinicas CFO, expressed objection to the Healthy Families allocation to Kaiser. She requested Gold Coast Health Plan fight the action because the decision is bad for Ventura County.

Committee Member Juarez stated that he did not believe that there was a State regulation requiring GCHP agree to do this with Kaiser.

CEO Engelhard reported that the State's issue is continuity of care for the 190,000 Healthy Families and Kaiser members across the State. The deal the State cut with Kaiser is if the Plan doesn't contract with Kaiser, the State will give Kaiser a Medi-Cal contract in the county. The State was very tough on the Plan and did not give the Plan a lot of options. He continued, stating that it is not in legislation, but there is an agreement with DHCS (Department of Health Care Services).

Chair Gonzalez requested that the CEO keep the Commission updated on the progress and confirmed that when it comes down to the decision, the CEO will provide the Commission with an assessment of the pros and cons, CEO Engelhard confirmed.

2. ACCEPT AND FILE CEO UPDATE

CEO Engelhard expressed his pleasure to be at the Plan and noted that he not only believes it will succeed, but do very well. He reported that the Plan is in need of securing a Director of Health Services; however it is likely that a search firm will be required as it is very competitive for health professionals all around the State. In recent months the Plan has lost two RN's, three have been hired, but more case managers are needed.

There have been a large number of Ultrasound OB claims; they are being reviewed as they are from a single Perinatologist, who is the only specialist in our network. Doctor Cho will meet with him to develop a policy and approach for these high risk cases.

DHCS has informed us that we must hire a site review nurse. We will be looking at that once we get through the hiring freeze.

The Compliance Fraud Hotline is up. Staff attended a fraud seminar held by the Department of Justice on July 18. Gold Coast Plan Code of Conduct has been recently adopted by the Commission and will be sent to all employees.

Compliance 360 software is in the process of being built out. Staff is working on internal processes to ensure compliance. The next scheduled Compliance Committee Meeting is on September 26, 2012.

Quality Improvement staff is in the process of implementing HEDIS software. Patient accessibility audits need to be completed. Staff was trained on the Milliman database and working on quality reports.

CEO Engelhard closed stating that he met with the external auditors on September 5; regarding year ending June 2011. They found no issues with the statement of the condition of the Plan. An interim report will come to the Committee at the October 4,

2012 Meeting. Financial Statements need to be filed with the State by October 28, 2012.

Committee Member Juarez asked the status of implementation of the 3-1 Auto Assignment for Safety Net Providers by ACS, which was supposed to have been in place 18 months ago. Cassie Undlin responded that it is in the process of being completed and will be done by the end of the month; and the issue with regard to resident physicians was dealt with sometime back.

3. FINANCE REPORT

a. June Financials

Interim CFO DeMarta reported that staff has met with Berkeley Research Group (BRG) and they have expressed a concern that the Plan does not have adequate claims reserves. The Plan also received a letter from Milliman expressing the same. They are at different ends of the spectrum as to what the adjustment should be. (In June, Milliman expressed that the Plan had an excess of $5 million in IBNR reserves, but things shifted in July and August.)

Staff did an assessment of the reserves looking at three different methodologies: a lag analysis, using factors from BRG and Tatum, and compared those to the book to budget numbers received from Milliman. They were so different that staff took an average and then adjusted June and booked an additional $2 million in reserves, therefore the healthcare costs increased by $2 million in the June report. Result of net income went from $2.4 million to $129,000 for the month. Due to late invoices that came in there were minor changes to Accounts Payable. The only changes to the Balance Sheet were an increase in Incurred But Not Reported (IBNR) of approximately $2 million; it was $33 million and is now $35 million.

There is no impact on the Cash Flow Statement and very minimal impact on the Administrative Costs.

Chair Gonzalez asked if the IBNR increase affected the TNE. Interim CFO DeMarta replied yes, but we are at $4.8 million and the Plan was able to meet the July 36% requirement as well.

It was asked whether BRG's numbers matched Milliman's. Interim CFO DeMarta responded no, they use different guidelines and BRG takes a much more conservative approach. Further discussion was held. Interim CFO DeMarta noted that when the Plan made adjustments in the past it was when BRG advised the Plan that the IBNR should be adjusted.

Committee Member Rodriguez expressed her concern about using different guidelines. Interim CFO DeMarta responded that due to the great variance, staff took an average; this was run past Milliman and discussed with Mark Abernathy of BRG before it was booked.

Interim CFO DeMarta explained that a large problem was that ACS (Xerox) changed the way they were producing their lag tables. Initially they were creating lag tables based on payments only. Early in the year we started identifying over payments and started getting refunds. *As those over payments were identified, the initial claims must be reversed and new claims must be submitted. When the claims were resubmitted ACS was not using correct dates and would show payment dates as of the date they were processing the new documents, not the original dates, etc.*

Milliman is working under a normal assumption that payments occur when it shows up in the system. There was a change of when a payment shows two months ago when we make adjustments or reverse out payments.

Interim CFO DeMarta continued stating that Milliman is working on more assumptions on changes in the system. They also did not take into account reinsurance that would be received.

A meeting is scheduled for next week on discrepancies and differences between Milliman and BRG.

IBNR is an estimate of what happened in the past and what will happen in the future. The tails on some of these claims are very long, In August we received $240,000 on July 2011 claims. Everyone states that there is 1 ½ - 3 years of data needed on claims before we will know for sure.

Chair Gonzalez noted that more clarification will most likely be required. CEO Engelhard added that the auditors will have a big impact on the way June will be stated. They have their own actuary staff and will most likely be in touch with Milliman.

Chair Gonzalez questioned the $240,000 bills from July, Interim COO Undlin explained that most were originally denied and are coming back with the appropriate attachments. CEO Engelhard reminded the Committee that due to the previous “retroactive” nature of the COHS, it is not uncommon to have large claims come through.

Interim CFO DeMarta closed her report stating that the Balance Sheet IBNR went up by $2 million additional. Prepaid Expense and Accounts Payable came in after the June 30th date, as the June financials were held open for a longer period of time.

b. <u>July Financials</u>

Interim CFO DeMarta reviewed the Summary Financial Results of July 2012; major change is the first month without membership retroactivity so the membership declined. In addition there is overall decline in membership from this month versus the prior month, which resulted in a 6.4% decline in revenue, $25.4 million in June versus $23.8 in July.

Health Care Costs reflect a reduction as a result of reduction of retro members. We met required TNE at 15.7%.

Interim CFO DeMarta reviewed the graphs on page 3b-2 which showed that costs went down due to the membership numbers going down. Discussion was held regarding Chair Gonzalez' previous request that long-term care and hospital versus acute be broken out. Interim CFO DeMarta responded that staff had been working on that and it should be provided by the next report.

Discussion regarding how much revenue is being used for hospitalization was held. Cassie Undlin reported that the Plan is pre-authorizing a number of hospital days. We will deny the claim if the number of days are not pre-authorized.

Committee Member Chawla noted there are high expenses and more health education is required. Cassie Undlin noted that information does go to the UM Committee. Milliman has the ability to do more reports but our capabilities are not very strong on using them but we are starting to focus on them. A daily report is received that shows people in the hospital. This is used in the medical management area to see how many patients we have. There has been an increase in nursing for the utilization side when the patient is admitted. Committee Member Rodriguez asked about the utilization report (days per thousand) and where we are. CEO Engelhard indicated that he would look into that matter.

Interim CFO DeMarta reviewed the Balance Sheet total cash in hand $24.4 million at the end of July. Medi-Cal receivables, $26 million July payment had not been received as of the end of the month. We see Provider receivables going down. Other receivables include receivables for reinsurance. IBNR is approximately $35 million, for net equity of $5.8 million.

Chair Gonzalez noted that claims payable was about the same for two months. There was a $10 million difference in IBNR. Interim CFO DeMarta said that our membership has dropped and no longer doing retros. Cassie Undlin added that losing 7,000 members for the month is important and you will see a decline, we made an adjustment for June and not for July. Claim payments are made on how many refunds are processed back into the system. CEO Engelhard noted we will have a written explanation to demonstrate the numbers so it is on paper for review as well as for a paper trail.

Interim CFO DeMarta explained that on the Profit & Loss side we are still booking reserve for rate reductions AB97. Our net premium revenue was $23 million. Fairly close to what was budgeted.

Healthcare costs based on budget numbers we received from Milliman. No major changes in the Medi-Cal review costs from June. They are fairly consistent under General and Administrative. Still high due to consulting charges.

No changes in Medi-Cal. Reinsurance administrative went up from June $91,000 up to $234,000. The premium tripled. Costs are consistent under General and Administrative. Some decrease in outside services, ACS due to enrollment numbers. Some savings without RGS (Regional Government Services); no dramatic change.

Interest Expenses coming in for late claims payments $61,000 in July. Chair Gonzalez asked what the interest rate was. Cassie Undlin responded that she had asked for a report (in writing) on interest payments, but she had not received it as of yet. It may be due to the way it is being calculated. There may be a reversal. There was discussion as to what causes the delay's in payment. There will be a follow-up at the next meeting.

Interim CFO DeMarta said that the Plan has been doing a focus group reviewing members in LTC if that is where they belong or in a different facility. We may see some improvement in that area.

Committee Member Rodriguez questioned the increase in consulting charges ($121,000). Discussion was held, it was noted that it was due to a late invoices received in July; combination of RGS and Tatum. Normally consulting is in outside services. June was very high and that was the BRG invoice. Legal Counsel Schreiner questioned the $85,000 in legal fees for June. It was due to a late invoice being received. Interim CFO DeMarta said it would be looked into. It was suggested that a report be prepared showing these different accounts and funds for the next meeting.

Cash Flow Statement. Biggest source of cash is from premiums and paid claims. Collected premiums was $26 million, spent $22 million for claims, $633,000 for capitation and $2 million for Pharmacy. Cash at the beginning of period was $23.7 million and cash at the end of the period was $24 million and cash provided by operations was $683,559.

Pharmacy utilization highest usage is in Generic and highest cost is with Brand drugs.

Inventory of Claims – there is a slight decline. Claims rejected - upward trend a little higher than normal. Committee Member Juarez asked if there is a standard where we want them because of a lot of fluctuations. Cassie Undlin said our goal is to be about at the nine day level and there has been a lot of work to bring it down. There has been an increase in their staffing level at ACS so they can meet their requirements.

Chair Gonzalez indicated that when BRG became a monitor they consistently brought up the IBNR, lag, rejected claims and it is important that we have sense that improvement occurred, when I look at the claims report it looks like we are slipping backwards.

Cassie Undlin responded that it might be good to put in the most current claim lags because things look different.

There was a consensus that the year-end budget numbers be reviewed one more time prior to the next Commission Meeting and that there be a Special Committee Meeting prior to the Commission Meeting.

Committee Member Juarez stated there was a report issued from BRG. A second report has been kept from the Commission and it needs to be seen because the Commission is responsible. We do not know what response has been given to date and what has or has not been accomplished. Cassie Undlin responded that the second report was given to the Compliance Committee and the State did not want the report released.

CEO Engelhard asked if it could be taken into a closed session. Legal Counsel Schreiner said it was her understanding that the second report is a draft and not a public record. Committee Member Juarez said if the Plan is stamping things draft so they don't get released or published and to keep things behind "closed doors." It appears we are hiding something when we aren't. Legal Counsel Schreiner responded that it is the State it is not the Plan and it has to do with enforcement.

Chair Gonzalez asked that this item be brought back as an item at the Special Meeting for discussion, keeping it behind closed doors does not sound good. Legal Counsel Schreiner suggested that they may wish to have a closed session. The State is viewing this as a corrective action. Legal Counsel Schreiner reminded the Committee that the item was not agendized.

c. Benefits

Interim CFO DeMarta stated that discussion had been held regarding the benefits and how the 43% was loaded. Staff contacted RGS and they thought it was 32%. A large portion is paid time off, almost 24%. There are 10 days of Jury Duty and normally an employee only uses 1-2 days of Jury Duty or Bereavement which would take the number down, as well. She further reviewed her handout.

CEO Engelhard stated that a majority of the openings are higher compensated individuals so the benefit loads are lower. It is not a true benefit load. RGS had an extremely high load. We need to go back through the year and come up and get what an actual load would be.

Committee Members stated that the health benefits were still missing from the handout. CEO Engelhard stated we will have a very thorough understanding of expenses at the next meeting. We need to get our benefit plan done correctly.

Committee Member Juarez suggested that the benefits not be so rich, that they possibly be tiered.

Discussion of health insurance and whether employees only or employees and families should be covered, 3 weeks of vacation or whether it should only be two weeks for new employees. Committee Member Rodriguez asked if the new benefit package should just be applied to new employees and grandfathered in for existing employees.

Committee Member Juarez indicated that he was looking for a policy, whether the Plan will cover only the employee, the entire family, or 90% of the family, etc.

Interim CFO DeMarta noted that we would receive a final reconciliation from RGS.

Discussion was held regarding comparing the health coverage offered to employees by other health plans, grandfathering existing employees vs. offering new employees a different level of coverage than current employees. CEO Engelhard stated that some of these decisions will not be able to be done by the next meeting.

4. CBAS CONTRACT

CEO Engelhard stated that CBAS benefit will go live on October 1st. Discussion was deferred to the next meeting.

COMMENTS FROM COMMITTEE MEMBERS

Committee Members welcomed the new CEO.

ADJOURNMENT

The meeting adjourned at 5:05 pm.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan (GCHP) Executive / Finance Committee Meeting Minutes
September 20, 2012
(Not official until approved)

Notice of said meeting was duly given in the time and manner prescribed by law. Affidavit of compliance is on file in the Clerk of the Board's Office.

CALL TO ORDER

Chair Gonzalez called the meeting to order at 3:06 p.m. in Suite 280 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMITTEE MEMBERS PRESENT
Anil Chawla, Clinicas del Camino Real, Inc.
David Glyer, Private Hospitals / Healthcare System
Robert Gonzalez, Ventura County Medical Health System
Catherine Rodriguez, Ventura County Medical Health System (arrived at 3:39 p.m.)

EXCUSED / ABSENT COMMITTEE MEMBERS
Roberto Juarez, Clinicas del Camino Real, Inc.

STAFF IN ATTENDANCE
Michael Engelhard, CEO
Sonia DeMarta, Interim CFO
Nancy Kierstyn Schreiner, Legal Counsel
Guillermo Gonzalez, Government Affairs Director
Steve Lalich, Communications Manager
Traci R. McGinley, Clerk of the Board
Cassie Undlin, Consultant

PUBLIC COMMENT

None.

1. ACCEPT AND FILE CEO UPDATE

CEO Engelhard reported that he had signed the State Contract Amendment regarding the new CBAS benefit required by State law, funding $10 million annually and will be effective October 1st.

McGladrey and McMullen are at the Plan doing the 2012 annual audit. We now have the ability to do all EFT payments for all Providers; a press release will be going out.

CEO Engelhard reported that he and Interim COO Undlin are evaluating Claim Recovery vendors in order to check accuracy of claims. They audit claims accuracy and look for additional coverage, duplicate billing, coding, etc. Typically they have an upfront charge of $20,000 - $50,000 and then they work on a contingent basis, most work on a 10% - 25% recovery.

Discussion was held on how this would work due to ACS' systems and how this might impact the IBNR. CEO Engelhard stated that the State still has concerns about the Plan's IBNR, which is largely driven by claims processing, which we continue to have wide volatility with claims inventory numbers as they fluctuate greatly on a daily and weekly basis. BRG will be doing additional work to assist us on the claims estimation process, setting parameters, measuring and setting goals; as well as providing analytical tools.

CEO Engelhard closed stating the he and Government Affairs Director Guillermo Gonzalez will be on David Cruz' radio program in the morning.

3. FINANCE REPORT

a. July Financials

Interim CFO DeMarta stated that there were a few questions that came up regarding some changes to Healthcare expense and the IBNR. At the end of July the IBNR was 36%. We are in the process of doing a complete evaluation of our method for calculating IBNR. Because there has been discrepancy on calculating the IBNR, Milliman, BRG and GCHP will come up with what the appropriate methodology going forward should be and there may be retroactive adjustments.

CEO Engelhard added that it most likely means an increase in IBNR, our target date to get this cleaned up is by the end of the month.

Chair Gonzalez stated if the IBNR is going up, at some point incurred expenses can exceed revenue and the Plan is upside down and in trouble. He stated that staff is working on getting an accurate number, but asked if staff was working on bringing down the medical expenses.

CEO Engelhard responded yes, even without knowing whether there is a problem or how big the problem there is. We are reviewing our contracts to see if there is ability to bring payment rates down to industry standards for ones that might be outside of standards. We are looking at beefing up our medical management reporting capability so we can understand what is happing and we can have the appropriate interventions in the right place. I have spoken with UM to make sure we have the appropriate staffing levels and we are managing utilization properly. I am not waiting for the IBNR analysis to be done. We are moving aggressively to change and measure rates and utilization.

Chair Gonzalez suggested the Commission hear the things that are being done to assess the medical expenses at the Plan. The things that are be done, the SNIF Care, in patient hospitalizations, the approvals, that we are not paying for unauthorized services, etc.

Interim CFO DeMarta continued review of the financial report, it was previously requested that we breakout the LTC's. CEO Engelhard added that 27% is very consistent with other COHS. He added that we need to get the cost structure of the organization established; then we can determine if we can if we can improve on it by direct rates, incentive programs, or other models to improve funding for primary care services. He continued, stating that his immediate goal is to get a thorough analysis, if the cost structure of the organization is appropriate then we can look at ways of enhancing appropriate levels such as primary care.

Committee Member Chawla stated that she believed Specialty Services were categorized under "outpatient" and "professional" services and asked if staff had reviewed this to see what specialties were being utilized the most, the top three or four. That way those services could be capitated. If the Plan is spending $2 million on cardiologist we could capitate on a pmpm basis. They would have fixed income and the Plan could control its costs.

CEO Engelhard responded that it would be researched; one problem is that the Plan is data rich, but information poor. We are discussing this regularly in the Plan that we need UM reporting so we can understand what we are managing so we can affect some changes.

Interim CFO DeMarta reviewed the Balance Sheet; total cash on hand at the end of July was $24 million. We received $26 million premium check.

Question came up regarding change in IBNR and claims combined of $45 million to $35 million which gave us approximately $10 million decline. During the month we incurred additional claims of approximately $22.3 million for claims, $1.9 million pharmacy, additional adjustments of about $5 million, and total adjustments of approximately $29.3. decrease in claims which got us $35.7 million IBNR / claims payable balance.

CEO Engelhard broke it down further: $45 add $20 take $29 that is how you get reduction. Of the $5, $3 was lower enrollment and other $2 is combination of refunds processed, claims processed and insurance recovery.

Interim CFO DeMarta explained that June is higher than normal due to the IBNR retroactive adjustment. On the expenses there were specific questions. Accounting & Actuary Services work performed by Milliman and a final payment to McGladrey for the prior year's audit.

Committee Member Chawla indicated that there had been a question on the legal expenses. Interim CFO DeMarta responded that those expenses were $50,000 from Legal Counsel Kierstyn Schreiner's firm Nordman Cormany Hair & Compton LLP and addition $37,000 from RGS. Committee Member Chawla asked what was included in Legal Counsel Kierstyn Schreiner's bills. Legal Counsel Kierstyn Schreiner's responded that there were personnel issues, potential litigation, contracts.

Interim CFO DeMarta reviewed Outside Service Other versus Consulting. Outside Services Other is for outsource like payroll, IT solution, etc. Consulting we use as additional staff or supplementing our staff like Tatum. Consulting Services were higher in June because it included additional billing from Tatum, IT consultants, accounting consultants, RGS, two HR personnel, and timing of billings so there is a couple of months of billings.

On Shipping and Postage we received billing from Xerox / ACS for $150,000 which we receive on a quarterly basis, we will start accruing monthly.

Committee Member Glyer moved to approve the Financials. Committee Member Chawla seconded. The motion carried. **Approved 3-0.**

Chair Gonzalez suggested having a list available of the expenses in case there are questions at the Commission meeting.

Committee Member Rodriguez arrived.

Minor review of Legal Counsel Kierstyn Schreiner's billings, provider contracts and utilization management reports, as well as the IBNR was held.

b. FY10-11 Audit Results

Interim CFO DeMarta reviewed the Auditors findings; there were no Significant Accounting Estimates, Financial Disclosures, Audit Adjustments, Uncorrected Misstatements, Disagreements with Management, Consultations with Other Accountants, Difficulties Encountered in Performing Audit.

Suggestions from the Auditors. They believe we should have an Internal Auditor, the fact that there are so many issues that we deal with, they felt we should start with a Director of Internal Auditor and build on that. There should also be included an operational audit of medical claims processing with a focus on medical claims expenses, cash receipts and disbursements. There should be regular assessments of business risk management and assessment of new systems.

Suggest business continuity program; turnover in management. In closing, we submitted a written response which is attached. The Finance Department has created a shared drive and on that drive we put a copy of everything that changes a process.

Committee Member Rodriguez explained that the County has an assessment tool questionnaire that may be able to assist the Plan.

Chair Gonzalez indicated that he felt it seemed that they were recommending things we already had. Interim CFO DeMarta explained that our response is that we explained that we felt we do not have the full process; however, we have a "work around."

Interim CFO DeMarta further explained that when they came out it was right when the CEO had left, the CFO had left and information was contained on the CFO's computer. It was difficult to locate information timely for the Auditors immediately due to staffing levels, etc.

Discussion was held regarding the development of a Comprehensive Business Continuity Plan. CEO Engelhard responded that he would check into this matter and get back with the Committee.

Committee Member Glyer moved to accept Audit Report. Committee Member Rodriguez. The motion carried. **Approved 4-0.**

3. CONSIDERATION OF ELIMINATION OF HIRING FREEZE

CEO Engelhard reported that this occurred prior to his arrival, due to whether we should be hiring people with such a high benefit load. The analysis will show that the benefit load is not as it appeared in the budget. He further explained that staff is engaged with a broker to continue to refine the benefits and reduce costs even further.

Interim CFO DeMarta explained that staff went back and reviewed RGS billings to know what the real benefit load was. It includes 15 days of vacation, 12 sick, 10 holidays, 2 admin, 1 bereavement and 1 day for jury duty.

Chair Gonzalez asked if we had numbers from other COHS. CEO Engelhard responded that staff did not receive much of a response: one was a 42% load, CenCal is approximately 35% and CalOptima is at 35%. Committee Member Chawla stressed that it would be beneficial to know the full benefit package of other COHS.

Further discussion was held regarding RGS billings.

Legal Counsel Kierstyn Schreiner left the meeting at 4:12 p.m.

CEO Engelhard stated that the budget needs to be restated to show the benefit load at the 31-35%. If the hiring freeze stays the Plan will incur further costs because the work must be completed therefore we would have to hire consultants and due to overtime. It would cost more in the long run.

Chair Gonzalez asked if the CEO was suggesting hiring with 3 weeks' vacation, life insurance, the 10% 401k, and asked if the 401k a matching program. Interim CFO DeMarta responded that the 401k was not matching.

Chair Gonzalez stated that it needs to be at a place that can be presented to the Commission, people that are currently with the Plan would continue with the same benefit level, it would be a different level for new hires. Staff is assuming that since it is 31% or 35% and not 43% it will be approved, but you may not get that far.

CEO Engelhard responded that the State has indicated that the Plan must hire a QI Master Trainer (Facility Site Reviewer). If we do not have one we will be out of compliance and we will be on a Corrective Action Plan.

Chair Gonzalez suggested presenting comparisons of RGS vs. GCHP and verbally highlighting the things that you are looking at - such as potentially dropping down vacation, keeping health insurance at full benefit, but going out marketing it for better rates.

4. CONTRACT REVIEW

Consideration and Recommendation to Commission of Extension of Tatum Contract. The contract is currently through October.

CEO Engelhard advised the Committee that Cassie Undlin is currently filling the role of Interim Chief Operating Officer. It is over ACS Contract and Provider Contracting. There is not adequate time to get the work done therefore he is requesting additional time. There is also another individual and that person is currently filling the Director of IT so we have moved IT out from under Sonia DeMarta. We are currently working with a recruiter for a Director of IT but have been unsuccessful.

The Committee Members felt that $40,000 was extremely high for these positions. Chair Gonzalez suggested that CEO Engelhard and he discuss this with Linda Klute of Tatum before it goes to the Commission.

Committee Member Chawla moved to extend the Tatum Contract to November 30th, with the rates being negotiated prior to it going to the Commission. Committee Member Glyer seconded. The motion carried. **Approved 4-0.**

COMMENTS FROM COMMITTEE MEMBERS

Committee Member Rodriguez asked for clarification on how items get on the Commission Agenda. Chair Gonzalez responded that CEO puts the Agenda together and the Chair reviews the items.

Committee Member Rodriguez asked when the following items would come to the Commission: Progress Report; BRG Audit; CEO Hiring Plan; The State's Report; General Update; Budget Presentation; Business Plan.

CEO Engelhard responded that he would have to review what staff had previously committed and get back to the Commission. The IBNR would have to be completed. The hiring plan, benefit load, hopefully November meeting with a revised look at the budget

Chair Gonzalez commented on the BRG Reports, he indicated that there was talk about the reports, and the idea that they were not public. He stated that they were considered "draft" the Plan has nothing to hide.

CEO Engelhard stated that it is his understanding that BRG provides a proposed report to DHCS and at some point DHCS will say it is a "final" or filed report and at that point the Plan will say it is filed and the Plan will provide a copy.

Mark Abernathy of BRG responded that while they were preparing their findings they were sharing their findings with Cassie, but I have been told that until DHCS tells me to go final it is not final. CEO Engelhard, issues are not being resolved as quickly as DHCS would like them resolved like Executive openings are an issue, these are things that have been communicated to, there is nothing new, but continuation has them concerned.

Committee Member Rodriguez stated that in May or June Tatum presented Chart of needs assessments, such as in operational, the structure in itself or assessment of what was lacking of the structure. They identified all these things that were lacking, have they remedied those things that they brought up. It was brought to the full Commission.

Committee Member Rodriguez stated that with regard to processing of payments to Providers, when they were with Medi-Cal they knew when checks would come. Last week it was committed that the check would come, we need to ensure that the check will arrive.

Interim CFO DeMarta responded that previously the County has been coming and picking up its check. Last week wire transfers began. The wire transfers went out a day late. We process weekly. Discussion was held regarding EOB and delays.

Chair Gonzalez stated that in October or November of 2011, he had asked that a shared risk agreement be brought forward. At that meeting a discussion was held whether or not the CEO had the right to do contracts. Think there is a concern that we are messing up the Plan. When they get something the State gets. The Plan's staff and their attorneys do a lot of work, then Providers and their attorney, then the State has to approve before it can turn into a contract. The CEO has a responsibility to inform the Commission. Chair Gonzalez indicated that there may be a need to reverse the decision.

CEO Engelhard do you want to approve us to go into new relationship once we have approval. We have attorney review. The model and not the contract. Believe the Commission approves the concept. Other COHS the Commissions don't approve contracts they approve the models.

ADJOURNMENT

The meeting adjourned at 5:16 p.m.

Gold Coast Health Plan℠
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www.goldcoasthealthplan.org

To: Executive / Finance Committee of the Ventura County Medi-Cal Managed Care Commission

From: Michael Engelhard, Chief Executive Officer

Date: October 4, 2012

RE: Ratification of Contract with the Law Firm of Wilke-Fleury for Specialized Legal Services for Managed Care Contracting

BACKGROUND:

In the course of business, Gold Coast Health Plan requires the legal support in many areas. GCHP retained the services of Nordman Cormany Hair and Compton LLP on April 19, 2012 after the resignation of the plan's previous general counsel on March 13, 2012. Nordman Cormany is the largest law firm in Ventura County. It provides specialized services to GCHP primarily in the areas of public agency governance, employment law and real estate.

GCHP needs to enter into contracts for provider services in order the ensure access to quality health care for the plan's members. While Nordman Cormany supports GCHP's traditional managed care contracting efforts, it does not have a specialized managed care contracting expertise in-house. Therefore GCHP needed to find a firm with such experience to address certain pressing contracting needs of the organization.

After soliciting input from managed care plans around the state of California, and to meet a pressing need to consummate certain provider contracts on an expedited manner, Acting CEO Cassie Undlin engagement letter with Wilke-Fleury on July 31, 2012 for specialized managed care contracting legal services. The contract is expected to be for below $100,000, which is the authority granted to the CEO.

RECOMMENDATION:

Recommend the ratification of the legal services contract with Wilke-Fleury to support Gold Coast's managed care contracting efforts.

To: Executive / Finance Committee of the Ventura County Medi-Cal Managed Care Commission

From: Nancy Kierstyn Schreiner, Legal Counsel

Date: October 4, 2012

RE: Adoption of Claims Procedure

BACKGROUND:

The Ventura County Board of Supervisors adopted Ordinance No. 4409 creating the Ventura County Medi-Cal Managed Care Commission (GCHP). The enabling Ordinance provided that GCHP shall be deemed a separate public entity for purposes of Government Code section 810 *et seq.,* which is commonly known as the Tort Claims Act. GCHP, pursuant to Ordinance No. 4409 and the California Government Code, is authorized to establish a procedure for processing of claims.

RECOMMENDATION:

Recommend that the attached Resolution adopting a claim procedure be approved by the Commission at its next regular meeting.

RESOLUTION 2012-____

A RESOLUTION OF THE VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION ADOPTING CLAIMS PROCEDURE

WHEREAS, the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan hereinafter referred to as GCHP, is authorized to adopt rules and regulations for the processing of claims against GCHP; and

NOW, THEREFORE, BE IT RESOLVED that the Commission of the Plan does hereby adopt the following claims procedure effective immediately.

PASSED, APPROVED AND ADOPTED by the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan at a regular meeting on the ___ day of October, 2012 by the following vote:

AYE:
NAY:
ABSTAIN:
ABSENT:

_____
Robert Gonzalez, Chair

Attest:

_____
Traci R. McGinley, Clerk of the Board

CLAIMS PROCEDURE

For persons wishing to file a claim against the Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan (GCHP), a General Claim Form* must be completed and submitted to the Clerk of the Commission.

GCHP is prohibited from providing you with legal advice. The California Government Code beginning with Section 900 concerns claims against public entities. Please note the following:

Claims relating to causes of action for death or injury to a person or damage to personal property or growing crops must be presented to the GCHP no later than six months after the incident date.

Claims relating to any cause of action other than those for death or injury to a person or damage to personal property must be presented no later than one year after the incident date (California Government Code Section 911.2).

Once claims are received by the Clerk of the Commission, claims are referred to the Commission's Legal Counsel. The Legal Counsel conducts an investigation into the information in your claim. Your claim form is generally your only opportunity to present information you wish GCHP to consider. The Legal counsel makes a recommendation to the Commission based upon the information obtained and the laws of California.

The Commission must act within forty-five days after you submit your claim (California Government Code Section 911.6). If the Commission fails to act within forty-five days, the claim is deemed to have been denied as a matter of law (California Government Code Section 911.6).

INSTRUCTIONS FOR FILING A CLAIM WITH VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION doing business as GOLD COAST HEALTH PLAN

The following provides specific instructions for completing each section of the Claim Form:

1. Name, Mailing Address and Telephone Number of Claimant(s) .
   State full name, mailing address and telephone number of the person(s) claiming damage or injury.

2. Dollar Amount of Claim
   State the total amount being claimed as a result of any alleged damage or injury. If damage or injury is continuing, or is anticipated in the future, indicate by writing a plus sign "(+)" following the dollar figure.

3. Official Notices and Correspondence
   Provide the name and mailing address of the person to whom all correspondence should be sent, if other than the Claimant. This official contact person can be either the Claimant, or a representative of the Claimant.

4. When Did Damage/Injury Occur?
   State the exact month, day, year and time the incident occurred. Under state law, claims relating to causes of action for death or for injury to a Person or for damage to personal property or growing crops must be presented to GCHP no later than six months after the incident date.

   If you are filing a claim beyond the six-month period, an *Application for Leave to Present a Late Claim* must also be included with your claim. An *Application for Leave to Present a Late Claim* is your written explanation of the reason(s) why the claim was not filed within the six-month period. In considering the claim, the GCHP will first decide whether or not the *Application for Leave to Present a Late Claim* should be granted or denied. (See Government Code Section 911.4 for the legally acceptable reasons a claim may be filed late).

   ONLY IF *LEAVE TO PRESENT A LATE CLAIM* IS GRANTED, WILL THE GCHP CONSIDER THE MERITS OF THE CLAIM.

   Claims relating to any cause of action other than those for death or injury to a person, or for damage to personal property, must be presented no later than one year after the incident date. (GOVERNMENT CODE SECTIONS 911.2 and 911.4)

5. Location of Incident

   Include the city, county and street address of occurrence.

6. Presenting Facts on How Incident Occurred
   Provide in FULL detail the circumstances that led up to the incident. Identify ALL FACTS which support the claim. Include the name of the agency and/or employee

that allegedly caused the damage/injury, as well as a specific identification as to any condition of public property that allegedly caused the incident.

7. Describing the Damage/Injury and How Amount of the Claim was Computed.
Provide in full detail a description of the damage/injury that allegedly resulted from the incident. Provide a breakdown of how the total amount that is being claimed was computed. Expenses incurred and/or future anticipated expenses may be declared. Attach to the claim copies of all bills, payment receipts, any photos of scene, damage, etc. **ANY CLAIMS FOR DAMAGE TO A VEHICLE MUST BE ACCOMPANIED BY TWO ESTIMATES AND PHOTO(S) OF DAMAGE.** If you need more space, please write on the back of the Claim Form or separate piece of paper.

8. Signature.
The Claim Form must be signed by the Claimant, or by the attorney or representative of the Claimant. GCHP will not accept the Claim without a proper signature. GOVERNMENT CODE SECTION 910.2 PROVIDES: "The claim must be signed by the claimant or some person on his/her behalf."

Provide all information you wish GCHP to consider. You will not be contacted for additional information. Please submit by personal delivery or mail the **original Claim Form** and supporting documentation to the Clerk of the Commission at the following address:

Gold Coast Health Plan
Clerk of the Commission
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036

ANY CLAIM PRESENTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED WITH NO ACTION TAKEN BY GCHP (GOVERNMENT CODE SECTIONS 910, 910.2, 910.4, and 910.8.)

All claims will be investigated by GCHP and/or its Legal counsel. State Law allows the Commission of GCHP 45 days to respond to your claim. You will be notified in writing of the Commission's action or inaction in 45 days.

CLAIM Against the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION doing business as GOLD COAST HEALTH PLAN

To: Clerk of the Commission
Gold Coast Health Plan
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036
(805) 988-5100

Pursuant to the provisions of Sections 905 and 920 of the Government Code of the State of California, demand is hereby made against the City of Thousand Oaks, California. In support of said claim, the following information is submitted.

1. Name, Mailing Address, Telephone Number of Claimant(s):
_____
_____
_____
_____

2. Dollar Amount of Claim: _____

3. Address to Which Official Notices and Correspondence are to be Mailed:
_____
_____
_____

4. Date and Time Alleged Damage/Injury Occurred:_____

5. Location of Where Alleged Damage/Injury Occurred:_____
_____

6. Facts on How Alleged Damage/Injury Occurred (Include Name of GCHP Employee(s) Who Caused Injury, if Known): _____
_____
_____
_____

7. Describe Damage/Injury and How Amount of Claim was Computed:
_____
_____

8. _____ _____
Date Signature of Claimant Person Acting on Claimant's Behalf)

NOTE: Provide all information you wish GCHP to consider and submit **original signed claim form** and back-up documentation if any, to address listed above. ANY CLAIM PRESENTED WITH INSUFFICIENT INFORMATION WILL BE RETURNED WITH NO ACTION TAKEN BY THE CITY (GOVERNMENT CODE SECTIONS 910, 910.2, 910.4, AND 910.8)

Gold Coast Health Plan℠
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To: Executive / Finance Committee of the Ventura County Medi-Cal Managed Care Commission

From: Nancy Kierstyn Schreiner, Legal Counsel

Date: October 4, 2012

RE: Bylaws and Meetings of the Executive / Finance Committee

BACKGROUND:

The Ventura County Board of Supervisors adopted Ordinance No. 4409 creating the Ventura County Medi-Cal Managed Care Commission (GCHP). The enabling Ordinance provided that GCHP may establish committees. The Amended and Restated Bylaws adopted October 24, 2011 provide for the establishment of the Executive / Finance Committee. The Bylaws further provide in Article IV(b)(1) that "Meetings of this committee shall be at the request of the Chairperson or CEO to evaluate time sensitive matters." Subsequent to the adoption of the Bylaws the Commission and / or Executive / Finance Committee have taken action via motions to establish a set time and place for the Executive / Finance Committee. Such action was not necessary or required by the Bylaws.

RECOMMENDATION:

Recommend that the language set forth in the Bylaws be followed and that there is not further action required in the establishment of meetings for the Executive / Finance Committee by the Commission. It is suggested that this information be forwarded to the Commission at its next regular meeting.

GOLD COAST HEALTH PLAN

SUMMARY FINANCIAL RESULTS

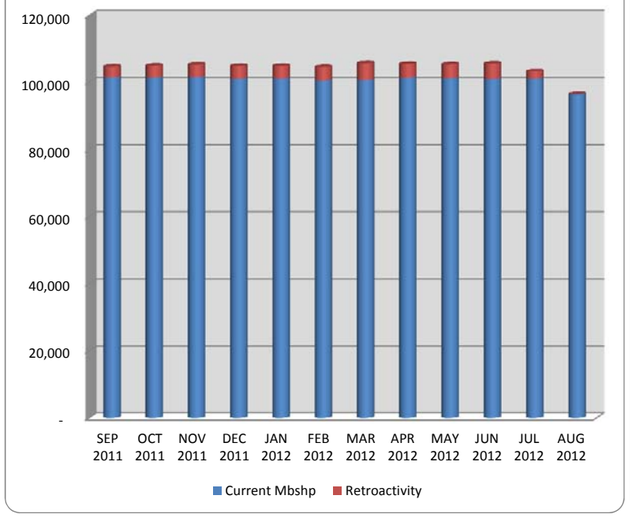
Rolling Twelve Months Actual Trend

Description	Actual September 2011 - June 2012 Monthly Results										FY 2012-13	
	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Member Months	104,821	105,245	104,979	105,079	104,418	104,839	106,503	105,446	105,262	105,875	96,540	95,797
Revenue	**23,740,361**	**25,199,998**	**24,946,694**	**25,440,875**	**24,990,447**	**24,231,927**	**25,411,162**	**25,427,262**	**25,299,965**	**25,447,390**	**23,806,175**	**24,430,512**
pmpm	*226.48*	*239.44*	*237.64*	*242.11*	*239.33*	*231.13*	*238.60*	*241.14*	*240.35*	*240.35*	*246.59*	*255.02*
Health Care Costs	**21,839,899**	**22,065,987**	**22,003,480**	**22,415,249**	**22,121,202**	**26,111,143**	**23,045,202**	**22,918,149**	**24,107,688**	**23,225,105**	**21,181,745**	**28,173,162**
pmpm	*208.35*	*209.66*	*209.60*	*213.32*	*211.85*	*249.06*	*216.38*	*217.34*	*229.03*	*219.36*	*219.41*	*294.09*
% of Revenue	92.0%	87.6%	88.2%	88.1%	88.5%	107.8% (1)	90.7%	90.1%	95.3% (2)	91.3% (3)	89.0%	115.3% (4)
Admin Exp	**1,413,721**	**1,672,837**	**1,084,862**	**1,440,127**	**1,529,225**	**1,516,129**	**1,615,365**	**1,829,630**	**1,883,097**	**2,092,320**	**1,587,586**	**1,683,028**
pmpm	*13.49*	*15.89*	*10.33*	*13.71*	*14.65*	*14.46*	*15.17*	*17.35*	*17.89*	*19.76*	*16.44*	*17.57*
% of Revenue	6.0%	6.6%	4.3%	5.7%	6.1%	6.3%	6.4%	7.2%	7.4%	8.2%	6.7%	6.9%
Net Income	**486,741**	**1,461,174**	**1,858,351**	**1,585,499**	**1,340,019**	**(3,395,346)**	**750,595**	**679,482**	**(690,820)**	**129,965**	**1,036,844**	**(5,425,678)**
pmpm	*4.64*	*13.88*	*17.70*	*15.09*	*12.83*	*(32.39)*	*7.05*	*6.44*	*(6.56)*	*1.23*	*10.74*	*(56.64)*
% of Revenue	2.1%	5.8%	7.4%	6.2%	5.4%	-14.0%	3.0%	2.7%	-2.7%	0.5%	4.4%	-22.2%
100% TNE	14,671,236	14,837,677	14,925,890	15,048,230	15,101,073	15,615,661	15,685,187	15,730,358	15,793,552	15,797,312	15,841,387	16,249,352
Required TNE	-	-	-	-	3,020,215	3,123,132	3,137,037	3,146,072	3,158,710	3,137,023	5,702,899	5,849,767
GCHP TNE	**1,113,773**	**2,574,946**	**4,433,298**	**6,018,797**	**7,358,815**	**3,963,469**	**4,714,065**	**5,393,547**	**4,702,727**	**4,832,692**	**5,869,536**	**443,858**

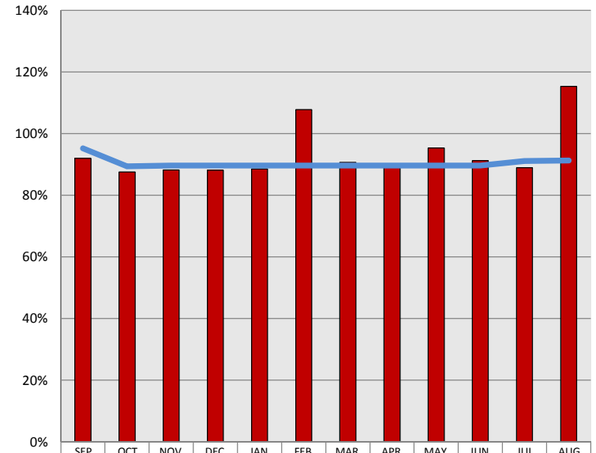
Note (1): February Health Care Costs include $4M added to reserves pursuant to updated Milliman IBNR methodology.
Note (2): May Health Care Costs include $3M added to reserves.
Note (3): June Health Care Costs include $2M added to IBNR.
Note (4): August Health Care Costs include $7M added to IBNR.

GOLD COAST HEALTH PLAN
Financial Scorecard - August 2012

Membership

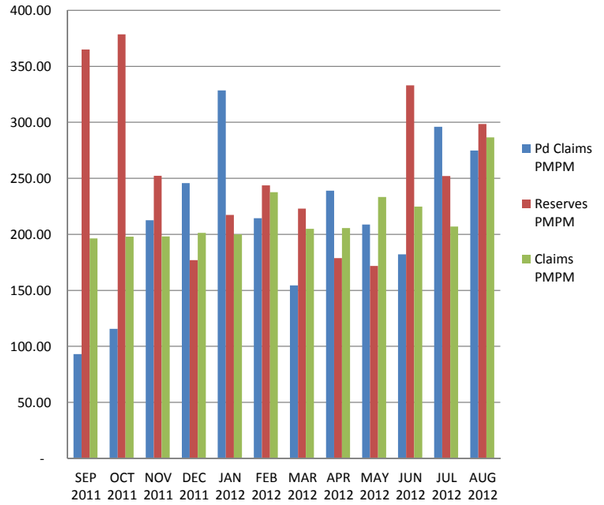


Health Care Cost (MLR)

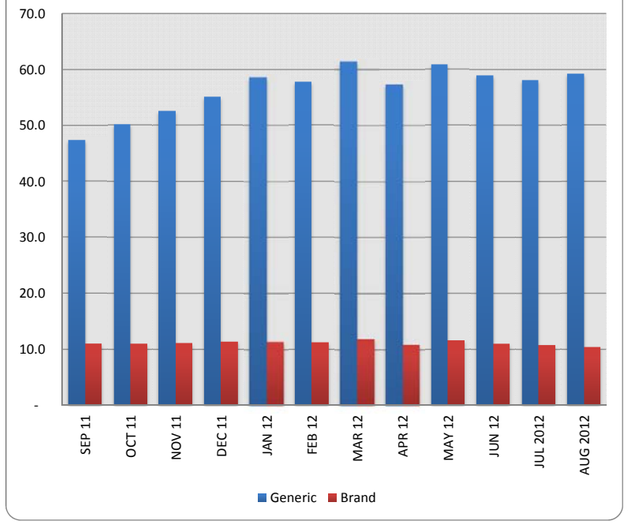


	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG
Series1	92.0%	87.6%	88.2%	88.1%	88.5%	107.8%	90.7%	90.1%	95.3%	91.3%	89.0%	115.3%
Series2	95.2%	89.4%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	89.6%	91.1%	91.3%

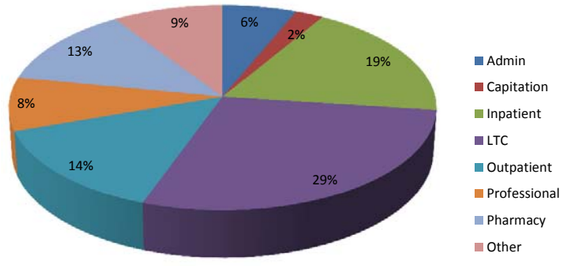
Claims - Reserves



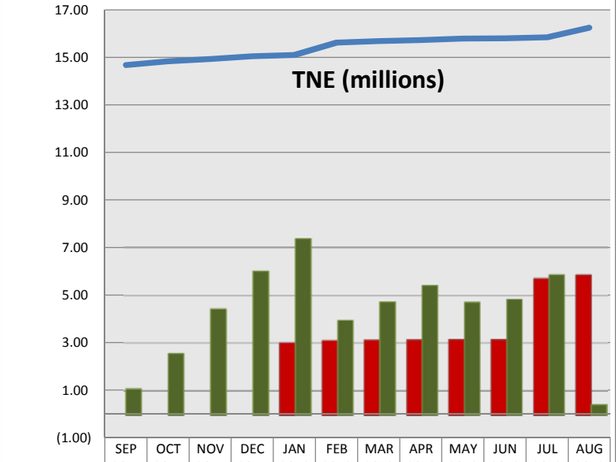
Pharmacy Encounters (Count in 000s)



Expenditures August YTD



TNE (millions)



	SEP 2011	OCT 2011	NOV 2011	DEC 2011	JAN 2012	FEB 2012	MAR 2012	APR 2012	MAY 2012	JUN 2012	JUL 2012	AUG 2012
Required TNE	-	-	-	-	3.02	3.12	3.14	3.15	3.16	3.16	5.70	5.85
GCHP TNE	1.11	2.57	4.43	6.02	7.36	3.96	4.73	5.41	4.72	4.85	5.87	0.44
100% TNE	14.67	14.84	14.93	15.05	15.10	15.62	15.69	15.73	15.79	15.80	15.84	16.25

Gold Coast Health Plan
Comparative Balance Sheet
August 31, 2012

	8/31/12	7/31/12	6/30/12
ASSETS			
Current Assets			
Total Cash and Cash Equivalents	**20,486,411**	**24,424,061**	**23,740,502**
Medi-Cal Receivable	25,211,484	26,815,002	28,534,938
Provider Receivable	3,825,803	3,128,213	6,233,287
Other Receivables	199,269	1,346,264	1,367,855
Total Accounts Receivable	**29,236,556**	**31,289,479**	**36,136,079**
Total Prepaid Accounts	1,079,417	1,092,941	1,128,838
Total Other Current Assets	-	375,000	750,000
Total Current Assets	**50,802,383**	**57,181,482**	**61,755,420**
Total Fixed Assets	**90,686**	**92,492**	**94,298**
Total Assets	**50,893,069**	**57,273,974**	**61,849,718**
LIABILITIES & FUND BALANCE			
Current Liabilities			
Incurred But Not Reported	28,597,754	24,868,367	35,251,106
Claims Payable	8,275,230	10,889,499	9,284,705
Capitation Payable	622,092	624,487	633,276
Accrued Premium Reduction	7,874,996	7,287,718	6,700,285
Accounts Payable	559,928	4,244,099	1,788,086
Accrued ACS	1,108,943	-	-
Accrued RGS	-	-	375,000
Accrued Premium Tax	1,188,600	1,188,600	602,900
Current Portion of Deferred Revenue	460,000	460,000	460,000
Current Portion Of Long Term Debt	458,333	500,000	500,000
Total Current Liabilities	**49,145,877**	**50,062,771**	**55,595,360**
Long-Term Liabilities			
Other Long-term Liability	-	-	41,667
Deferred Revenue - Long Term Portion	1,303,333	1,341,667	1,380,000
Total Long-Term Liabilities	**1,303,333**	**1,341,667**	**1,421,667**
Total Liabilities	**50,449,211**	**51,404,438**	**57,017,026**
Beginning Fund Balance	4,832,692	4,832,692	(4,422,819)
Net Income Current Year	(4,388,834)	1,036,844	9,255,511
Total Fund Balance	**443,858**	**5,869,536**	**4,832,692**
Total Liabilities & Fund Balance	**50,893,069**	**57,273,974**	**61,849,718**

Gold Coast Health Plan
Income Statement Comparison
For The Period Ended August 31, 2012

	2012 Actual Trend			Aug'12 Month-To-Date		Variance
	May	Jun	Jul	Actual	Budget	Fav/(Unfav)
Membership	101,041	101,207	96,540	95,797	96,564	(767)
Revenue:						
Premium	$ 26,432,002	$ 26,583,453	$ 24,923,409	$ 24,965,442	$ 24,943,457	$ 21,984
Reserve for Rate Reduction	(564,990)	(565,653)	(587,433)	(587,278)	(588,991)	1,713
MCO Premium Tax	(621,152)	(624,711)	(585,700)	-	(586,171)	586,171
Total Net Premium	**25,245,860**	**25,393,089**	**23,750,276**	**24,378,164**	**23,768,295**	**609,868**
Other Revenue:						
Interest Income	15,771	15,968	17,566	14,015	14,966	(951)
Miscellaneous Income	38,333	38,333	38,333	38,333	38,333	0
Total Other Revenue	54,105	54,301	55,899	52,349	**53,299**	(950)
Total Revenue	**25,299,965**	**25,447,390**	**23,806,175**	**24,430,512**	**23,821,594**	**608,918**
Medical Expenses:						
Capitation	634,809	633,276	624,487	622,092	626,585	4,493
Incurred Claims:						
Inpatient	5,050,059	4,879,263	4,053,600	5,672,169	4,195,454	(1,476,715)
LTC/SNF	7,675,933	7,307,150	6,286,933	8,671,611	5,964,122	(2,707,489)
Outpatient	3,049,193	2,941,681	2,431,578	3,404,140	2,514,004	(890,136)
Laboratory and Radiology	255,670	247,691	204,092	285,780	210,542	(75,238)
Emergency Room Facility Services	595,058	571,756	469,752	659,819	486,027	(173,792)
Physician Specialty Services	2,300,063	2,226,777	1,848,209	2,584,677	1,899,320	(685,357)
Pharmacy	3,292,480	3,330,093	3,186,191	3,458,256	3,206,472	(251,784)
Other Medical Professional	312,135	304,096	263,752	345,204	199,138	(146,066)
Other Medical Care Expenses	-	504	836	1,510	-	(1,510)
Other Fee For Service Expense	1,706,929	1,655,161	1,410,880	1,978,126	1,416,943	(561,183)
Transportation	333,734	321,236	272,336	383,168	271,559	(111,609)
Total Claims	24,571,254	23,785,408	20,428,159	27,444,459	20,363,581	(7,080,878)
Medical & Care Management Expense	529,018	545,482	516,815	541,067	535,590	(5,477)
Reinsurance	92,158	91,947	224,938	224,994	224,994	(0)
Claims Recoveries	(1,719,551)	(1,831,008)	(612,655)	(659,450)	-	659,450
Sub-total	(1,098,376)	(1,193,579)	129,099	106,611	**760,584**	653,973
Total Cost of Health Care	**24,107,688**	**23,225,105**	**21,181,745**	**28,173,162**	**21,750,750**	**(6,422,412)**
Contribution Margin	**1,192,277**	**2,222,285**	**2,624,430**	**(3,742,650)**	**2,070,844**	**(5,813,494)**
General & Administrative Expenses:						
Salaries and Wages	301,593	310,409	311,747	308,137	316,193	8,056
Payroll Taxes and Benefits	88,190	118,072	108,967	155,252	112,703	(42,549)
Total Travel and Training	2,005	4,833	1,472	6,977	4,950	(2,027)
Outside Service - ACS	956,991	910,666	864,935	856,106	867,555	11,450
Outside Service - RGS	9,732	10,198	10,858	12,571	11,651	(920)
Outside Services - Other	289,582	12,001	10,257	11,092	45,697	34,605
Accounting & Actuarial Services	28,495	42,907	-	18,120	38,500	20,380
Legal Expense	2,350	85,387	13,600	4,468	11,500	7,032
Insurance	2,959	2,958	3,424	3,424	3,255	(169)
Lease Expense - Office	11,869	8,389	11,869	11,869	13,420	1,551
Consulting Services Expense	69,350	269,744	121,319	125,727	29,640	(96,087)
Translation Services	1,051	2,736	1,020	85	743	658
Advertising and Promotion Expense	9,466	-	3,500	-	0	-
General Office Expenses	61,719	76,450	45,869	89,227	60,793	(28,434)
Depreciation & Amortization Expense	1,461	1,461	1,806	1,806	1,806	(0)
Printing Expense	2,977	27,618	2,386	22,538	2,069	(20,469)
Shipping & Postage Expense	2,467	155,250	13,572	2,535	432	(2,103)
Interest Exp	40,841	53,241	60,986	53,094	21,657	(31,437)
Total G & A Expenses	**1,883,097**	**2,092,320**	**1,587,586**	**1,683,028**	**1,542,564**	**(140,464)**
Net Income / (Loss)	**$ (690,820)**	**$ 129,965**	**$ 1,036,844**	**$ (5,425,678)**	**$ 528,280**	**$ (5,673,031)**

Gold Coast Health Plan
PMPM Income Statement Comparison
For The Period Ended August 31, 2012

	2012 Actual Trend			Aug'12 Month-To-Date		Variance
	May	Jun	Jul	Actual	Budget	Fav/(Unfav)
Members (Member/Months)	101,041	101,207	96,540	95,797	96,564	(767)
Revenue:						
Premium	261.60	262.66	258.17	260.61	258.31	2.30
Reserve for Rate Reduction	(5.59)	(5.59)	(6.08)	(6.13)	(6.10)	(0.03)
MCO Premium Tax	(6.15)	(6.17)	(6.07)	-	(6.07)	6.07
Total Net Premium	**249.86**	**250.90**	**246.01**	**254.48**	**246.14**	**8.34**
Other Revenue:						
Interest Income	0.16	0.16	0.18	0.15	0.15	(0.01)
Miscellaneous Income	0.38	0.38	0.40	0.40	0.40	0.00
Total Other Revenue	**0.54**	**0.54**	**0.58**	**0.55**	**0.53**	**0.02**
Total Revenue	**250.39**	**251.44**	**246.59**	**255.02**	**246.69**	**8.33**
Medical Expenses:						
Capitation	6.28	6.26	6.47	6.49	6.49	0.01
Incurred Claims:						
Inpatient	49.98	48.21	41.99	59.21	43.45	15.76
LTC/SNF	75.97	72.20	65.12	90.52	61.76	28.76
Outpatient	30.18	29.07	25.19	35.53	26.03	9.50
Laboratory and Radiology	2.53	2.45	2.11	2.98	2.18	0.80
Emergency Room Facility Services	5.89	5.65	4.87	6.89	5.03	1.85
Physician Specialty Services	22.76	22.00	19.14	26.98	19.67	7.31
Pharmacy	32.59	32.90	33.00	36.10	33.21	2.89
Other Medical Professional	3.09	3.00	2.73	3.60	2.06	1.54
Other Medical Care Expenses	-	0.00	0.01	0.02	-	0.02
Other Fee For Service Expense	16.89	16.35	14.61	20.65	14.67	5.98
Transportation FFS	3.30	3.17	2.82	4.00	2.81	1.19
Total Claims	243.18	235.02	211.60	286.49	210.88	75.60
Medical & Care Management	5.24	5.39	5.35	5.65	5.55	0.10
Reinsurance	0.91	0.91	2.33	2.35	2.33	0.02
Claims Recoveries	(17.02)	(18.09)	(6.35)	(6.88)	-	(6.88)
Sub-total	(10.87)	(11.79)	1.34	1.11	7.52	(6.40)
Total Cost of Health Care	238.59	229.48	219.41	294.09	225.25	68.85
Contribution Margin	11.80	21.96	27.18	(39.07)	**21.45**	**(60.51)**
Administrative Expenses						
Salaries and Wages	2.98	3.07	3.23	3.22	3.27	(0.06)
Payroll Taxes and Benefits	0.87	1.17	1.13	1.62	1.17	0.45
Total Travel and Training	0.02	0.05	0.02	0.07	0.05	0.02
Outside Service - ACS	9.47	9.00	8.96	8.94	8.98	(0.05)
Outside Service - RGS	0.10	0.10	0.11	0.13	0.12	0.01
Outside Services - Other	2.87	0.12	0.11	0.12	0.47	(0.36)
Accounting & Actuarial Services	0.28	0.42	-	0.19	0.40	(0.21)
Legal Expense	0.02	0.84	0.14	0.05	0.12	(0.07)
Insurance	0.03	0.03	0.04	0.04	0.03	0.00
Lease Expense -Office	0.12	0.08	0.12	0.12	0.14	(0.02)
Consulting Services Expense	0.69	2.67	1.26	1.31	0.31	1.01
Translation Services	0.01	0.03	0.01	0.00	0.01	(0.01)
Advertising and Promotion Expense	0.09	-	0.04	-	-	-
General Office Expenses	0.61	0.76	0.48	0.93	0.63	0.30
Depreciation & Amortization Expense	0.03	0.01	0.02	0.24	0.02	0.22
Printing Expense	0.02	0.27	0.14	0.03	0.02	0.01
Shipping & Postage Expense	0.40	1.53	0.63	0.55	0.00	0.55
Interest Exp	-	0.53	-	-	0.22	(0.22)
Total Administrative Expenses	**18.64**	**20.67**	**16.44**	**17.57**	**15.97**	**1.59**
Net Income / (Loss)	**(6.84)**	**1.28**	**10.74**	**(56.64)**	**5.47**	**(62.11)**

Gold Coast Health Plan
Income Statement Comparison
For The Period Ended August 31, 2012

	Aug'12 Year-To-Date		Variance
	Actual	Budget	Fav/(Unfav)
Membership	192,337	193,104	(767)
Revenue:			
Premium	$ 49,888,851	$ 49,880,680	$ 8,171
Reserve for Rate Reduction	(1,174,711)	(1,177,835)	3,124
MCO Premium Tax	(585,700)	(1,172,196)	586,496
Total Net Premium	**48,128,440**	**47,530,649**	**597,791**
Other Revenue:			
Interest Income	31,581	29,928	1,653
Miscellaneous Income	76,667	76,667	(0)
Total Other Revenue	108,248	**106,595**	1,653
Total Revenue	**48,236,688**	**47,637,244**	**599,444**
Medical Expenses:			
Capitation	1,246,580	1,253,013	6,433
Incurred Claims:			
Inpatient	9,725,769	8,389,859	(1,335,910)
LTC/SNF	14,958,544	11,926,753	(3,031,791)
Outpatient	5,835,718	5,027,381	(808,337)
Laboratory and Radiology	489,872	421,031	(68,841)
Emergency Room Facility Services	1,129,571	971,932	(157,639)
Physician Specialty Services	4,432,886	3,798,165	(634,721)
Pharmacy	6,644,446	6,412,143	(232,303)
Other Medical Professional	608,956	398,226	(210,730)
Other Medical Care Expenses	2,346		(2,346)
Other Fee For Service Expense	3,389,006	2,833,537	(555,469)
Transportation	655,504	543,050	(112,454)
Total Claims	47,872,618	40,722,077	(7,150,541)
Medical & Care Management Expense	1,057,882	1,033,472	(24,410)
Reinsurance	449,932	449,933	1
Claims Recoveries	(1,272,105)	-	1,272,105
Sub-total	235,710	**1,483,405**	1,247,695
Total Cost of Health Care	**49,354,907**	**43,458,495**	**(5,896,412)**
Contribution Margin	**(1,118,220)**	**4,178,749**	**(5,296,969)**
General & Administrative Expenses:			
Salaries and Wages	619,885	609,876	(10,008)
Payroll Taxes and Benefits	264,219	212,613	(51,606)
Total Travel and Training	8,449	12,067	3,618
Outside Service - ACS	1,721,040	1,734,909	13,869
Outside Service - RGS	23,429	21,847	(1,582)
Outside Services - Other	21,349	86,394	65,045
Accounting & Actuarial Services	18,120	46,000	27,880
Legal Expense	18,068	23,000	4,932
Insurance	6,848	6,510	(338)
Lease Expense - Office	23,738	26,840	3,102
Consulting Services Expense	247,046	54,280	(192,766)
Translation Services	1,105	1,486	381
Advertising and Promotion Expense	3,500	0	(3,500)
General Office Expenses	135,096	109,278	(25,818)
Depreciation & Amortization Expense	3,612	3,612	(0)
Printing Expense	24,924	4,070	(20,854)
Shipping & Postage Expense	16,107	847	(15,260)
Interest Exp	114,080	43,662	(70,418)
Total G & A Expenses	**3,270,614**	**2,997,291**	**(273,323)**
Net Income / (Loss)	**$ (4,388,834)**	**$ 1,181,458**	**$ (5,023,646)**

Gold Coast Health Plan
Income Statement Comparison
August vs. July 2012 Actual Month Activity

	2012 Actual		$ Variance	% Variance	
	JUL	AUG	Fav/(Unfav)	Fav/(Unfav)	Explanation
Members (Member/Months)	96,540	95,797	(743)	-0.8%	
Revenue					
Premium	$ 24,923,409	$ 24,965,442	$ 42,033	0.2%	
Reserve for Retro-Active Rate Reduction	(587,433)	(587,278)	155	0.0%	
MCO Tax	(585,700)	-	585,700	-100.0%	Awaiting clarification on MCO sunset
Total Net Premium	**23,750,276**	**24,378,164**	**627,888**	2.6%	
Other Revenue:					
Interest Income	17,566	14,015	(3,551)	-20.2%	
Miscellaneous Income	38,333	38,333	-	0.0%	
Total Other Revenue	**55,899**	**52,349**	**(3,551)**	-6.4%	
Total Revenue	23,806,175	24,430,512	624,337	2.6%	
Medical Expenses:					
Capitation	624,487	622,092	2,395	0.4%	
Incurred Claims					
Inpatient FFS Expense	4,053,600	5,672,169	(1,618,569)	-39.9%	Add'l $7M IBNR across all categories
LTC/SNF Expense	6,286,933	8,671,611	(2,384,678)	-37.9%	
Outpatient FFS Expense	2,431,578	3,404,140	(972,562)	-40.0%	
Laboratory and Radiology Expense	204,092	285,780	(81,688)	-40.0%	
Emergency Room Facility Services FFS	469,752	659,819	(190,067)	-40.5%	
Physician Specialty Services FFS	1,848,209	2,584,677	(736,468)	-39.8%	
Pharmacy	3,186,191	3,458,256	(272,065)	-8.5%	Higher utilization; higher brand %
Other Medical Professional	263,752	345,204	(81,452)	-30.9%	
Other Medical Care Expenses	836	1,510	(674)	-80.6%	
Other Fee For Service Expense	1,410,880	1,978,126	(567,246)	-40.2%	
Transportation FFS	272,336	383,168	(110,832)	-40.7%	
Total Claims	20,428,159	27,444,459	(7,016,301)	-34.3%	
Medical & Care Management	516,815	541,067	(24,251)	-4.7%	
Reinsurance	224,938	224,994	(56)	0.0%	
Claims Recoveries	(612,655)	(659,450)	46,796	-7.6%	
Sub-total	129,099	106,611	22,489	17.4%	
Total Cost of Health Care	21,181,745	28,173,162	(6,991,417)	-33.0%	
Contribution Margin	2,624,430	(3,742,650)	6,367,080	242.6%	
Administrative Expenses					
Salaries and Wages	311,747	308,137	3,610	1.2%	
Payroll Taxes and Benefits	108,967	155,252	(46,284)	-42.5%	
Total Travel and Training	1,472	6,977	(5,505)	-374.0%	
Outside Service - ACS	864,935	856,106	8,829	1.0%	
Outside Service - RGS	10,858	12,571	(1,713)	-15.8%	
Outside Services - Other	10,257	11,092	(836)	-8.1%	
Accounting & Actuarial Services	-	18,120	(18,120)	-100.0%	Milliman actuarial, contract support
Legal Expense	13,600	4,468	9,132	67.1%	
Insurance	3,424	3,424	-	0.0%	
Lease Expense -Office	11,869	11,869	-	0.0%	
Consulting Services Expense	121,319	125,727	(4,408)	-3.6%	
Translation Services	1,020	85	935	91.7%	
Advertising and Promotion Expense	3,500	-	3,500	100.0%	
General Office Expenses	45,869	89,227	(43,357)	-94.5%	H/R recruiting software, furniture purch
Depreciation & Amortization Expense	1,806	1,806	-	0.0%	
Printing Expense	2,386	22,538	(20,153)	-844.7%	
Shipping & Postage Expense	13,572	2,535	11,036	81.3%	Winning Health newsletter - Summer'12
Interest Exp	60,986	53,094	7,891	12.9%	
Total Administrative Expenses	**1,587,586**	**1,683,028**	**(95,441)**	-6.0%	
Net Income / (Loss)	**$ 1,036,844**	**$ (5,425,678)**	**$ (6,462,521)**	**623.3%**	

Gold Coast Health Plan
General Office Expense
Period Ended August 31, 2012

	JUL 2012	AUG 2012
Committee/Advisory	-	750
Non-Capital - Furniture & Equip.	580	18,177
Non-Capital Equipment - Computer	5,650	1,752
Software Licenses	24,590	37,759
Repairs & Maintenance	631	90
Telephone Services/ Internet Charges	1,825	7,356
Office & Operating Supplies	869	3,276
Bank Service Fees Expense	37	347
EE Recruitment	5,942	12,839
Prof Dues, Fees and Licenses	5,427	5,381
Subcriptions and Publications	319	-
Charitable Contributions and Donations	-	1,500
General Office Expenses	**45,869**	**89,227**

Gold Coast Health Plan
Statement of Cash Flows
Month Ended August 31, 2012

Cash Flow From Operating Activities	
Collected Premium	26,568,960
Miscellaneous Income	14,015
Paid Claims	
Medical & Hospital Expenses	(21,746,052)
Pharmacy	(5,032,455)
Capitation	(624,487)
Reinsurance of Claims	(224,938)
Reinsurance Recoveries	
Payment of Withhold / Risk Sharing Incentive	
Paid Administration	(2,892,693)
Repay Initial Net Liabilities	
MCO Taxes Expense	-
Net Cash Provided by Operating Activities	**(3,937,651)**
Cash Flow From Investing/Financing Activities	
Proceeds from Paid in Surplus/Issuance of Stock	-
Costs of Capitalization	-
Net Acquisition of Property/Equipment	-
Net Cash Provided/(Used) by Investing/Financing	**-**
Net Cash Flow	**(3,937,651)**
Cash and Cash Equivalents (Beg. of Period)	24,424,061
Cash and Cash Equivalents (End of Period)	20,486,411
	(3,937,651)
Adjustment to Reconcile Net Income to Net Cash Flow	
Net (Loss) Income	(5,425,678)
Depreciation & Amortization	1,806
Decrease/(Increase) in Receivables	2,052,924
Decrease/(Increase) in Prepaids & Other Current Assets	388,524
(Decrease)/Increase in Payables	(1,987,950)
(Decrease)/Increase in LT Liabilities	(80,000)
Changes in Withhold / Risk Incentive Pool	-
Change in MCO Tax Liability	-
Changes in Claims and Capitation Payable	(2,616,664)
Changes in IBNR	3,729,387
	(3,937,651)
Net Cash Flow from Operating Activities	**(3,937,651)**

Gold Coast Health Plan
Statement of Cash Flows
Two Months Ended August 31, 2012

Cash Flow From Operating Activities	
Collected Premium	53,212,305
Miscellaneous Income	31,581
Paid Claims	
Medical & Hospital Expenses	(44,372,287)
Pharmacy	(6,961,685)
Capitation	(1,257,764)
Reinsurance of Claims	(266,025)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(3,640,218)
Repay Initial Net Liabilities	-
MCO Taxes Expense	-
Net Cash Provided/(Used) by Operating Activities	**(3,254,092)**
Cash Flow From Investing/Financing Activities	
Proceeds from Paid in Surplus/Issuance of Stock	-
Costs of Capitalization	-
Net Acquisition of Property/Equipment	-
Net Cash Provided/(Used) by Investing/Financing	**-**
Net Cash Flow	**(3,254,092)**
Cash and Cash Equivalents (Beg. of Period)	23,740,502
Cash and Cash Equivalents (End of Period)	20,486,411
	(3,254,092)
Adjustment to Reconcile Net Income to Net Cash Flow	
Net Income/(Loss)	(4,388,834)
Depreciation & Amortization	3,612
Decrease/(Increase) in Receivables	6,899,524
Decrease/(Increase) in Prepaids & Other Current Assets	799,421
(Decrease)/Increase in Payables	680,496
(Decrease)/Increase in LT Liabilities	(160,000)
Changes in Withhold / Risk Incentive Pool	-
Change in MCO Tax Liability	585,700
Changes in Claims and Capitation Payable	(1,020,660)
Changes in IBNR	(6,653,352)
	(3,254,092)
Net Cash Flow from Operating Activities	**(3,254,092)**

FINANCIAL OVERVIEW

FOR THE MONTH ENDED AUGUST 31, 2012

Summary Key Points

- Membership enrollment remains steady.
- Utilization is 23.0% of total enrollment.
- **Cost Per Claim Summary:**
  - Total number of claims paid per member is 0.07 favorable to budget (0.71 Actual vs. 0.78 Budget).
  - The average cost per claim for the month ended July 31, 2012 is $177.44 (Brand) vs. $21.96 (Generic). Generic tends to remain flat but Brand tends to fluctuate in relation to fluctuations in number of claims paid and utilization.
  - Plan combined (Brand and Generic) expense is $20K favorable in comparison to budget ($3.19M Actual vs. $3.21M Budget); cost per pmpm is $.21 favorable to budget ($33.00 Actual vs. $33.21 Budget).
  - The actual cost combined (Brand and Generic) per encounter amount to $46.22 as compared to a budgeted $42.46, resulting in ($3.75) unfavorable variance .
  - Brand accounted for 15.6% and Generic of 84.4% of total Pharmacy orders.

Gold Coast Health Plan

Script Care Plan Utilization and Cost Trend

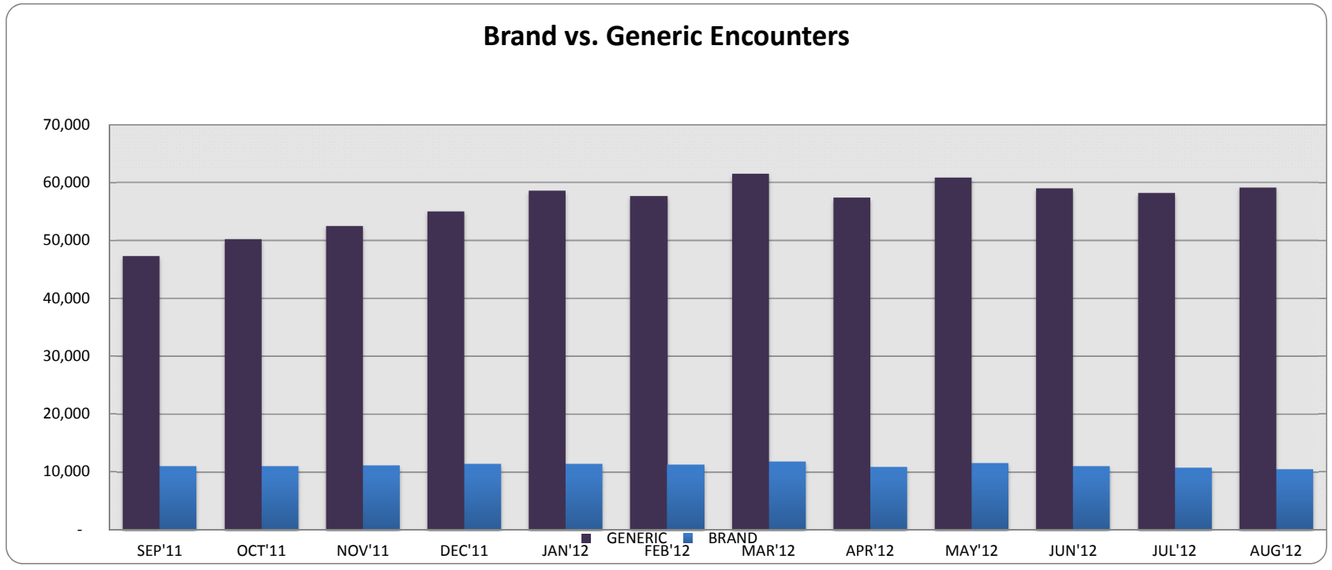
For The Month Ended August 31, 2012

	SEP'11	OCT'11	NOV'11	DEC'11	JAN'12	FEB'12	MAR'12	APR'12	MAY'12	JUN'12	JUL'12	AUG'12	BUDGET	FAV/ (UNFAV)
Enrollment [1]	101,470	101,619	101,174	101,243	100,636	100,768	101,439	101,272	101,041	101,207	96,540	95,797	96,564	(24)
Utilization [2]	20,731	21,710	22,389	23,000	23,775	23,926	24,981	23,349	24,216	23,089	22,167	22,373		
% (enrollment)	***20.4%***	***21.4%***	***22.1%***	***22.7%***	***23.6%***	***23.7%***	***24.6%***	***23.1%***	***24.0%***	***22.8%***	***23.0%***	***23.4%***		
Number Of Claims Paid [2]														
BRAND	11,068	11,060	11,197	11,482	11,421	11,267	11,903	10,888	11,617	11,052	10,757	10,499	18,873	8,116
GENERIC	47,334	50,240	52,560	55,093	58,588	57,714	61,435	57,443	60,861	58,950	58,183	59,204	56,618	(1,565)
Total	58,402	61,300	63,757	66,575	70,009	68,981	73,338	68,331	72,478	70,002	68,940	69,703	74,908	5,968
pmpm	*0.58*	*0.60*	*0.63*	*0.66*	*0.70*	*0.68*	*0.72*	*0.67*	*0.72*	*0.69*	*0.71*	*0.73*	*0.78*	0.06
BRAND %	**19.0%**	**18.0%**	**17.6%**	**17.2%**	**16.3%**	**16.3%**	**16.2%**	**15.9%**	**16.0%**	**15.8%**	**15.6%**	**15.1%**	**25.2%**	**9.6%**
GENERIC %	**81.0%**	**82.0%**	**82.4%**	**82.8%**	**83.7%**	**83.7%**	**83.8%**	**84.1%**	**84.0%**	**84.2%**	**84.4%**	**84.9%**	**75.6%**	**-8.8%**
Plan Cost [2]														
BRAND	1,733,036	1,800,249	1,760,284	1,963,430	1,815,536	1,816,430	1,908,982	1,951,084	1,939,649	2,056,168	1,908,700	2,077,303		
GENERIC	1,014,144	1,100,743	1,153,712	1,254,143	1,304,658	1,259,202	1,348,636	1,293,842	1,370,173	1,273,925	1,277,492	1,380,952		
Total	$ 2,747,179	$ 2,900,992	$ 2,913,996	$ 3,217,573	$ 3,120,194	$ 3,075,632	$ 3,257,618	$ 3,244,925	$ 3,309,822	$ 3,330,093	$ 3,186,191	$ 3,458,255	$ 3,206,472	$ 20,281
pmpm	*$27.07*	*$28.55*	*$28.80*	*$31.78*	*$31.00*	*$30.52*	*$32.11*	*$32.04*	*$32.76*	*$32.90*	*$33.00*	*$36.10*	*$33.21*	*$0.20*
avg. claim cost (Br & Gen)	*$47.04*	*$47.32*	*$45.70*	*$48.33*	*$44.57*	*$44.59*	*$44.42*	*$47.49*	*$45.67*	*$47.57*	*$46.22*	*$49.61*	*$42.81*	*($3.41)*
BRAND %	**63.1%**	**62.1%**	**60.4%**	**61.0%**	**58.2%**	**59.1%**	**58.6%**	**60.1%**	**58.6%**	**61.7%**	**59.9%**	**60.1%**		
GENERIC %	**36.9%**	**37.9%**	**39.6%**	**39.0%**	**41.8%**	**40.9%**	**41.4%**	**39.9%**	**41.4%**	**38.3%**	**40.1%**	**39.9%**		
avg. claim cost (Brand)	*$156.58*	*$162.77*	*$157.21*	*$171.00*	*$158.96*	*$161.22*	*$160.38*	*$179.20*	*$166.97*	*$186.04*	*$177.44*	*$197.86*		
avg. claim cost (Generic)	*$21.43*	*$21.91*	*$21.95*	*$22.76*	*$22.27*	*$21.82*	*$21.95*	*$22.52*	*$22.51*	*$21.61*	*$21.96*	*$23.33*		

Note:

1) The actual stats obtained from California Department of Health Care Services.

2) The actual stats obtained from Script Care, Ltd.



MEDICAL SERVICES AGREEMENT

Between VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

and

_____

This Medical Services Agreement (this "Agreement") is made entered into as of the ____ day of _____, 20__, by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as "GCHP" and _____, hereinafter referred to as "Plan"

This agreement is subject to 1) The State of California and the United States providing funds for the term of this agreement and for the purposes with respect to which it is entered into; 2) The approval of this agreement by the State of California.

IN WITNESS WHEREOF, the following Agreement between GCHP and Plan is entered into by and between the undersigned parties.

Plan:

_____
Name of Entity

Executed by:

_____
Signature

_____
Printed Name

_____
Title

_____
Date

Address for Notices:

GCHP:

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan)

Executed by:

_____
Signature

Cassie Undlin

Interim Chief Operating Officer

_____
Date

Address for Notices:

2220 East Gonzales Road
Suite 200
Oxnard, CA 93035

TABLE OF CONTENTS

RECITALS

A. WHEREAS, GCHP is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.

B. Whereas, GCHP has entered into and will maintain contracts (the "Medi-Cal Agreements") with the State of California, Department of Health Care Services in accordance with the requirements of W&I Code, Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations, under which Ventura County Medi-Cal Beneficiaries assigned to Plan as Members, will receive all medical services hereinafter defined as "Covered Services", through GCHP and Plan.

C. Whereas, GCHP will arrange for Covered Services for its Medi-Cal Members under the Case Management of designated Primary Care Physicians chosen by such Medi-Cal Members or to whom such Medi-Cal Members are assigned, and all Specialist Physician Services will be delivered only with authorization from GCHP or its delegated entity if services being provided require prior authorization.

D. Whereas, Plan desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. Whereas, Plan is a California corporation which employs or otherwise contracts with physicians licensed to practice medicine in the State of California either directly or through medical corporations or partnerships, Federally Qualified Health Centers, or other authorized providers of Covered Services.

F. Whereas, Plan will contract with Providers to provide or arrange for Covered Services to Medi-Cal Members and will receive payment from GCHP for the rendering of those Covered Services.

G. Whereas, GCHP and Plan desire to enter into this Agreement on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

Section 1 - Definitions

1.1 Administrative Member. Eligible Medi-Cal Beneficiary enrolled with GCHP who are not required to select a Primary Care Physician; these include: members with Share of Cost; those in Foster Care; those living outside of Ventura County; those with other health insurance; and those receiving hospice care.

1.2 Administrative Services. Those non-clinical functions that are the responsibility of the Plan and are required to discharge the obligations and meet the requirements set

forth in this Agreement, in GCHP Policies, in Memoranda of Understanding, and in Contract Interpretation and Financial Bulletins.

1.3 Advance Directive. A written instruction such as, a California Natural Death Act Declaration, a living will or durable power of attorney for health care, recognized under State law.

1.4 Agreement. This written instrument and all Addendums, Attachments and Exhibits attached hereto and incorporated herein by reference. This shall include any Memoranda of Understanding entered into by GCHP which are binding on Plan, DHCS Medi-Cal Managed Care Policy Division Policy Letters, and Contract Interpretation and Financial Bulletins issued pursuant to this Contract.

1.5 Aid Code. The two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.6 Approved Drug List. GCHP's list of medications and supplies that may be obtained without prior authorization.

1.7 Attending Physician. (a) any physician who is acting in the provision of Emergency Services to meet the medical needs of the Member; (b) any physician who is, through referral from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition; or (c) any physician designated by the Medical Director to provide services for Administrative Members.

1.8 California Children's Services (CCS). A public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800.

1.9 Capitation Payment. The prepaid monthly amount that GCHP pays to Plan as compensation for those Covered Medical Services which are set forth in Attachment F, attached to and incorporated herein.

1.10 Capitation Rate. The rate set by GCHP for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.11 Case Management. The responsibility for primary and preventive care, and for the referral, consultation, ordering of therapy, admission to Hospitals, provision of Medi-Cal covered Health Education and preventive services, follow-up care, coordinated Hospital discharge planning that includes necessary post-discharge care, and maintenance of a Medical Record with documentation of referred and follow-up services.

1.12 Child Health and Disability Prevention Services (CHDP). Those health care preventive services for beneficiaries under 21 years of age provided in accordance

with the provisions of Health and Safety Code Section 124025, et. seq., and Title 17, CCR, Sections 6842 through 6852.

1.13 Complete Claim. This term, commonly referred to as "Clean Claim," is defined in Title 28, CCR Section 1300.71(a)(2).

1.14 Complex Case. Members requiring comprehensive care management and coordination of services including health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex care needs, and those with high acute impact scores or high forecasted costs. Criteria include: complex health conditions, barriers, and/or risks needing ongoing intervention. Frequently managed conditions, diseases or high-risk groups include, but are not limited to: AIDS, cancer, chronic illnesses that result in high utilization or under-utilization of health care resources, congenital anomalies, multiple chronic illnesses, serious trauma, spinal injuries, and transplants.

1.15 Compliance Program. Policies that promote, monitor and ensure that GCHP's operations and practices and the practices of its board members, employees, contractors and providers comply with applicable law and ethical standards.

1.16 Comprehensive Perinatal Services Program (CPSP). Those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR).

1.17 Concentration Languages. Those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.18 Contract Year. The 12-month period following the effective date of this Agreement between Plan and GCHP and each subsequent 12-month period following the anniversary of the Agreement. If the date of commencement of operations is later than the effective date, the GCHP operational date will apply.

1.19 Covered Medical Services. Those services that are set forth in Attachment A as the financial responsibility of the Plan and are to be provided to, or arranged for, Members by the Plan, within the scope of its licensure, pursuant to this Agreement.

1.20 Covered Services. Those services provided under the Fee-for-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which (i) are included as Covered Services under the State Contract; (ii) are Medically Necessary; and are set forth in Attachment A (which may be revised from time to time at the discretion of GCHP), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR),

which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.21 DHCS. The State of California Department of Health Care Services.

1.22 Disease Management. A multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions that: supports the physician/patient relationship, emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management, and continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.23 Early and Periodic Screening, Diagnostic and Treatment (EPSDT). A comprehensive preventive child health program for individuals under the age of twenty-one (21) defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid GCHP to the rest of the Medicaid population.

1.24 Eligible Medi-Cal Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific Aid Codes set forth in the State Contract, who resides in the GCHP Service Area and who is certified as eligible for Medi-Cal by the county agency responsible for determining the initial and continuing eligibility of persons for the Medi-Cal program's Service Area.

1.25 Emergency Medical Condition. A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

1.26 Emergency Services. Inpatient and Outpatient Covered Services furnished by a qualified Provider that is qualified to furnish those health services which are needed to evaluate or Stabilize an Emergency Medical Condition.

1.27 Encounter. Any single medically related service provided to a Member enrolled with GCHP during the date of service regardless of Health Network or Physician Group reimbursement methodology. It includes any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services. It includes, but is not limited to, all services for which GCHP or Plan incurred any financial liability.

1.28 Enrollment. The process by which an Eligible Medi-Cal Beneficiary selects or is assigned to the GCHP.

1.29 Facility. Premises owned, leased, used or operated directly or indirectly by or for the Plan for purposes related to this Agreement; or maintained by a Provider or Subcontractor to provide Covered Services pursuant to this Agreement.

1.30 Family Planning. Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

a) Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

b) Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

c) Patient visits for the purpose of Family Planning;

d) Family Planning counseling services provided during a regular patient visit;

e) IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

f) Tubal ligations;

g) Vasectomies;

h) Contraceptive drugs or devices;

i) Treatment for complications resulting from previous Family Planning procedures; and

j) Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.31 Federally Qualified Health Center (FQHC). An entity as defined in 42 USC Section 1396d(l)(2)(B).

1.32 Fee-For-Service Payment (FFS). The maximum allowable fee-for-service rate determined by DHCS for services provided under the Medi-Cal Program.

1.33 Fiscal Year. The twelve month period starting July 1.

1.34 Foster Care. An out-of-home placement for a child either on a temporary or permanent basis.

1.35 FTP Site. File Transfer Protocol site used to transfer files between computers on a network.

1.36 GCHP Policy or Policies. GCHP Policies and procedures relevant to this Agreement, as amended from time to time, at the sole discretion of GCHP. The Operations Manual, the Provider Manual, the MOUs, and Contract Interpretation and Financial Bulletins comprise the GCHP Policies.

1.37 Government Agency(ies). Any agency that has legal jurisdiction over GCHP, Medi-Cal or Medicaid, such as: the DHCS, United States Department of Health and Human Services (HHS), United States Department of Justice (DOJ), and California Attorney General.

1.38 Health Education. Any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.39 Health Maintenance Organization (HMO). An organization that is not a federally qualified health maintenance organization, but meets the DHCS definition of health maintenance organization under the DHCS Medicaid State Plan filed pursuant to Title XIX of the Social Security Act, including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined fixed prepayment. An HMO includes, but is not limited to, a health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) (Knox-Keene Act).

1.40 Health Network. The Primary Care Physicians, Referral Physicians, and other providers of professional services, and the Hospitals and other providers of Facility or ancillary services which are, either directly or through a physician hospital consortium, Physician Group, FQHC, community or other non-profit or governmental clinic, or other duly authorized provider under a shared risk contract or other subcontract, or a full service or specialty health care service plan, as defined in the Knox-Keene Act, contracted by Plan to provide Covered Services to Members.

1.41 Healthcare Effectiveness Data and Information Set (HEDIS). The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.42 HHS. The United States Department of Health and Human Services.

1.43 Hospital. A general acute care or psychiatric hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act).

1.44 Indian Health Services (IHS) Facilities. Facilities operated with funds from the HIS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract to the eligible Indian population within a defined geographic area. (See Title 22, Section 55000).

1.45 Joint Commission (JCAHO). The Joint Commission on the Accreditation of Health Care Organizations.

1.46 Long Term Care Facility. A Facility that is licensed to provide skilled nursing Facility services, intermediate care Facility services, or sub-acute care services.

1.47 Management Services Organization (MSO). Any organization, firm, company or entity providing Administrative Services on behalf of Plan.

1.48 Medical Director. The Medical Director of GCHP or his/her designee, a physician licensed to practice medicine in the State of California, employed by GCHP to monitor the quality assurance and implement Quality Improvement Program of GCHP.

1.49 Medical Necessity or Medically Necessary. Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

1.50 Medi-Cal. The Medicaid program in the State of California. Medicaid is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.51 Medi-Cal Fee Schedule. The Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.52 Medi-Cal Managed Care Program. The program that GCHP operates under its Medi-Cal Agreement with the DHCS for the Service Area.

1.53 Medical Record. Any record kept or required to be kept by any Provider that documents all the medical services and evidences treatment received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.54 Medical Screening Examination (MSE). An examination within Physician's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.55 Medical Supplies. Items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.56 Medical Transportation. The transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, litter vans or wheelchair

vans licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances or regulations. Medical Transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.

1.57 Medicare. The federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.58 Member. An Eligible Medi-Cal Beneficiary who is enrolled in GCHP who has been assigned or who chose a Primary Care Physician for their medical care; i.e., all GCHP beneficiaries excluding Administrative Members as defined above.

1.59 Member Handbook. The GCHP Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Medi-Cal Member is entitled under the Medi-Cal Managed Care Program, the limitations and exclusions to which the Medi-Cal Member is subject and terms of the relationship and agreement between GCHP and the Medi-Cal Member.

1.60 Member with Special Health Care Needs. A Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the Foster Care system; (iv) CCS program eligible.

1.61 Memorandum of Understanding (MOU). Agreements between GCHP and external agencies, which delineate responsibilities for coordinating care to Members.

1.62 Minimum Standards. The minimum participation criteria established by GCHP that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from GCHP or Plan for items and/or services furnished to Members as described in GCHP Policies.

1.63 National Committee on Quality Assurance (NCQA). The non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.64 Non-Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide Primary Care Services under Physician supervision.

1.65 Non-Medical Transportation. Transportation by passenger car, taxicabs, or other forms of public or private conveyances required for access to medical appointments and other Medically Necessary Covered Services by Members who do not have a medical condition necessitating the use of Medical Transportation.

1.66 Other Health Coverage (OHC). Health related services or entitlements for which a Member is eligible under private health plan, any indemnification insurance program, any other State or Federal medical care program, or other contractual or legal entitlement. The responsibility of an individual or entity, other than GCHP, Plan or

Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

1.67 Operations Manual. The Manual of Operational Policies and Procedures for the GCHP Medi-Cal Managed Care Program.

1.68 Out-of-Network Provider. A Provider who is not obligated by a written contract with Plan to provide Covered Services to Members.

1.69 Participating Provider. A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Plan. All Participating Providers shall be considered Subcontractors.

1.70 Pediatric Preventive Services (PPS). Well child services which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.71 Perinatal Support Services (PSS). Obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.72 Physician. An individual licensed as a Physician by the Medical Board of California, is enrolled in the Medi-Cal program, and who has contracted with GCHP or Plan to provide medical services to Medi-Cal members.

1.73 Physician Group. A group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom holds an unrestricted license to practice medicine or osteopathy in the state of California and has contracted with GCHP or Plan to provide medical services to Medi-Cal members. Physician Group also includes, when appropriate in the context, a governmental or non-profit entity, such as a community clinic or FQHC, which is authorized to provide physician services.

1.74 Physician Incentive Plan. Any compensation arrangement between Plan and a Physician or Physician Group designed to motivate Physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.75 Plan Physician: a PCP or Referral Physician who participates in the Plan's Health Network.

1.76 Plan's Provider: a Physician, hospital, or other provider of health professional, Facility, or ancillary services who or which is in Plan's Health Network.

1.77 Practitioner. A licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine

(DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in GCHP Policies.

1.78 Primary Care Physician (PCP). A physician duly licensed by the Medical Board of California or Osteopathic Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing initial and Primary Care Services to Members; serving as the medical home for Members; initiating Referral Services; and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Physician. Primary Care Physicians include general and family Practitioners, internists, obstetrician-gynecologists and pediatricians.

1.79 Primary Care Services. Those services provided to Members by a Primary Care Physician. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs.

1.80 Provider. A Physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, Hospital, laboratory, FQHC, Physician Group, hospital, Health Maintenance Organization or other person or institution who furnishes health care items or services.

1.81 Provider Manual. GCHP's Manual describing operational policies and procedures relevant to Providers.

1.82 Quality Improvement Program (QIP). Systematic activities and studies to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and the State Contract. The QIP consists of processes, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis towards an identified, target outcome measurement. QIPs may be in collaboration with DHCS and other participating health plans.

1.83 Quality Indicators. Measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.84 Referral Physician. Any qualified Physician who meets the Medi-Cal standards of participation, has been enrolled in the state Medi-Cal program in accordance with Article 3, Title 22, CCR, and who performs Referral Services. Exception to this requirement must be authorized by GCHP CEO and/or Medical Director. A Referral Physician must have an Agreement with GCHP or Plan. The Referral Physician must have a referral from the Primary Care Physician for consultation or treatment of a Member for Referral Services.

1.85 Referral Services. Covered services, which are not Primary Care Services, provided by Referral Physicians upon referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.

1.86 Reinsurance. Coverage secured by Plan which limits the amount of risk or liability for the cost of providing Covered Services.

1.87 Seniors and Persons with Disabilities. Medi-Cal beneficiaries eligible for benefits through blindness, age or disability, in accordance with 42 C.FR. Section 1381 et. seq.

1.88 Service Area. The County of Ventura.

1.89 Specialty Mental Health Provider. A person or entity who is licensed, certified or otherwise recognized or authorized under the California law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.90 Specialty Mental Health Services means:

1.90.1 Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health Facility services.

1.90.2 Psychiatric inpatient hospital services.

1.90.3 Targeted Case Management services to assist members within specified target groups to gain access to needed medical, social, educational and other services.

1.90.4 Psychiatrist services.

1.90.5 Psychologist services.

1.90.6 Early Periodic Screening Diagnosis and Treatment (EPSDT) supplemental Specialty Mental Health Services.

1.91 Stabilize or Stabilized. With respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a Facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.92 State Contract. The written agreement between GCHP and the State pursuant to which GCHP is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Ventura County, California.

1.93 State. The State of California.

1.94 Subcontract. An agreement entered into by the Plan with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Plan specifically related to fulfilling Plan's obligations to GCHP under the terms of this Agreement.

1.95 Subcontractor. A Provider or any organization or person who has entered into a Subcontract with Plan.

1.96 Sub-delegation. The process by which Plan expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Plan in order to meet its obligations under, and the intent of this Agreement.

1.97 Threshold Languages. Those languages as determined by GCHP from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof. As of the effective date of this Agreement, the Threshold Languages are English and Spanish.

1.98 Urgent Care Services. Covered Services required to prevent serious deterioration of a Member's physical or mental health following the onset of an unforeseen condition or injury, perceived by the Member as serious but not life threatening, that disrupts normal activities of daily living and which requires assessment by a Provider and if necessary, treatment within 24-72 hours.

1.99 Utilization Management Program / UM Program. The program(s) approved by GCHP, which are designed to review and monitor the utilization of Covered Services to evaluate the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities. Such program(s) are set forth in the GCHP's Provider Manual.

1.100 Vaccines for Children (VFC). The federally funded program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.101 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

Section 2 – Financial Obligations of Plan

2.1 FINANCIAL VIABILITY REQUIREMENTS --- Plan must meet and maintain financial viability/standards compliance to DHCS' satisfaction for each of the following elements:

a) Plan, at all times, shall be in compliance with the tangible net equity requirements in accordance with Title 28 CCR Section 1300.76.

b) Plan's administrative costs shall not exceed the guidelines as established under Title 28 CCR Section 1300.78.

c) Plan shall maintain a working capital ratio of at least 1:1 or provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

d) Plan shall maintain a system to evaluate and monitor the financial viability of all subcontracting risk-bearing organizations; as such organizations are defined in Health and Safety Code Section 1375.4(g).

2.2 PROFESSIONAL AND GENERAL LIABILITY INSURANCE --- Plan shall ensure that insurance is maintained as follows:

2.2.1 Each Participating Provider providing Covered Services to Members shall maintain a professional liability insurance policy with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Ventura County, California, for the specialty or type of service which the Participating Provider provides, except that each PCP or Specialist providing Covered Services for Members shall maintain a professional liability insurance policy with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year; and

2.2.2 Plan, at their sole cost and expense, shall maintain such policies of general liability insurance and other insurance as shall be necessary to insure themselves and their employees, agents, and representatives against any claim or claims for damages arising by reason of: (a) personal injuries or death occasioned in connection with the performance of any Covered Services provided hereunder; (b) the use of any property and Facilities of the Plan; and (c) activities performed in connection with this Agreement.

2.2.3 Such insurance shall be provided by an insurer:

a) Rated by A. M. Best with a rating of A VI or better; and

b) Admitted to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

2.2.4 Where any of the insurance(s) mentioned in Sections 2.2.1 and 2.2.2 above are provided by a captive risk retention group or self-insured, Section 2.2.3 above may be waived at the sole discretion of GCHP, but only after review

of the captive risk retention group's or self-insured's audited financial statements.

2.2.5 Memorandum copies of the above insurance policies and/or evidence of self-insurance shall be provided to GCHP upon request.

2.3 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- Plan shall reimburse the Local Health Department (LHD) on a FFS basis according to the current Medi-Cal Fee Schedule for certain Covered Services provided to Members, in accordance with GCHP Policy. This Section 2.3 shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

2.4 PLAN FINANCIAL RESPONSIBILITY FOR PHARMACEUTICAL AND MEDICAL SUPPLY ITEMS --- Plan shall be responsible for authorizing and paying for all injectable medications, or medications in an implantable dosage form, costing less than two hundred fifty dollars ($250) per dose, when administered in a clinic or practitioner's office.

2.4.1 As set forth in Attachment A, the Division of Financial Responsibilities, Plan shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.4.2 This Section 2.4 shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

2.5 PLAN PAYMENTS TO PROVIDERS ---

2.5.1 Capitation Payments. Plan and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Plan receives payment from GCHP, but in no event later than the 15th day of the calendar month following the calendar month of service.

2.5.2 Claims Turnaround Time. Plan shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Plan, unless the claim or portion thereof is reasonably contested by Plan, in which case the claimant shall be notified in writing that the claim is contested or denied within thirty (30) calendar days after receipt of the claim by Plan.

2.5.3 Claims Adjudication. Plan shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71,

1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations, and GCHP Policies..

2.5.4 Dispute Resolution. Plan shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and GCHP Policies.

2.5.5 Right of Appeal. Plan shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Plan's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have right of appeal for that claim dispute to GCHP's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Plan's date of determination.

2.5.6 GCHP Payment on Behalf of Plan

a) If GCHP receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, GCHP will follow all notification and acknowledgement procedures pursuant to GCHP Policies which, at a minimum shall require at least ten (10) business days prior written notice to Plan that GCHP intends to pay the claim unless it is paid or reasonably contested by Plan, before GCHP shall pay the claim, in order to allow Plan to show that the claim is paid or is for services included in a capitation or other rate, is not payable, is payable at a specified rate, or to allow Plan to pay said claim.

b) If Plan does not either notify GCHP that the claim is reasonably contested, as set forth in GCHP Policies, or pay the Complete Claim within the thirty (30) working day period, GCHP shall pay the Claim on behalf of Plan, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with GCHP Policies.

2.5.7 Assumption of Delegated Functions.

- Assumption of Claims Processing. In the event that Plan fails to timely and accurately reimburse its claims (including the payment of interest and penalties), GCHP may, at its sole discretion, either assume responsibility from Plan for claims payment, as provided for in the de-delegation procedures set forth in Attachment L, below, or terminate this Agreement as provided for in Section 12.1 of this

Agreement. GCHP's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Plan has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

- Assumption of Dispute Resolution. In the event that Plan fails to resolve its Provider disputes in a timely manner, GCHP may, at its sole discretion, assume responsibility from Plan for dispute resolution, as provided for in the de-delegation procedures set forth in Attachment L, below or terminate this Agreement as provided for in Section 13.1 of this Agreement.

- Recoupment of Costs For Assumption of Claims Processing and/or Dispute Resolution. GCHP, at its sole and absolute discretion, may reduce Plan Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Plan, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by GCHP. Such reduction to recoup administrative costs shall be in a reasonable amount, such as GCHP's per claim cost or the charges to it by GCHP's subcontractor which processes the claim, shall be itemized in monthly statements to Plan, and shall be subject to dispute by the Plan.

2.5.8 Quarterly Claims Payment Performance Report.

a) Plan shall submit, in a format specified by GCHP Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to GCHP within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Plan's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations. The format of the Quarterly Claims Report shall be a DMHC or ICE document currently in use by HMOs in California.

b) Plan shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Plan, stating that the report is true and correct to the best knowledge and belief of the principal officer.

c) Plan's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type

of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to GCHP.

2.5.9 Forwarding of Misdirected Claims

a) Plan shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Physician Group. Plan shall retrieve these files daily from the GCHP FTP Site and load into their system to ensure timely claims processing as provided in section 2.5.2 of this Agreement.

Plan shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that involve Emergency Services that are the financial responsibility of GCHP within 10 working days of receipt of the claim. GCHP shall retrieve these files daily from the GCHP FTP Site and load into their system to ensure timely claims processing.

2.5.10 FQHC Payments. Plan shall reimburse FQHCs at a rate comparable to any other Subcontract arrangement for similar services.

2.5.11 Indian Health Service Payments. Plan shall reimburse Indian Health Service Facilities for Covered Services provided to Members who are qualified to receive services from an Indian Health Service Facilities. Plan shall reimburse Indian Health Service Facilities at the approved Medi-Cal rate.

2.5.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments. If there are no CNMs or CNPs in Plan's provider network (its Health Network), Plan shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in GCHP Policy.

2.5.13 Family Planning Provider Payments. Plan shall reimburse non-contracting Family Planning providers at no less than one hundred percent (100%) of the Medi-Cal Fee Schedule as identified in GCHP Policy. Plan shall reimburse non-contracting Family Planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

2.5.14 Sexually Transmitted Disease (STD) Treatment Payments. Plan shall reimburse local health departments and non-contracting Family Planning providers at no less than one hundred percent (100%) of the Medi-Cal Fee Schedule as identified in GCHP Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Plan may elect to provide reimbursement only if STD treatment providers provide treatment

records or documentation of the Member's refusal to release Medical Records to Plan along with billing information.

2.5.15 HIV Testing and Counseling Payments. Plan shall reimburse local health departments and non-contracting Family Planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as identified in GCHP Policy. Plan shall provide reimbursement only if local health departments and non-contracting Family Planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Plan.

2.5.16 Information Disclosures to Participating Providers. Plan shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in GCHP Policies, the following:

a) A complete fee schedule.

b) Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.5.17 Section 2.5 shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

2.6 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Plan shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Plan shall inform GCHP of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with GCHP Policy.

2.7 OTHER HEALTH COVERAGE (OHC) --- Plan shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Plan and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Plan cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a third party tort liability action or make a claim against the estates of deceased Members. Plan shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. Plan shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.7.1 Cost Avoidance - If Plan reimburses a Provider on a Fee-for-Service Payment basis, Plan shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an

OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A, M, Y or Z.

2.7.2 Post-Payment Recovery - If Plan reimburses a Provider on a Fee-for-Service Payment basis, Plan shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A, M, Y or Z; for services defined by DHCS as prenatal or PPS; or in child support enforcement cases. If Plan does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Plan shall follow the procedure above for cost avoidance. If Plan does not reimburse a Provider on a Fee-for-Service Payment basis, then Plan shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.7.3 Plan shall have written policies implementing these requirements.

2.7.4 Plan shall submit monthly reports to GCHP identifying OHC in accordance with GCHP Policies.

2.7.5 Plan shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon GCHP request.

2.7.6 Plan shall identify OHC unknown to DHCS within ten (10) days of discovery to GCHP in accordance with GCHP Policies.

2.7.7 Plan shall demonstrate to GCHP where Plan does not cost avoid or perform post payment recovery that the aggregate cost of this activity exceeds the total revenues Plan projects it would receive from such activity.

2.7.8 This Section 2.7 shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

2.8 RISK POOLS --- Risk pool arrangements, if any, shall be pre-approved by GCHP.

2.9 MEDICAL LOSS RATIO --- Plan shall maintain a minimum medical loss ratio of eighty-five percent (85%).

2.10 FINANCIAL VIABILITY STANDARDS AND REPORTING--- Plan shall maintain a cash-to-claims ratio of no less than .75 at all times during this Agreement. Plan shall substantiate compliance with this requirement by submitting all applicable reports to GCHP and the Department of Managed Health Care that are required under Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

2.11 COOPERATION WITH DHCS --- Plan shall fully cooperate and comply with the Department of Health Care Service's review and audit process, and permit DHCS to obtain and evaluate supplemental financial information related to Plan, in accordance with Section 1300.75.4.7 of Title 28 of the California Code of Regulations. Plan shall also fully cooperate and participate in DHCS's Corrective Action Plan (CAP) process, in accordance with Section 1300.75.4.8 of Title 28 of the California Code of Regulations.

Section 3- Obligations of Plan: Legal and Administrative

3.1 EQUAL OPPORTUNITY

3.1.1 Plan and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Plan will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Plan shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212). Such notices shall state Plan's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

3.1.2 Plan and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Plan and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.1.3 Plan and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative

of Plan and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.1.4 Plan and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.1.5 Plan and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.1.6 In the event of Plan and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part, and Plan and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.1.7 Plan and its Subcontractors will include the provisions of Paragraphs 3.1.1 through 3.1.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR

part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Plan and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Plan and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Plan and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.2 NON-DISCRIMINATION

3.2.1 During the performance of this Agreement, neither Plan nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Plan and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Plan and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Plan and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Plan shall include the non-discrimination and compliance provisions of this Section 3.2.1 in all Subcontracts to perform work under this Agreement.

3.2.2 Plan and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45

CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Plan nor Subcontractors shall discriminate against Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.2.3 For the purpose of this Agreement, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Agreement, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.2.4 Plan shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.2.5 Plan shall act upon all complaints alleging discrimination against Members in accordance with GCHP Policies and shall forward copies of all such grievances to GCHP within five (5) days of receipt of same.

3.3 PARTICIPATION STATUS --- Plan shall not employ, maintain a contract with or contract with directly or indirectly, entities or individuals excluded, suspended or terminated from participation in the Medicare or Medi-Cal programs, for the provision of any Covered Services to Members, including but not limited to, health care services, utilization review, medical social work, or Administrative Services with respect to Members.

3.4 PLAN ORGANIZATION AND OPERATIONS STRUCTURE --- Plan shall maintain the organization and staffing for implementing and operating the Contract in accordance with 28 CCR Section 1300.67.3 and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28 CCR Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code, Section 1375.1. Plan shall comply with the following organization and operations structure requirements:

3.4.1 Single Board of Directors and management team.

3.4.2 Plan shall employ a Physician(s) to serve as Chief Medical Officer (CMO)/medical director(s) on a full-time or part-time basis, but no less than twenty percent full-time equivalent (20% FTE) or the percentage necessary to comply with requirements set forth in this Agreement, whichever is greater, and whose responsibilities shall include, but not be limited to, the following:

a) Ensuring that medical decisions are rendered by qualified medical personnel and are not unduly influenced by fiscal or administrative management considerations.

b) Ensuring that the medical care provided meets the standards for acceptable medical care.

c) Ensuring that medical protocols and Standards of Conduct for plan medical personnel are followed.

d) Developing and implementing medical policy.

e) Resolving grievances related to medical quality of care. For purposes of this provision, the resolution of grievances related to medical quality of care may be by the CMO's Physician designee.

f) Having a role in the implementation of Quality Improvement activities.

g) Actively participating in the functioning of the Plan's grievance procedures.

h) Ensuring that the Plan complies with the access standards set forth in Section 5 of this Agreement.

3.4.3 Plan shall employ a full time or part-time (but no less than ten percent full time equivalent (10% FTE) or the percentage necessary to comply with the requirements set forth in this Agreement, whichever is greater) financial officer to maintain financial records and books of account maintained on the accrual basis, in accordance with Generally Accepted Accounting Principles, which fully disclose the disposition of all Medi-Cal program funds received.

3.4.4 No employee of Plan, including but not limited to CMO, that make decisions regarding the authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding authorization and/or provision of Covered Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments.

3.4.5 Single (meaning for Plan's entire Health Network) credentialing committee and credentialing policies, procedures and standards.

3.4.6 Single and unified health care delivery system including but not limited to:

a) Participating Providers must be accessible to all members enrolled with Plan.

b) Members can select any contracted PCP with an open panel.

c) A PCP can refer members to any contracted specialist.

d) Plan must report to GCHP all required data for the total enrollment of the Plan and its entire Health Network regardless of Sub-delegation or other contractual relationships including but not limited to; complaints, Encounter data, utilization management data, financial reports, PCP changes and PCP assignments.

e) Centralized call center receiving all member and provider calls.

f) Single access number to call center.

g) Standard member communication for all members.

3.4.7 Plan shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under the Agreement. This will include, at a minimum, systems or programs to address the following functions:

a) Management information systems,

b) Quality improvement system,

c) Utilization Management Program,

d) Case Management and coordination of care,

e) Local health department coordination,

f) Provider network,

g) Provider compensation,

h) Provider relations and grievances,

i) Care access and availability,

j) Member Services,

k) Comply and/or coordinate with GCHP Polices and procedures for Member Enrollment and disenrollment,

l) Member grievance system,

m) Members Health Education services, clinical preventive services and patient education,

n) Comply and/or coordinate with GCHP Policies and procedures for marketing,

o) Claims processing, and

p) Other organization and operations structure requirements as may be established and modified from time to time by GCHP and/or DHCS, consistent with the other terms of this Agreement and applicable law.

3.4.8 The Plan's ability to maintain administrative capacity as set forth in this Section 3.4 shall be subject to delegation oversight by GCHP to assess the Plan's ability to comply with timely authorization, claims administration, and other standards.

3.5 MANAGEMENT INFORMATION SYSTEM (MIS) CAPABILITY. Plan shall implement and maintain an MIS system that can process and provide data on all Medi-Cal eligibility, Members enrolled with Plan, Provider claims payment and status, Encounter-level health care services delivery, Provider network, financial, and any other data necessary to carry out all processes and procedures needed by Plan to perform and administer all of the functions required under this Agreement.

3.5.1 Plan shall implement policies and procedures for ensuring the complete, accurate, and timely submission of data for all services for which Plan incurred any financial liability whether directly or through Subcontracts or other arrangements. All data shall be available to GCHP, DHCS, the Centers for Medicare and Medicaid Services and other Government Agencies upon request. The MIS shall be able to collect, process, edit, and submit: utilization and statistical data, cost and administrative expense data, quality of care data, and financial information required for auditing purposes or calculations of capitation rates.

3.5.2 Data shall be submitted by the Plan in a format and time frame acceptable to the GCHP and Government Agency.

3.5.3 The Plan shall provide GCHP, on a monthly basis, Encounter and paid claims information, having the data elements as defined in the Medi-Cal 35-file Paid Claims Data Dictionary, in the format approved by GCHP and DHCS. Plan shall deliver all of the required data outlined above in the form of computer generated file which shall be submitted within six (6) business days of the end of each month following the month of payment. These files shall contain Encounter and claims payment information on Members for which there was a Member Encounter or claim, which was paid the previous month. Such files shall be IBM mainframe compatible with DHCS Data Processing Potential Case Master file system.

3.5.4 Upon written notice by GCHP and/or DHCS of any problems related to the submittal of data as required under this Agreement, or upon written notice of concerns regarding any other changes or clarifications made by Plan to its MIS system, Plan shall submit corrective actions with measurable benchmarks within five (5) working days from the date of the postmark of GCHP and/or DHCS' written notice to Plan. Within 30 days of GCHP and/or DHCS' receipt of Plan's corrective action plan, GCHP and/or DHCS shall approve the corrective action plan or request revisions. Within 15 days after receipt of a request for revisions to the corrective action plan, Plan shall submit a revised corrective action plan to GCHP for DHCS approval.

3.5.5 Plan shall submit to GCHP any proposed material changes or modifications to the MIS system for approval 60 working days prior to changes/modifications being implemented. Within 30 days of receipt of Plan's modifications or proposed changes, GCHP shall acknowledge the modifications or change requests.

3.5.6 Plan shall ensure that the Paid Claims and Encounter data submitted to GCHP are timely, complete and accurate and in compliance with the requirements of DHCS' most recent Medi-Cal 35-file Paid Claims Data Dictionary and if applicable the Encounter Data Element Dictionary formanaged care plans. Upon written notice by GCHP and/or DHCS that paid claims and Encounter data is insufficient or inaccurate, Plan shall ensure that corrected data is submitted within 15 calendar days. If Plan fails to do so, GCHP may impose a capitation withhold of up to two percent (2%) on subsequent monthly Capitation Payments until the Plan submits the necessary corrections. All amounts so withheld shall be disbursed to Plan in accordance with Section 11.3, below, after Plan has submitted the necessary corrections, provided that it is not then in default with respect to its subsequent paid claims and Encounter data submissions.

3.5.7 Plan shall comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements and all federal and State regulations promulgated from HIPAA, as they become effective.

3.5.8 Participation in the State pharmacy rebate program. Plan shall submit all pharmacy claims to GCHP on a monthly basis, within ten (10) business days of the end of each month following the month of payment, in the form and manner agreed upon and confirmed in writing by GCHP and Plan.

a) Plan shall implement policies and procedures to ensure that data submitted for data elements identified by GCHP and/or DHCS as "critical" meet or exceed a 99 percent reliability standard (i.e. 99 percent must pass edits).

b) Plan shall submit a test file to GCHP, 60 calendar days prior to submission of the pharmacy claims file, in the event of programming changes and/or a change in pharmacy benefit management services that impact pharmacy claims data submission. GCHP and DHCS must approve test files prior to submission of the live file.

3.6 QUALITY IMPROVEMENT SYSTEM. Plan shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28 CCR Section 1300.70. Plan shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Plan shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Plan and the provider. This provision does not create a cause of action against the Plan on behalf of a Medi-Cal beneficiary for malpractice committed by a Subcontractor.

3.6.1 Plan shall maintain a system of accountability which includes the participation of the governing body of the Plan's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracting Physicians and Participating Providers in the process of QIS development and performance review. Participation of non-contracting providers is at the Plan's discretion.

3.6.2 Plan shall implement and maintain policies that specify the responsibilities of the Plan's governing body, including at a minimum the following:

a) Approves the overall QIS and the annual report of the QIS.

b) Appoints an accountable entity or entities within Plan's organization to provide oversight of the QIS.

c) Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.

d) Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

3.6.3 Plan shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the Plan's medical director or a Physician designee shall actively participate on the committee. Plan must ensure that Subcontractors, who are representative of the composition of the contracted provider network including but not limited to Subcontractors who provide health care services to Seniors and Persons with Disabilities or chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to QIC.

a) The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

b) Plan shall maintain minutes of committee meetings and minutes shall be submitted to GCHP quarterly. Plan shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

3.6.4 Plan shall ensure that Participating Providers and other providers from the community shall be involved as an integral part of the QIS. Plan shall maintain and implement appropriate procedures to keep Participating Providers informed of the written QIS, its activities, and outcomes.

3.6.5 Plan is accountable for any and all quality improvement functions and responsibilities (e.g. utilization management, credentialing and site review) delegated to Subcontractors. If Plan delegates quality improvement functions, Plan and delegated entity (Subcontractor) shall include in their Subcontract, at minimum:

a) Quality improvement responsibilities, and specific delegated functions and activities of the Plan and Subcontractor.

b) Plan's oversight, monitoring, and evaluation processes and Subcontractor's agreement to such processes.

c) Subcontractor's responsibility to report findings and actions taken as a result of the Quality Improvement Program activities at least quarterly.

d) Plan's actions/remedies if Subcontractor's obligations are not met.

e) Description of Plan's system to ensure accountability for delegated Quality Improvement Program activities, that at a minimum:

i. Evaluates Subcontractor's ability to perform the delegated activities including an initial review to assure that the Subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

ii. Ensures Subcontractor meets standards set forth by the Plan, GCHP and DHCS.

iii. Includes the continuous monitoring, evaluation and approval of the delegated functions.

3.6.6 Plan shall implement and maintain a written description of its QIS that shall include the following:

a) Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives, which are approved by Plan's governing body and periodically evaluated and updated.

b) Organizational chart showing the key staff and the committees and bodies responsible for Quality Improvement Program activities including reporting relationships of QIS committee(s) and staff within the Plan's organization.

c) Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

d) A description of the system for provider review of QIS findings, which at a minimum, demonstrates Physician and other appropriate professional involvement and includes provisions for providing feedback to staff and providers, regarding QIS study outcomes.

e) The role, structure, and function of the quality improvement committee.

f) The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation,

health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

g) A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. The description shall include methods to ensure that members are able to obtain appointments within established standards.

h) Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

i) Description of the activities, including activities used by Members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of Case Management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and Case Management.

3.6.7 Plan shall develop an annual quality improvement report for submission to GCHP on an annual basis. The annual report shall include:

a) A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to, the collection of aggregate data on utilization; the review of quality of services rendered; the results of the external accountability set measures; and, outcomes/findings from Quality Improvement Projects (QIPs), consumer satisfaction surveys and collaborative initiatives.

b) Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) if relevant to the Plan's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

c) An assessment of Subcontractor's performance of delegated quality improvement activities.

3.6.8 At least annually or as designated by GCHP and/or DHCS, GCHP and/or DHCS shall arrange for an external quality of care review of the Plan. The DHCS quality of care review will be by an entity qualified to conduct such reviews. Plan shall cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in the conduct of this review.

3.6.9 On an annual basis, Plan shall submit to an on-site External Accountability Set Compliance Audit (also referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the Plan's information and reporting systems, as well as the Plan's methodologies for calculating performance measure rates. Plan shall use the DHCS-selected plan for performance of the EAS/HEDIS Compliance Audit and calculation of DHCS developed performance measures that constitute the EAS. Compliance Audits performed by DHCS would be performed by an EQRO as contracted and paid for by the State.

a) Plan shall calculate and report all EAS performance measures at the county level unless otherwise approved by GCHP.

b) HEDIS rates are to be calculated by the Plan and verified by the DHCS-selected EQRO. Rates for DHCS-developed performance measures will be calculated by the EQRO.

c) Plan shall report audited results on the EAS performance measures to GCHP no later than June 15 of each year or such date as established by GCHP or DHCS. Plan shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.

d) Plan shall meet or exceed the DHCS established Minimum Performance Level (MPL) for each HEDIS measure.

e) For each measure that does not meet the MPL set for that year, or is reported as a "Not Report" (NR) due to an audit failure, Plan must submit a plan outlining the steps that will be taken to improve the subsequent year's performance.

f) The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.

g) Improvement plans are due to GCHP and/or DHCS within 60 calendar days of GCHP and/or DHCS notification that the Plan has performed at or below the MPL for the period under review.

h) Additional reporting may be required of the Plan until such time as improvement is demonstrated.

3.6.10 In addition to the EAS performance measures, Plan shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures. These measures will be audited as part of the EAS/HEDIS Compliance Audit and rates shall be submitted with the EAS audited rates. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The

measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify plans of the HEDIS measures selected for inclusion in the following year's utilization monitoring measure set.

3.6.11 For this Agreement, Plan is required to conduct or participate in two (2) Quality Improvement Projects (QIPs) approved by GCHP and/or DHCS.

a) One QIP must be either an internal quality improvement project (IQIP) or a small group collaborative (SGC) facilitated by a health plan or DHCS. The SGC must include a minimum of two (2) DHCS health plan and must use standardized measures and clinical practice guidelines. Additionally, all contracting health plans participating in a SGC must agree to the same goal, timelines for development, implementation, and measurement. Contracting health plans participating in a SGC must also agree on the nature of contracting health plan commitment of staff and other resources to the collaborative project.

b) One QIP must be a DHCS facilitated statewide collaborative. If this Agreement's operation start date is after the statewide collaborative has begun implementation, upon GCHP and/or DHCS' approval, Plan may substitute a SGC or an IQIP in place of the statewide collaborative.

c) Plan shall comply with All Plan Letter 06010 and shall use the QIP reporting format designated therein to request approval of proposed QIPs from DHCS and to report at least annually to GCHP on the status of each QIP. The required documentation for QIP proposals and for QIP status reports shall include but is not limited to:

i. In-depth qualitative and quantitative analysis of barriers and results.

ii. Evidence-based interventions and best practices, when available, and system wide intervention, when appropriate.

iii. Interventions that address health disparities.

iv. Measurement of performance using objective Quality Indicators.

v. Strategies for sustaining and spreading improvement beyond the duration of the QIP.

3.6.12 At intervals as determined by GCHP and/or DHCS, GCHP or DHCS' contracted EQRO will conduct a consumer satisfaction survey. Plan shall provide appropriate data to the GCHP or the EQRO to facilitate this survey.

3.6.13 Plan shall conduct site reviews on all Primary Care Physician sites according to the Site Review Policy Letter, MMCD Policy Letter 02-02. (http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx) using the DHCS approved Facility Site Review Survey incorporated therein. The number of site reviews to be completed prior to initiating plan operation in the Service Area shall be based upon the total number of new primary care sites in the provider network. For more than 30 sites in the provider network, a five (5) percent sample size or a minimum of 30 sites, whichever is greater in number, shall be reviewed six (6) weeks prior to plan operation. Reviews shall be completed on all remaining sites within six (6) months of plan operation. For 30 or fewer sites, reviews shall be completed on all sites six (6) weeks prior to plan operation.

3.6.14 A site review is required as part of the credentialing process when both the Facility and the provider are added to the Plan's provider network. If a provider is added to Plan's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing.

a) Plan shall ensure that a corrective action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in MMCD Policy Letter 02-02. Primary Care Physcian sites that do not correct cited deficiencies are to be terminated from Plan network according to guidelines set forth in MMCD Policy Letter 02-02.

b) Plan shall submit the site review data to GCHP by January 31 and July 31 of each year. All data elements defined by DHCS in MMCD Policy Letter 02-02 shall be included in the data submission report.

c) Plan shall retain accountability for all site review activities whether carried out by the Plan, completed by other Medi-Cal managed care plans or delegated to other entities.

3.6.15 Plan shall implement and maintain policies and procedures that set forth how diseases or conditions that must be reported to public health authorities as required by State law shall be reported. Policies and procedures shall include, for each reporting requirement, whether reporting shall be performed by Plan or by Plan's Providers, or both.

3.6.16 Plan shall develop, and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of Physicians including Primary Care Physicians and specialists in accordance with the MMCD, Credentialing and Recredentialing Policy Letter, MMCD Policy Letter 02-03. Plan shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Plan shall

ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

3.6.17 All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs and a valid National Provider Identifier (NPI) number. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Plan's provider network.

3.6.18 Plan shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3.6.19 Plan may delegate credentialing and recredentialing activities. If Plan delegates these activities, Plan shall comply with provisions above.

3.6.20 Plan and their Subcontractors (e.g. a Physician Group) may obtain credentialing provider organization certification (POC) from the NCQA. Plan may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

3.6.21 Plan shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a Participating Provider to the appropriate authorities. Plan shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a Participating Provider's privileges. Plan shall implement and maintain a provider appeal process.

3.6.22 The Plan will verify that its subcontracted Providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider list. Terminated providers in either Medicare or Medi-Cal/Medicaid or on the Suspended and Ineligible Provider list, cannot participate in the Plan's provider network.

3.6.23 If Plan has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the Plan shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of credentialing.

3.6.24 Plan shall develop and maintain policies and procedures that ensure that the credentials of contracting nurse practitioners, certified nurse midwives, clinical nurse specialists and physician assistants have been verified in accordance with State requirements applicable to the provider category.

3.6.25 Plan shall ensure that appropriate Medical Records for Members, pursuant to Title 28, CCR, Section 1300.80(b)(4), Title 42 United States Code (USC)

Section 1396a(w), 42 CFR 456.111 and 42 CFR 456.211, shall be available to health care providers at each Encounter in accordance with Title 28, CCR Section 1300.67.1(c) and Title 22 CCR Section 53861 and MMCD Policy Letter 02-02.

a) Plan shall develop, implement and maintain written procedures pertaining to any form of Medical Records:

   i. Initial Health Assessment within 120 days of enrollment.

   ii. For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

   iii. To ensure that Medical Records are protected and confidential in accordance with all Federal and State laws.

   iv. For the release of information and obtaining consent for treatment.

   v. To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

b) Plan shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each site.

c) Plan shall ensure that a complete Medical Record is maintained for each Member that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

   i. Member identification on each page; personal/biographical data in the Medical Record.

   ii. Initial Health Assessment within 120 days of Enrollment in accordance with MMCD Policy Letter 08-003.

   iii. Member's preferred language (if other than English) prominently noted in the Medical Record, as well as the request or refusal of language/interpretation services.

   iv. All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.

   v. The Medical Record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

vi. Allergies and adverse reactions are prominently noted in the Medical Record.

vii. All informed consent documentation, including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6, if applicable.

viii. Reports of Emergency Services provided (directly by the Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

ix. Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the Medical Record.

x. For Medical Records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

xi. Health Education behavioral assessment and referrals to health Education services.

d) Plan and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out-of-Network Provider, at no cost to GCHP or to the Member when:

i. Such a transfer of records facilitates the continuity of that Member's care; or

ii. The Member is transferring from one Provider to another for treatment; or

iii. A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.7 UTILIZATION MANAGEMENT PROGRAM. Plan shall develop, implement, and continuously update and improve, a Utilization Management (UM) Program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Plan is responsible to ensure that the UM Program activities shall be done in accordance with Health and Safety Code Section 1363.5 and includes:

3.7.1 Qualified staff responsible for the UM Program.

3.7.2 The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

3.7.3 Allowances for a second opinion from a qualified health professional at no cost to the Member.

3.7.4 Established criteria for approving, modifying, deferring, or denying requested services. Plan shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Plan shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Plan.

3.7.5 Communications to Providers of the procedures and services that require prior authorization and ensure that Participating Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

3.7.6 An established system to track and monitor services requiring prior authorization through the Plan. The system shall include authorized, denied, deferred, or modified prior authorizations, and the timeliness of the determination. Plan shall ensure that all contracted health care practitioners and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

3.7.7 The integration of UM Program activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

3.7.8 Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

3.8 Plan shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Plan's internal reporting mechanisms used to detect Member utilization patterns shall be reported to GCHP and/or DHCS upon request.

3.9 Plan shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

3.9.1 Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician will review all denials that are made, whole or in part, on the basis of Medical Necessity. For purposes of this provision, the review of the denial of a pharmacy prior authorization may be by a qualified Physician or Plan's pharmacist.

3.9.2 There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

3.9.3 Reasons for decisions are clearly documented.

3.9.4 Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

3.9.5 Notification to Members regarding denied, deferred or modified referrals is made as specified in State Contract Exhibit A, Attachment 13, Member Services. There shall be a well-publicized appeals procedure for both Providers and Members.

3.9.6 Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

3.9.7 Prior Authorization requirements shall not be applied to Emergency Services, minor consent services, Family Planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing. Records, including any notice of action, shall meet the retention requirements described in State Contract Exhibit E, Attachment 2, Provision 17.B,. Records Retention.

3.9.8 Plan must notify the requesting Provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be orally or in writing.

3.10 TIMEFRAMES FOR MEDICAL AUTHORIZATION. Plan must adhere to the following requirements:

3.10.1 Emergency Services: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

3.10.2 Post-stabilization: Upon receipt of an authorization request from an Emergency Services Provider, Plan shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4.

3.10.3 Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.

3.10.4 Concurrent review of authorization for treatment regimen already in place: Within 24 hours of the decision, consistent with urgency of the Member's

medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3).

3.10.5 Retrospective review: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1).

3.10.6 Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).

3.10.7 Therapeutic Enteral Formula for Medical Conditions in Infants and Children: Timeframes for medical authorization of Medically Necessary therapeutic enteral formulas for infants and children and the equipment/supplies necessary for delivery of these special foods are set forth in MMCD Policy Letter 07-016, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.

3.10.8 Routine authorizations: five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's Provider requests an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

3.10.9 Expedited authorizations: For requests in which a Provider indicates, or the Plan determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) working days after receipt of the request for services. The Plan may extend the three (3) working days' time period by up to 14 calendar days if the Member requests an extension, or if the Plan justifies, to GCHP and DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

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3.11 ACCESS TO RECORDS --- It is understood that all Plan, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Agreement:

3.11.1 Shall be made available for inspection or copying at Plan, Participating Providers' and/or Subcontractors' expense by GCHP or authorized representative of State or federal government at all reasonable times at the Plan, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.11.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.12 RECORDS RETENTION --- Plan and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Agreement, including claim forms and Encounter data, for a period of not less than five (5) years from the date of the State's Fiscal Year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed, except that, in the event Plan or Subcontractor has been duly notified that DHCS, HHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Agreement or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than five (5) years following the termination of litigation. Pediatric records shall be maintained until Member is twenty-one (21) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of GCHP, provided that the microfilming procedures are approved by GCHP as reliable and are supported by an effective retrieval system. Plan shall upon request by GCHP, transfer copies of such records to GCHP's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of GCHP. This provision shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise.

3.13 ACCESS TO PREMISES --- GCHP, Government Agency and the State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of Plan or Subcontractor, Plan shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work. Through the end of the records retention period specified in Section 3.14., Plan shall allow the DHCS, HHS, the Comptroller General of the United States, DOJ, Bureau of Medi Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies,

or their duly authorized representatives, including DHCS' external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Agreement, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Plan and Subcontractors pertaining to these services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.14., Plan shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Plan's sole expense. GCHP and DHCS may conduct unannounced validation reviews of the Plan's Primary Care Service or other service sites, selected at GCHP's or DHCS' discretion, to verify compliance of these sites with State and federal regulations and Agreement requirements. GCHP and authorized State and Federal agencies will have the right to monitor all aspects of Plan's operation for compliance with the provisions of this Agreement and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Plan, Subcontractor, and Provider facilities, management systems and procedures, and books and records as the GCHP or DHCS deems appropriate, at any time during the Plan's or other Facility's normal business hours. The monitoring activities will be either announced or unannounced. To assure compliance with the Agreement and for any other reasonable purpose, GCHP, the State and their authorized representatives and designees will have the right to premises access, with or without notice to Plan. This will include the MIS operations site or such other place where duties under the Agreement are being performed. Staff designated by GCHP and authorized State agencies will have access to all security areas and Plan will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the GCHP or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Plan and/or the Subcontractor(s).

3.14 ACCESS TO AND AUDIT OF AGREEMENT RECORDS --- Throughout the duration of the Agreement, and for a period of five (5) years from the end of the State's Fiscal Year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed Plan and Subcontractors shall provide duly authorized representatives of the State or federal government or GCHP access to all records and material relating to Plan's provision of and reimbursement for activities contemplated under the Agreement, and to Plan's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the Agreement. All information so obtained shall be accorded confidential treatment as provided under applicable law. GCHP employees shall sign Plan's statement of confidentiality prior to being admitted access to Plan's premises. This provision shall

survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise.

3.15 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by GCHP, Plan shall timely gather, preserve and provide to GCHP, in the form and manner specified by GCHP, any information specified by GCHP, subject to any lawful privileges, in Plan's or its Subcontractors' possession, relating to threatened or pending litigation by or against GCHP or DHCS. If Plan asserts that any requested documents are covered by a privilege, Plan shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against GCHP or DHCS. Plan acknowledges that time may be of the essence in responding to such request. Plan shall use all reasonable efforts to immediately notify GCHP of any subpoenas, document production requests, or requests for records, received by Plan or its Subcontractors related to this Agreement or subcontracts entered into under this Agreement.

3.16 DISCLOSURE OF OWNERSHIP --- Plan shall keep GCHP informed as to the names of the officers and owners of Plan holding more than ten percent (10%) of the stock issued by Plan, and major creditors holding more than five percent (5%) of the debt of Plan. Plan shall comply with Title 42 of the Code of Federal Regulations (42 CFR) Section 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105 (Disclosure by providers: Information related to business transactions), 42 CFR 455.106. Plan shall complete the Welfare and Institutions Code Section 14452 Disclosure form which lists the current officers, directors, general partners, co-owners, stock holders holding more than ten percent (10%) of Plan’s stock and major creditors holding more than five percent (5%) of the Plan’s debt and shall submit the completed form to GCHP. Plan shall immediately notify GCHP of any change in the information provided in this form. Plan shall provide GCHP with an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

3.17 FRAUD, WASTE AND ABUSE --- Plan represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, Program integrity requirements at 42 CFR Section 438.608, the Federal False Claims Act (31 USC Section 3729 et seq.), Employee Education About False Claims Recovery (42 USC Section 1396a(a)(68)), the California State False Claims Act (California Government Code Section 12650 et seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act).

3.18 FRAUD, WASTE AND ABUSE REPORTING --- Plan shall report to GCHP: 1) all allegations relating to fraud, waste and/or abuse, and 2) all cases of suspected fraud, waste and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or Plan's employees, within ten (10) working days of the date when Plan first becomes aware of or is on notice of such activity.

3.18.1 Plan shall notify GCHP, and GCHP shall notify DHCS prior to Plan conducting any investigations. Plan shall conduct an investigation after notification has been given.

3.18.2 Plan shall establish, for approval by GCHP and DHCS, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.18.3 Plan shall report all investigation results to GCHP within ten (10) working days of conclusion of any fraud and/or abuse investigation.

3.19 COMPLIANCE WITH APPLICABLE LAW --- Plan shall observe and comply with all federal and State law in effect when the Agreement is signed or which may come into effect during the term of the Agreement, which in any manner affects the Plan's performance under this Agreement. This Agreement shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.20 COMPLIANCE WITH GCHP'S COMPLIANCE PROGRAM ---Plan and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Agreement ("Plan's Agents") shall comply with the requirements of GCHP's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. GCHP shall make its Compliance Manual and Code of Conduct available to Plan and Plan shall make them available to Plan's agents.

3.21 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Plan shall comply with requirements established State and/or federal programs relating to its performance under this Agreement. Compliance shall include, but not be limited to, provisions of the State Contract requirements for GCHP to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and State and/or federal regulations.

3.22 COMPLIANCE WITH POLICIES AND PROCEDURES --- Subject to Section 3.39, Plan agrees to comply with and be bound by GCHP Policies. GCHP reserves the right to adopt, amend and/or discontinue GCHP Policies at its sole discretion. Subject to Section 3.37, Plan acknowledges and agrees that it shall implement GCHP Policies applicable to its obligations under this Agreement.

3.23 COMPLIANCE WITH FINANCIAL AND CONTRACT INTERPRETATION BULLETINS --- Subject to Section 3.37, Plan agrees to comply with and be bound by any and all GCHP Financial Bulletins and Contract Interpretation Bulletins as may be issued by GCHP from time to time

3.24 COMPLIANCE WITH MEMORANDA OF UNDERSTANDING (MOUs) --- Subject to Section 3.37, Plan agrees to comply with and be bound by any and all applicable MOUs entered into by GCHP.

3.25 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Plan shall have policies and procedures to verify the participation status of Plan's agents. In addition, Plan warrants and agrees as follows:

3.25.1 Plan and Plan's agents shall meet GCHP's participation status requirements during the term of this Agreement.

3.25.2 Plan shall immediately disclose to GCHP any pending investigation involving, or any determination of, suspension, exclusion or debarment by Plan or Plan's agents occurring and/or discovered during the term of this Agreement.

3.25.3 Plan shall take immediate action to remove any Plan agent that does not meet Participation Status requirements from furnishing items or services related to this Agreement (whether medical or administrative) to Members.

3.25.4 Plan shall include the obligations of this Section in its Subcontracts.

3.26 LINGUISTIC AND CULTURAL SENSITIVITY --- Plan shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Agreement and GCHP Policies.

3.26.1 Plan shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Plan shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Plan shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Plan shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.26.2 Pursuant to GCHP Policies, Plan shall provide translation of written materials in the Threshold Languages and Concentration Languages. Written materials to be translated include, but are not limited to, signage, the Member Handbook, enrollee information, Explanation of Coverage, member

forms, notices and welcome packages, as well as form letters, including notice of action letters and grievance acknowledgement and resolution letters. Plan shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the GCHP's group needs assessment, approved by DHCS, and communicated in writing to Plan. If a Member requests materials in a language not meeting the numeric thresholds, Plan shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Plan shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Plan shall be responsible for ensuring the quality of translated materials.

3.27 PROVISION OF INTERPRETERS --- Plan shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient Encounters, and all sites utilized by Plan or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or Health Education. Plan shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Plan shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Plan shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Plan must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Plan shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's Medical Record. This documentation shall be available to GCHP at GCHP's request. Plan shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Plan shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.28 MEMBER RIGHTS --- Plan shall ensure that each Member's rights, as set forth in State and federal law and GCHP Policy, are fully respected and observed.

3.29 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Plan and GCHP shall not prohibit, or otherwise restrict, a health care professional acting

within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient, for the following:

3.29.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.2 Any information the Member needs in order to decide among all relevant treatment options.

3.29.3 The risks, benefits, and consequences of treatment or non-treatment.

3.29.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE --- Plan and GCHP shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.30.1 Plan shall comply with HIPAA requirements as currently established in GCHP Policies. Plan shall also take actions and develop capabilities as required to support GCHP compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.30.2 The parties agree to comply with the terms and conditions of the HIPAA Business Associates Agreement (attached as Attachment H).

3.31 CONFIDENTIALITY OF INFORMATION

3.31.1 Plan and GCHP and their respective employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Plan, its employees, agents, or Subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person. Plan and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Plan's obligations under this Agreement. Plan and its employees, agents, or Subcontractors shall promptly transmit to the GCHP all requests for disclosure of such identifying information not emanating from the Member. Plan shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member, any such identifying information to anyone other than DHCS or GCHP without prior written authorization from GCHP. For purposes of this provision, identity

shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

3.31.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Plan from unauthorized disclosure. Plan may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Plan is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Agreement that is obtained by Plan or its Subcontractors, Plan:

a) will not use any such information for any purpose other than carrying out the express terms of this Agreement,

b) will promptly transmit to GCHP all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

c) will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or GCHP without GCHP's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

d) will, at the termination of this Agreement, return all such information to GCHP or maintain such information according to written procedures sent to the Plan by GCHP for this purpose.

3.32 REINSURANCE --- Plan may, at its option and sole expense purchase supplemental Reinsurance from a source other than GCHP. Additionally, Plan shall:

3.32.1 Identify a Reinsurance coordinator who shall serve as GCHP's contact for all Reinsurance issues; and

3.32.2 Comply with GCHP's Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.33 CLAIMS MANAGEMENT AND ADMINISTRATION --- Plan shall have a process for claims management and administration. Plan shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all

Provider claims (i.e., paid, denied, pended, other), and when action was taken. Plan shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

3.34 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE --- Plan shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at any time (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all GCHP Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.34.1 Have authority to approve Covered Services; or

3.34.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.34.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.34.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Plan being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.34.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Plans, for all Members who have received a MSE or Emergency Services and have been Stabilized.

3.34.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. Plan shall notify GCHP if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.35 ECONOMIC PROFILING --- If Plan or any of its Subcontractors uses economic profiling information related to any of its individual Physicians or other health care Practitioners, it shall provide a copy of such information related to an individual Practitioner, upon request, to that Practitioner in accordance with the requirements of Section 1367.02 of the California Health and Safety Code. Additionally, Plan, upon request, shall make available to GCHP its policies and procedures related to economic profiling used by Plan. The term "economic profiling" as used in this Section 3.35 shall be defined in the same manner as that term is defined in Section 1367.02 of the Health and Safety Code. The requirement of this Section 3.35 to provide a copy of economic profiling information to an individual Practitioner shall

survive termination of this Agreement in accordance with Section 1367.02 of the Health and Safety Code.

3.36 SUBCONTRACTS. Plan may enter into Subcontracts with other entities in order to fulfill the obligations of the Agreement. When doing so, Plan shall evaluate the prospective Subcontractor's ability to perform the requested services, shall oversee and remain accountable for any functions and responsibilities delegated, and shall meet the subcontracting requirements as stated in 42 CFR 438.230(b)(3), (4) and Title 22 CCR Section 53867 and this Contract. All Subcontracts shall be in writing and in accordance with the requirements of the 42 CFR 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, Section 1300 et seq.; Welfare and Institutions Code Section 14200 et seq.; Title 22 CCR Section 53800 et seq.; and other applicable Federal and State laws and regulations. Each Subcontract shall contain:

1. Specification of the services to be provided by the Subcontractor.

2. Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Agreement.

3. Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in the State Contract Exhibit A, Attachment 6, Provision 13 Subcontracts, subparagraph C. Departmental Approval – Non-Federally Qualified HMOs, or subparagraph D, Departmental Approval – Federally Qualified HMOs.

4. Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.

5. Language comparable to State Contract Exhibit A, Attachment 8, Provision 12, Contracting & Non-Contracting Emergency Service.

6. Providers and post-stabilization for those Subcontractors at risk for non-contracting Emergency Services.

7. Subcontractor's agreement to submit reports as required by GCHP.

8. Subcontractor's agreement to make all of its books and records, pertaining to the goods and services furnished under the terms of the Subcontract, available for inspection, examination or copying:

a) By GCHP, DHCS, Department of Health and Human Services (HHS), Department of Justice (DOJ), and Department of Managed Health Care (DMHC) and Government Agency.

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

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

d) For a term of at least five (5) years from the close of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

e) Including all Encounter data for a period of at least five (5) years.

9. Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor from the Plan, but GCHP shall keep those terms confidential whenever possible, and shall notify Plan at least thirty (30) days in advance of any disclosure if GCHP believes that those terms, with respect to one or more Subcontractors are public records.

10. Subcontractor's agreement to maintain and make available to GCHP and/or DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Sub-Subcontractor:

a) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by GCHP, DHCS, HHS, and DOJ.

b) Retain such books and records for a term of at least five (5) years from the close of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

11. Subcontractor's agreement to assist Plan in the transfer of care pursuant to phase-out requirements set forth in Section 8, in the event of Agreement termination.

12. Subcontractor’s agreement to assist Plan in the transfer of care in the event of sub-subcontract termination for any reason.

13. Subcontractor's agreement to notify GCHP in the event the agreement with the Plan is terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached.

14. Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from GCHP and DHCS.

15. Subcontractor's agreement to hold harmless GCHP, the State and Members in the event the Plan cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract.

16. Subcontractor's agreement to timely gather, preserve and provide to GCHP and/or DHCS, any records in the Subcontractor's possession, related to Recovery for Litigation as stipulated in this contract.

17. Subcontractor's agreement to arrange interpreter services for Members at all provider sites.

18. Subcontractor's right to submit a grievance and Plan's formal process to resolve Provider grievances.

19. Subcontractor's agreement to participate and cooperate in the Plan's Quality Improvement System.

20. If Plan delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in this contract.

21. Subcontractor's agreement to comply with all applicable requirements specified in: this Agreement and subsequent amendments, the State Contract, federal and State laws and regulations.

22. Pursuant to Health & Safety Code Section 1261, Subcontractor's agreement by any subcontracting or sub-subcontracting health Facility, if Subcontractor is licensed pursuant to Health & Safety Code Section 1250, to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

23. Subcontractor's agreement to provide Plan and GCHP with the disclosure statement set forth in Title 22 CCR Section 51000.35, prior to commencing services under the Subcontract.

3.37 CHANGES IN GCHP POLICIES AND MANUALS --- In the event that a right or obligation of Plan under this Agreement is added, deleted, or otherwise materially changed by a change in any GCHP Policies, Provider Manual, Operations Manual, other Manual, or Contract Interpretation and Financial Bulletins (a "GCHP Change"), GCHP shall give Plan not less than thirty (30) days prior notice of the specific GCHP Change unless a change in State or federal law or regulations, DHCS requirement, or any accreditation requirements of a private sector accreditation organization requires a shorter timeframe for compliance.

3.38 MARKETING GUIDELINES --- Plan shall comply with the marketing guidelines set forth in GCHP's Policies.

3.39 GCHP LOGO --- Plan shall display the GCHP logo on all Plans' written communication to Members pursuant to GCHP Policies, and in a manner such that it is clear to the Member that the communication is referring to the GCHP program.

Plan shall not otherwise use GCHP's logo for any business unrelated to this Agreement.

3.40 MEMBER INQUIRIES AND CALLS --- Plan shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Plan's call center shall meet requirements established by GCHP Policies. Plan shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure Plan will be able to supply call center reports as required by GCHP Policies.

3.41 WRITTEN MATERIALS --- Except as otherwise provided in this Agreement, Plan shall ensure that all written Member information provided by Plan to Members is provided at a sixth grade reading level, or at a lower level as determined appropriate through GCHP's group needs assessment and approved by GCHP and DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member-informing materials, including the Member Handbook, and all grievance acknowledgment and resolution letters, shall be translated into the identified Threshold Languages Written Member informing materials shall be provided in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested. Plan shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.42 COMPLAINTS AND GRIEVANCES

3.42.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by a Plan. Plan shall implement and comply with GCHP Policies relating to Member grievances. Plan shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.42.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Plan. Plan shall implement and comply with GCHP Policies relating to Provider grievances.

3.43 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES --- Except as otherwise limited by the State contract, this Agreement and/or GCHP Policies, Plan may sub-delegate to an MSO, medical group and/or IPA administrative functions required of Plan, but such delegation shall not absolve Plan of oversight responsibilities. All Sub-delegation must be approved by GCHP. Such approval shall not be unreasonably withheld, denied, or delayed. Sub-delegation to another entity does not alter Plan's ultimate obligation and responsibilities set forth in this Agreement. Plan is accountable for all functions performed in its purview whether by Plan, by any sub-delegate or by any sub-sub-delegate. If Plan chooses to

sub-delegate a function, Plan must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its membership and provider network. At a minimum, Plan shall provide GCHP, no later than one hundred twenty (120) days prior to the proposed effective date of the Sub-delegation, with written evidence of the Sub-delegation including:

3.43.1 A copy of the written agreement which meets the requirements of Section 3.36 of this Agreement and which describes the relationship between the Provider and the sub-delegate entity including the following information:

a) The sub-delegated functions;

b) The responsibilities of the Plan and the sub-delegate entity;

c) The frequency of the sub-delegate entity's performance;

d) The process by which the Plan evaluates the sub-delegate entity's performance; and

e) The Plan's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the Sub-delegation.

3.43.2 A description of the Plan's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.43.3 A record of the Plan's ongoing oversight process, as requested by GCHP including:

a) The Plan's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Agreement and NCQA standards;

b) The Plan's review of the sub-delegate entity's regular reports; and

c) Reports and data required to be submitted to GCHP.

3.43.4 Plan shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from GCHP, any Sub-delegation that fails to meet standards established by GCHP and/or any of the requirements in this Agreement or in GCHP Policies.

3.43.5 Plan shall report to GCHP in accordance with all requirements established in this Agreement and in GCHP Policies, data and information that includes and encompasses all of Plan's Members, including those receiving services from a sub-delegate of Plan.

3.43.6 Plan shall oversee and monitor its subdelegates, and audit subdelegates no less than once in any twelve (12) month period. Plan shall establish standards and performance requirements for the sub-delegate function(s) and requirements for subdelegates shall require sub-delegate to meet or exceed all requirements of Plan in this Agreement and in GCHP Policies. Plan may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

a) Contracted directly with GCHP as a Health Network or Physician Group, Hospital, or Long Term Care Facility, or as a participant in a Health Network (i.e. shared risk group, Plan Physician Group or Plan Hospital), or

b) NCQA or The Joint Commission accredited or certified for the function(s) sub-delegated by Plan to sub-delegate.

3.43.7 Subdelegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Plan shall notify GCHP of any sub-delegate providing services to GCHP Members that is on a CAP. Plan shall provide GCHP a copy of the CAP if requested.

3.44 SUBCONTRACTS: ADDITIONAL REQUIREMENTS --- As further set forth in Section 3.36, above, Plan may Subcontract for certain functions covered by this Agreement subject to the requirements of this Agreement. Plan is required to ensure that all Subcontracts are in writing and include any general requirements of this Agreement and all provisions required by this Agreement to be incorporated into Subcontracts. Plan is required to inform GCHP of the name and business addresses of all Subcontractors within thirty (30) days of execution of subcontract. All subcontracting with an offshore entity must be approved by GCHP prior to execution of the Subcontract. Additionally, Plan shall require all Subcontracts that relate to the provision of Covered Services, include the following:

3.44.1 An agreement to make all books and records relative to the provision of and reimbursement for items and services furnished by Subcontractor to Plan available at all reasonable times for inspection, examination or copying by GCHP or duly authorized representatives of the State or federal government;

3.44.2 An agreement to maintain such books and records: (a) in accordance with the general standards applicable to such books and records and any record requirements in this Agreement and GCHP Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California; and (c) for a term of at least five (5) years from when the date of service occurred, when the records or data were created or applied, and when the financial record was completed;

3.44.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.26 and 3.27 of this Agreement;

3.44.4 An agreement for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Sections 3.11, 3.12, 3.14, and 3.15 of this Agreement;

3.44.5 An agreement for access to premises as set forth in Section 3.13 of this Agreement;

3.44.6 An agreement requiring compliance with any MOU entered into by GCHP, which are binding on Plan;

3.44.7 An agreement requiring Subcontractors to provide Covered Services to GCHP Members in the same manner as those services are provided to other patients;

3.44.8 An agreement to comply with all provisions of this Agreement with respect to providing Emergency Services;

3.44.9 An agreement that Subcontractors shall notify Plan of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.44.10 An agreement to comply with (a) GCHP's Compliance Program including, without limitation, GCHP Policies; and (b) any Medi-Cal Provider Bulletins, Financial Bulletins, DHCS Medi-Cal Managed Care Policy Division Policy letters and/or Contract Interpretation Bulletins issued pursuant to this Agreement;

3.44.11 An agreement that Participating Providers comply with the GCHP Approved Drug List, as set forth in Section 6.12 of this Agreement;

3.44.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed by DHCS and filed by GCHP with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.44.13 An agreement to hold harmless the State, Members and GCHP, in the event Plan cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract;

3.44.14 An agreement to cooperate with Plan and/or GCHP in the transfer of care of a Member in the event of termination of the Subcontract for any reason; and

3.44.15 In the event that Plan implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly

under the incentive plan to a Physician or Physician Group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by Plan.

3.45 ENROLLMENT --- GCHP and Plan shall accept as Members all persons indicated by GCHP's information system and through regular transmission from GCHP to Plan.

3.46 PCP ASSIGNMENT --- Plan shall assign Members who have been automatically assigned to Plan by GCHP to a PCP within seven (7) days of the Member's assignment to Plan.

3.47 REQUIRED ENROLLMENT INFORMATION AND NOTICE --- Within seven (7) days of being notified that a Member has been enrolled with Plan, Plan shall mail to Member's head of household a notice of enrollment and a Plan Member handbook or GCHP approved supplement to the GCHP Member Handbook. The Plan Member handbook and GCHP approved supplement to the GCHP Member Handbook and the notice of enrollment shall be written at the "fourth (4th) - fifth (5th) grade reading level" in all Threshold Languages. The Plan Member handbook shall include, at a minimum that which is required by GCHP Policies.

3.47.1 Should Plan choose to utilize the GCHP Member Handbook, Plan-specific information on each topic as defined by GCHP Policies must be included in a supplement to the GCHP Member Handbook given to all of Plan's GCHP Members.

3.47.2 If Plan chooses to produce and use a Member handbook other than the GCHP Member Handbook, in addition to the requirements in this Agreement, Plan's Member handbook shall contain all information included in the GCHP Member Handbook. GCHP may provide Plan with templates for Member handbooks and/or supplements. Should GCHP provide templates, Plan shall utilize these templates. In the absence of templates provided by GCHP, Member handbooks and supplements prepared by Plan shall be submitted to GCHP for approval prior to printing. Plan shall not distribute to Members materials not approved by GCHP. All materials shall be professionally produced and presented.

3.47.3 Plan shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. GCHP shall approve all updates prior to printing. Plan shall also provide one (1) copy of its enrollment information including its Plan Member handbook or supplement to every Participating Provider.

3.48 SPECIAL DISENROLLMENT --- Plan may request and GCHP may approve according to GCHP Policies disenrollment for specific Members.

3.49 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. GCHP shall process Member disenrollment in accordance with GCHP Policies.

3.50 ADDITIONAL SERVICES --- Plan shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by GCHP.

Section 4- Obligations of Plan: Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Plan shall provide Covered Services to Members under this Agreement in the same manner as those services are provided to other patients of Plan, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Plan is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Plan shall coordinate Members' needs for Covered Services and provide Case Management services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Plan shall provide Covered Services to Members and Plan agrees as follows:

4.1.1 Provider Network Capacity. Plan shall provide a complete provider network that is adequate to provide required Covered Services for Members in the Service Area. Plan will increase the capacity of the network as necessary to accommodate enrollment growth.

4.1.2 Plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through contracting or referral. Plan shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care, as detailed in Attachment G.

4.1.3 Plan shall maintain a network of Primary Care Physicians that are located within 30 minutes or ten (10) miles of a Member's residence.

4.1.4 Plan shall ensure that network providers offer hours of operation that are no less than the hours of operation offered to other patients or comparable to the Medi-Cal Fee-For-Service Program, if the provider serves only Medi-Cal beneficiaries.

4.1.5 Plan shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of practice of his or her license or certification under applicable State law, solely on the basis of that license or certification. If the Plan declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Plan's provider selection

policies must not discriminate against providers that serve high-risk populations or specialize in conditions requiring costly treatment. This section shall not be construed to require Plan to contract with providers beyond the number necessary to meet the needs of Plan's Members; preclude Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with Plan's responsibilities to Members.

4.1.6 Plan shall submit to GCHP, in a format specified by GCHP, a report summarizing changes in the provider network. The report shall be submitted at a minimum:

1. Quarterly; submitted within thirty calendar days following the end of the reporting quarter.

2. Within five business days when there is a significant change to the network affecting provider capacity and services, including:

a) Change in services or benefits;

b) Geographic service area or payments; or

c) Enrollment of a new population.

4.1.7 Plan shall provide and pay for, consistent with the terms and provision of this Agreement, Contract Interpretation and Financial Bulletins and GCHP Policies, the provision of all Covered Services to Members that are the financial responsibility of Plan;

4.1.8 If Plan's network is unable to provide necessary medical services covered under this Agreement to a particular Member, Plan must adequately and timely cover these services out of network for the Member, for as long as Plan is unable to provide them. Plan shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable GCHP Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.9 Plan shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.10 GCHP may incorporate any change in Covered Services mandated by federal or State law or regulation into the Agreement effective the date the change goes into effect. Whenever possible, GCHP shall give the Plan thirty (30) calendar days' notice of any such change. GCHP shall determine the effective date of the change in Covered Services.

4.1.11 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other Physicians in the Plan's Health Network as to the Medical Necessity of the service, except that, as applicable, GCHP or Plan shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.12 Plan shall comply with *Jackson v. Rank*, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Plan denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.13 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Plan acknowledges that disputes between the respective Plan and Members about Medical Necessity can be appealed pursuant to GCHP Policies;

4.1.14 Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Plan may place appropriate limits on a service on the basis of criteria such as Nedical nNecessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.15 In no event, including but not limited to, non-payment by GCHP or Plan, GCHP's or the Plan's insolvency, or breach of this Agreement by the Plan or GCHP, shall Plan or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Agreement. This provision does not prohibit Plan or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Agreement or for recoveries related to other health coverage, as identified in Section 2.7 of this Agreement. Plan or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Plan further agrees:

a) That this 4.1.15 shall survive the termination of this Agreement for those Covered Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

b) That this 4.1.15 shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Plan and Participating Providers or Subcontractors;

c) That language to ensure the foregoing shall be included in all of the Plan's Subcontracts with Participating Providers;

d) That no change or amendment to this 4.1.15 or to similar section(s) in Subcontracts between the Plan and Participating Providers shall be made without the prior written approval of GCHP; and

e) That, in the event of a violation of this 4.1.15 by Plan or Subcontractor, GCHP shall take appropriate remedial action against Plan or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 12.2.

4.2 EMERGENCY CARE --- Plan is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Plan shall have as a minimum a designated emergency service Facility within the Service Area, providing care on a 24 hours a day, 7 days a week basis. This designated emergency service Facility will have one or more Physicians and one (1) nurse on duty in the Facility at all times.

4.2.2 Plan shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with GCHP Policy. Payment may be denied only if Plan reasonably determines that Emergency Services were never performed.

4.2.3 Plan shall reimburse those physicians providing services in an Emergency Department with whom Plan has a contract according to the terms of that contract. Plan shall offer to enter into a contract with any Physician Group contracting with GCHP for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that GCHP contract. Plan shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D).

4.2.4 Plan shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.25, turned out to be non-emergency in nature.

4.2.5 If there is a disagreement between Plan or any Participating Provider and Out-of-Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the Attending Physician(s) actually caring for the Member at the treating Facility shall prevail. Plan may establish relationships with treating Facility whereby the Plan may send a Participating Provider with privileges to assume the Attending Physician's responsibilities to establish treatment or may arrange to have a Participating

Provider under contract with Plan agree to accept the transfer of the Member after the Member has been Stabilized.

4.2.6 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Plan is financially responsible for post-stabilization services obtained within or outside Plan's Health Network that are pre-approved by Plan's medical director or other authorized Plan representative. Plan is financially responsible for post-stabilization care services obtained within or outside Plan's Health Network that are not pre-approved by its medical director or other Plan representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to Plan for pre-approval of further post-stabilization care services.

4.2.6.1 Plan is financially responsible for post-stabilization care services obtained within or outside Plan's network that are not pre-approved by a Plan Physician or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Plan does not respond to a request for pre-approval within thirty (30) minutes; Plan cannot be contacted; or Plan's representative and the treating Physician cannot reach an agreement concerning the Member's care and a Plan Physician is not available for consultation. In this situation, Plan must give the treating Physician the opportunity to consult with a Plan Physician and the treating Physician may continue with care of the patient until a Plan Physician is reached or one of the criteria of 422.113(c)(3) is met.

4.2.6.2 Plan's financial responsibility for post-stabilization care services it has not pre-approved ends when either a Plan Physician with privileges at the treating hospital assumes responsibility for the Member's care, a Plan Physician assumes responsibility for the Member's care through transfer, a Plan representative and the treating Physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.6.3 Consistent with 42 CFR 438.114(e), 422.113(c)(2), and 422.214, Plan is financially responsible for payment for post-stabilization services following an emergency admission. Plan or its delegate shall reimburse those Providers providing post-stabilization services with whom Plan or its delegate has a contract according to the terms of that contract. Plan shall reimburse all non-contracted Providers providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in GCHP Policy.

4.3 NEWBORN SERVICES --- Plan shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- Plan is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Plan shall provide Family Planning information to GCHP, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. Plan's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services, shall not be required.

4.4.1 Plan shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires Plan to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out-of-Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve Plan from financial responsibility for such services.

4.4.2 Plan shall not prevent Members from receiving Family Planning Covered Services from Out-of-Network Providers.

4.4.3 Plan shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. Plan shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 Plan shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with GCHP Policies, for any reason including if the Member has reason to believe that the Plan has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 Plan shall incorporate specifications of this Section 4.4 in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- Plan shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the Facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH PHYSICIAN OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Plan shall arrange for the timely referral and coordination of Covered Services to which Plan or a Subcontractor has religious or ethical objections to perform or otherwise support and

shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

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Section 5- Obligations of Plan: Access

5.1 TWENTY-FOUR (24) HOUR PHYSICIAN COVERAGE ---- Plan shall ensure that it has, at a minimum, two Physician Participating Providers or Physicians employed by Plan as follows: One (1) Physician Participating Provider or Physician employed by Plan who is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services, and one (1) Physician Participating Provider or Physician employed by Plan available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for authorizations.

5.2 URGENT CARE SERVICES --- Plan shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 EPSDT SERVICES --- Plan shall cover and ensure the provision of screening, preventative and Medically Necessary diagnostic and treatment services for Members under 21 years of age, including EPSDT supplemental services. Provider shall inform Members that EPSDT services are available for Members under 21 years of age, as well as how to access services. Provider shall ensure that appropriate EPSDT services are initiated as soon as possible but no later than 60 calendar days following either a preventative screening or other visit that identifies a need for follow-up.

5.4 VISION CARE SERVICES --- Plan shall cover and ensure the provision of Vision Care services as specified in Title 22 CCR Sections 51306, 51317, 51518, 51519, 51519.1, and 51519.2, as appropriate for all Members, with the exception that Plan shall arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories. Plan shall cover the cost of dispensing of the lenses for Members. DHCS will reimburse PIA for the fabrication of the ophthalmic lenses in accordance with the interagency agreement between DHCS and PIA.

5.5 INITIAL HEALTH ASSESSMENT APPOINTMENT --- Plan shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with Plan, unless otherwise directed by GCHP Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under GCHP Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. GCHP may

establish minimum performance requirements for completion of the initial health assessment. Plan's failure to perform at or in excess of minimum performance requirements shall subject Plan to sanctions in accordance with this Agreement and GCHP Policies.

5.6 APPOINTMENT FOR PEDIATRIC PREVENTIVE SERVICES --- Plan shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.7 DAYS TO APPOINTMENT---

5.7.1 Non-Emergency Covered Services - Plan shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within twenty-one (21) calendar days of a Member's request.

5.7.2 Specialist Services – Plan shall ensure that appointments are scheduled with specialists within thirty (30) calendar days of referral.

5.7.3 Preventive Covered Services - Plan shall schedule health assessments and general physical examinations within thirty (30) calendar days of Member's request for an appointment.

5.7.4 Maternity Covered Services - Plan shall provide first and second trimester appointments within seven (7) calendar days of request by a Member. The Plan shall provide third trimester appointments within three (3) calendar days of request by a Member. The Plan shall provide high-risk pregnancy appointments within three (3) calendar days of identification of high-risk by or to the Plan or PCP and immediately if an Emergency Medical Condition exists.

5.7.5 Measurement - Plan shall periodically measure days to appointment.

5.8 OFFICE WAITING TIMES --- Plan will ensure that Participating Providers comply with appointment standard requirements established by Title 28, California Code of Regulations, §1300.67.2.2. Plan shall periodically measure office waiting times to ensure compliance with this regulation by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. Plan's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Agreement may subject Plan to sanctions as set forth in this Agreement and GCHP Policies.

5.9 TIME LIMIT FOR DECISION ON REFERRALS --- Plan shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including specialty plan referrals and Referral Services as set forth in GCHP's Utilization Management Program. These Covered Services shall be provided or made available to the Member to the Member within thirty (30) calendar days after authorization is granted. Plan shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.10 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Agreement requires the prior written approval of GCHP and DHCS. Plan's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to GCHP at least 75 days prior to the proposed effective date. GCHP's or DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Plan's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.9 of this Agreement.

5.11 NOTICES ABOUT PROVIDER CHANGES --- Plan shall give Members thirty (30) calendar days' notice if their PCP withdraws from Plan. All notices sent to Members shall be submitted to GCHP for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Plan. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within the Plan for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.12 CHOICE OF PCP --- Plan shall offer each Member the opportunity to choose a PCP affiliated with the Plan. A Member may elect to obtain Primary Care Services from a contracted Non-Physician Medical Practitioner as long as there is a Physician who has ultimate responsibility for the Member's Care Management Services. When Plan receives the Member's files from GCHP and determines that the Member has not indicated a PCP choice, Plan shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment in Plan. Plan shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.13 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Plan shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Agreement. Providers shall: (i) not be suspended, excluded or otherwise

ineligible to participate in any federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of a criminal offense related to health care in the prior seven (7) years.

5.14 PROVIDER TO MEMBER STAFFING RATIOS --- As specified by the State, Plan shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

a) Per 2,000 persons, one (1) PCP under contract;

b) Per 1,200 persons, one (1) referral specialty Physician; and

c) Per 1,000 persons, one (1) Non-Physician Medical Practitioner.

5.14.2 Supervising Physicians - Plan shall ensure that Physicians who supervise Non-Physician Medical Practitioners are certified to supervise by the California Medical Board. As specified by the State, the ratio of Physician supervisor to Non-Physician Medical Practitioner shall satisfy the requirement of a minimum of one (1) physician to:

1. Four (4) nurse practitioners; or

2. Three (3) nurse midwives; or

3. Two (2) physician assistants; or

4. Four (4) Non-Physician Medical Practitioners in any combination that does not include more than three (3) nurse midwives or two (2) physician assistants and maintains the full-time equivalence limits.

5.15 PCP GEOGRAPHIC DISTRIBUTION --- Plan shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or fifteen (15) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.16 SPECIALIST GEOGRAPHIC DISTRIBUTION --- Plan shall make available to every Member, specialists whose offices are located within a reasonable driving distance from the Member's place of residence. Plan shall provide Medical Transportation or Non-Medical Transportation, as applicable, for Members when the nearest available specialist is more than thirty (30) miles from Member's place of residence.

5.17 PHYSICAL ACCESS --- Plan's and its Subcontractor's Facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall

ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.18 SAFE OPERATION --- Plan's and its Subcontractor's Facilities shall comply with the requirements regulating the operations and safety of Facilities, including but not limited to, Title 22 CCR Section 53230.

Section 6- Obligations of Plan – Clinical Quality

6.1 LICENSURE --- Plan shall ensure that every Physician providing Covered Services and employed or engaged by Plan or Subcontractor shall retain at all times during the period of this Agreement a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- Plan shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of Health Education and prevention (HEP) available in accordance with the delineation of responsibilities in Attachment J.

6.2.1 Plan shall:

6.2.1.1 Coordinate and integrate with GCHP's QIP;

6.2.1.2 Refer Members to appropriate HEP, based on the Member's needs;

6.2.1.3 Implement and utilize the Staying Healthy Assessment Tool as defined in GCHP Policies; and,

6.2.1.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Plan shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 CASE MANAGEMENT SERVICES --- Plan shall offer a comprehensive Case Management services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in Attachment J. The Case Management services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.4.1 Plan shall develop and implement policies and procedures that outline processes to support Case Management services including but not limited to:

6.4.1.1 Pro-active identification mechanisms of high risk Members;

6.4.1.2 Referral processes;

6.4.1.3 Triage mechanisms with appropriate time frames;

6.4.1.4 Comprehensive assessment processes and formats;

6.4.1.5 Care plan development and care plan implementation guidelines and format;

6.4.1.6 Carve-out service coordination;

6.4.1.7 Documentation and communications processes for all Case Management services; and

6.4.1.8 Mechanism for evaluation of Case Management program outcomes.

6.4.2 Plan Case Management services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.4.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.4.2.2 Demonstrate high recidivism;

6.4.2.3 Are chronically ill;

6.4.2.4 Have a catastrophic diagnosis;

6.4.2.5 Have inadequate family/community support;

6.4.2.6 Are cost and/or length of stay outliers;

6.4.2.7 Are receiving six (6) or more chronic medications per month;

6.4.2.8 Are transitioning between Providers that may cause continuity of care, concerns; and

6.4.2.9 Are Members with special health care needs.

6.4.3 GCHP shall be entitled to periodically review Plan's Case Management services program to determine compliance with Case Management services

standards. Plan shall furnish Case Management services records and information to GCHP upon request.

6.4.4 Plan Case Management shall collaborate with GCHP on cases identified by GCHP as needing care coordinator interventions.

6.4.5 As a component of the Case Management requirements in this Agreement, Plan shall assure that Plan possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by GCHP in GCHP Policies.

6.5 OBLIGATION OF PLAN UPON TERMINATION OF CONTRACTED PROVIDERS --- Plan shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site, and assisting them in selecting a new PCP or PCP site. Plan shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date, and assist them in selecting a new PCP or PCP site. Plan shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. Plan shall obtain the prior written approval of GCHP before furnishing such notice, as GCHP must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or Plan decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with Plan, but the rest of the group continues its contract with Plan, then Plan shall allow Members to have continued access to that Provider under the following circumstances:

6.5.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.5.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.6 CCS SERVICES --- Plan and GCHP shall be responsible for identifying children with qualifying medical and surgical conditions, giving prompt, appropriate, notice to each other of potential CCS referrals, and coordinating appropriate referrals of children to CCS for CCS eligible conditions as defined in Title 22, CCR Section 41800. Plan shall continue to provide all Medically Necessary Covered Services and Case Management Services, until eligibility for the CCS program is established by CCS. Once eligibility has been established, Plan shall continue to provide all Primary Care Services and Medically Necessary Covered Services unrelated to the CCS eligible condition and shall ensure coordination of services between PCPs, the CCS specialty providers and the local CCS Program.

6.6.1 Non-Emergency Services for problems related to the qualifying CCS condition for CCS eligible children shall be authorized by CCS prior to the time service is provided. Requests for authorization of an emergency hospital admission shall be referred to CCS on the day of admission or the following business day. Plan shall require that Providers seek authorization from CCS as appropriate. Plan shall provide and pay for all Medically Necessary Covered Services for children with a known CCS condition until CCS authorizes the care for that condition. Plan shall make Members aware of potential eligibility for CCS. Plan shall attempt to obtain authorization from CCS for all CCS eligible services. Plan shall not delay providing Covered Services awaiting CCS authorization.

6.7 CREDENTIALING REQUIREMENTS --- Plan acknowledges and agrees that GCHP has delegated credentialing and recredentialing obligations to Plan. Plan shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with GCHP Policies and in accordance with the delineation of responsibilities in Attachment J. Plan shall comply with all credentialing and recredentialing obligations as specified in this Agreement and GCHP Policies.

6.7.1 Plan shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.7.2 Plan shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet GCHP's Minimum Standards as specified in GCHP Policies. Plan shall ensure that any Participating Provider who is required to meet Minimum Standards, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. Plan shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.7.3 Plan shall provide to GCHP or have available for GCHP review upon request the following:

6.7.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.7.3.2 A signed attestation that all Participating Providers who are required to meet GCHP Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished

to Members meet GCHP's Minimum Standards as specified in GCHP Policies.

6.7.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by GCHP.

6.7.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of Facility site review (if applicable) and decision date.

6.7.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8 BOARD CERTIFICATION --- --- Plan shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in GCHP Policy regarding board certification.

6.8.1 Plan shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. Plan shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.2 Plan acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any Physician Group and/or other organization or entity that contracts with Plan to furnish Covered Services to Members.

6.9 FACILITY SITE/MEDICAL RECORDS REVIEW (FSR/MRR) --- Plan shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. Plan shall comply with GCHP Policies related to PCP site reviews including those addressing collaborative programs.

6.10 COORDINATION AND CONTINUATION OF CARE --- Plan shall have systems in place to ensure managed patient care, including at a minimum:

6.10.1 Management and integration of health care, including Covered Services, through a PCP.

6.10.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.10.3 Plan shall clearly specify referral requirements to Participating Providers and Subcontractors and keep copies of referrals (approved and denied) in a central file and in the Members' Medical Records.

6.10.4 Plan shall have a Utilization Management Program that meets guidelines as set forth in GCHP Policies and is in accordance with the delineation of responsibilities in Attachment J.

6.10.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.10.6 The provision of Case Management services as set forth in this Agreement, GCHP Policies and in coordination with GCHP's Case Management program.

6.10.7 Systems for the consideration and approval of standing referrals, in accordance with GCHP Policy.

6.10.8 Plan shall be responsible for coordinating care of certain services including:

6.10.8.1 Participating Providers providing CHDP Services shall document such services on the PM160 Information Only Form (PM160 INF). Participating Providers shall submit the PM160 INF to GCHP within thirty (30) calendar days following the month of service;

6.10.8.2 Participating Providers providing CHDP agree to coordinate with the Ventura County CHDP Program as set forth in the CHDP MOU;

6.10.8.3 Plan shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.10.8.4 Plan shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.10.8.5 Plan shall make referrals for perinatal Members to the PSS program pursuant to GCHP Policy;

6.10.8.6 Plan shall make referrals to the Regional Center of Ventura County (RCVC), as set forth in the RCVC MOU;

6.10.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent

recommendations of the AAP, as part of periodic health assessment;

6.10.8.8 Plan shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in GCHP Policy. Plan shall develop referral and prior authorization policies and procedures to implement the above requirements. Plan shall submit these policies to GCHP for review and approval;

6.10.8.9 Plan shall provide outpatient mental health services within the PCP's scope of practice. Plan shall refer Members requiring inpatient mental health services to the Ventura County Health Care Agency (HCA) Mental Health Services. Plan shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient Facility. This assessment shall be performed by a Facility Physician or by the Member's PCP. Plan shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services;

6.10.8.10 For outpatient Specialty Mental Health Services, Plan shall refer Members to the Administrative Service Organization (ASO) contracted by Ventura County to provide assessment, referral and authorization services for Specialty Mental Health Services. Plan shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. GCHP shall retain financial responsibility for certain mental health psychotherapeutic drugs. Plan shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Plan shall comply with all responsibilities, policies and procedures as set forth in the HCA MOU; and

6.11 Plan shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Drug Medi-Cal or Short-Doyle alcohol and drug treatment programs. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.VACCINES --- Plan shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine

immunizations are provided to Members consistent with Plan's immunization policy. GCHP shall not reimburse Plan for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to GCHP Policies.

6.12 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the GCHP Approved Drug List and its associated drug utilization and Disease Management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by GCHP. The prescribing Physician shall be responsible for obtaining authorization through the GCHP Pharmacy Authorization. The prescribing Physician shall provide GCHP all information necessary to process Medi-Cal point of sale authorization system (CPAS) requests.

6.12.1 Plan may be subject to sanctions for Participating Provider's failure to comply with the CPAS process.

6.12.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.13 RESEARCH --- Plan agrees to participate in and make data available for research projects initiated or approved by GCHP.

6.14 ADVANCE DIRECTIVES --- Plan shall maintain written policies and procedures related to Advanced Directives in compliance with current State law, including, but not limited to, Title 42 CFR Sections 422.128 and 438.6(i) and California Probate Code Sections 4673 to 4678 and Sections 4800 to 4806, and applicable regulations. Plan shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.15 SECOND OPINIONS --- Plan shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by GCHP Policies.

6.16 DISEASE MANAGEMENT --- Plan shall assist GCHP in implementation of a Disease Management program in accordance with the delineation of responsibilities in Attachment J.

6.17 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- Plan shall identify, assess and implement care plans as appropriate for Members with special health care needs. The Plan shall have processes for monitoring and tracking Members with special health care needs and the provision of services under the implemented plan of care.

6.18 MEMBER VISITS --- Plan shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Plan shall include the requirement of this section in its Subcontracts with such health facilities.

6.19 DHCS DIRECTIONS --- If required by GCHP and/or DHCS, Plan and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from GCHP and/or DHCS.

Section 7- Obligations of Plan: Reporting

7.1 DATA REPORTING REQUIREMENTS --- Plan shall comply with the data reporting requirements set forth in this Agreement, including but not limited to the requirements specified in Standard Reporting Requirements set forth in Attachment D. Plan shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by GCHP Policies. This provision shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

7.2 ENCOUNTER REPORTING --- Plan shall submit Encounter data pursuant to standards defined by GCHP Policies. As set forth in Sections 3.5.6 and 12.2, Plan shall be subject to financial penalties and/or sanctions if GCHP determines that Plan is reporting to GCHP less than all professional Encounters in the GCHP required format and timelines. Financial penalties or sanctions shall be assessed upon Plan should GCHP determine that Plan is not meeting the standards as defined in GCHP Policies. This provision shall survive the expiration or termination of this Agreement, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Agreement prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Plan shall ensure that an annual audit is performed according to Welfare and Institutions Code Section 14459.

7.3.1 Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Plan separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Plan shall have separate certified Financial Statements prepared for each entity. The independent accountant shall state in writing reasons for not preparing combined Financial Statements.

7.3.2 Plan shall provide supplemental schedules that clearly reflect all inter entity transactions and eliminations necessary to enable GCHP to analyze the overall financial status of the entire health care delivery system.

7.3.3 In addition to annual certified Financial Statements, Plan shall complete the Plan's State Department of Managed Health Care (DMHC) required financial reporting forms. The Certified Public Accountant's audited financial statements and the DMHC required financial reporting forms shall be submitted to GCHP no later than 120 calendar days after the close of Plan's Fiscal Year.

7.3.4 Plan shall submit to GCHP within 45 calendar days after the close of Plan's fiscal quarter, quarterly financial reports. The required quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

7.3.4.1 Jurat.

7.3.4.2 Report 1A and 1B: balance sheet.

7.3.4.3 Statement of cash flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95. (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

7.3.4.4 Report 4: enrollment and utilization table.

7.3.4.5 Schedule F: unpaid claims analysis.

7.3.4.6 Appropriate footnote disclosures in accordance with GAAP.

7.3.4.7 Schedule H: aging of all claims.

7.3.5 Plan shall authorize its independent accountant to allow GCHP designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.

7.3.6 Plan shall submit to GCHP all financial reports relevant to affiliates.

7.3.7 Plan shall submit to GCHP copies of any financial reports submitted to other public or private organizations if such reports differ in content from any financial report already submitted to GCHP.

7.3.8 Plan shall submit to GCHP, within 45 calendar days after the close of the Plan's fiscal quarter, a statement of revenues, expenses, and net worth including only Medi-Cal revenues and expenses using the reporting forms required by DMHC.

7.3.9 Plan shall submit to GCHP, no later than June 30th of each Contract Year, projected revenues, expenses and net worth for each quarter of the following State Fiscal Year. The submission must include a detailed explanation of the assumptions used to develop the financial forecasts.

7.4 FINANCIAL REPORTING --- Plan shall file monthly financial statements with GCHP. Plan shall prepare financial information requested in accordance with GAAP. Financial statements and projections must be prepared in accordance with requirements applicable to Plan. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Plan and/or Subcontractors shall submit financial information consistent with filing requirements of the DMHC or DHCS unless otherwise specified by GCHP. Plan shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the DMHC required financial reporting format.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- Plan shall report in compliance with GCHP Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting Plan's provider network.

7.6 PHYSICIAN ORGANIZATION PROFILE --- Plan shall report in compliance with GCHP Policies, a profile of the Plan and Plan's organization, including, but not limited to, Plan and Plan's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- Plan shall provide to GCHP copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Plan, Plan shall provide GCHP with copies of current contract templates. In addition, upon request from GCHP or DHCS, Plan shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Plan's obligations under this Agreement.

7.8 DISCLOSURE --- Subcontracts entered into by the Plan and all information received in accordance with this subparagraph will be public records on file with GCHP and/or DHCS, except as specifically exempted in statute. Plan, and any Subcontractors shall make available to GCHP, GCHP's authorized agents, and appropriate representatives of the State and federal government any of Plan's or Subcontractor's records related to Plan's capacity to perform this Agreement, to include the ability to bear the risk of potential financial losses, or the Covered Services performed and amounts paid or payable under this Agreement. GCHP and/or DHCS shall ensure the confidentiality of information and contractual provisions to the extent they are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Plan, or any of its officers, employees, agents,

or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, Plan shall report said unauthorized disclosure to GCHP immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Plan had reasonable control to avoid the disclosure.

Section 8- Obligations of Plan: Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Agreement, it is understood and agreed that Plan shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Plan at the time of such termination, until the services being rendered to Members are completed, unless GCHP, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Plan received Capitation Payment and termination occurred, Plan shall be paid according to the Medi-Cal Fee Schedule, as defined in GCHP Policy applicable to such services in effect on the date the services is provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Agreement, including termination due to termination or expiration of GCHP's State Contract, and upon request by DHCS or GCHP to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Plan shall make available to DHCS and/or GCHP copies of any pertinent information, including information maintained by any Subcontractor necessary for efficient care management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and GCHP, as applicable.

8.3 TERMINATION PLANS --- Plan shall have a plan for the orderly termination of services under this Agreement. Plan shall submit a plan regarding coordination of care and payment of claims to GCHP at least 60 days prior to expiration or termination of this Agreement. The termination plan shall be in accordance with GCHP Policy, and shall require the written approval of GCHP.

8.4 NOTICE TO DHCS --- GCHP and Plan agreed to notify the State, in the event this Agreement is amended or terminated. Notice is considered given when properly addressed to the Contracting Officer and deposited in the United States Postal Service as first-class registered mail, postage attached.

Section 9- Obligations of GCHP - Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by GCHP by multiplying the Capitation Rate set forth in Attachment F, by the number of Members enrolled with Plan, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - GCHP agrees to pay Capitation Payment to Plan on or about the fifteenth (15th) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Plan.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates paid by GCHP to the Plan may be adjusted through a Capitation Rate reduction by GCHP during the Contract Year to reflect implementation of State or federal laws or regulations; changes in the State budget, the State Contract or DHCS policy; implementation of a DHCS rate reduction applied by DHCS to GCHP's rates or through application of law (for example, a provider rate reduction); any holdbacks, sometimes referred to as "claw backs," taken by the State; and/or changes in Covered Services. If the State has provided GCHP with advance notice of the reduction, GCHP shall provide notice thereof to Plan as soon as practicable. Subject to Attachment L, Capitation Rates may also be reduced in the event of de-delegation of any function delegated under this Agreement. In the event the Plan's Capitation Rates have been reduced by GCHP due to a holdback by the State (pursuant to AB 97,or otherwise), GCHP shall promptly notify the Plan when the holdback is released, refunded, or otherwise paid to GCHP, and GCHP shall release, refund, or otherwise pay the Plan a proportional amount based upon the Plan's previously reduced Capitation Rate not later than fifteen (15) business days after the holdback dollars are received from the State by GCHP.

9.3 FINANCIAL SECURITY REQUIREMENT --- Plan must establish and maintain, throughout the term of this Agreement, financial security reserves, in the form of irrevocable standby letters of credit, surety bonds naming GCHP as beneficiary, and/or other forms of financial instruments acceptable by GCHP equal to a minimum of one month Capitation Payment. In the event of Plan's insolvency or other broad and continuing failure to timely pay Providers for Covered Services rendered to Members assigned to Plan, the Plan will ensure the reserves are released to GCHP to enable GCHP to pay Providers for Covered Services rendered to Members assigned to Plan. A broad and continuing failure to timely pay Providers for Covered Services for purposes of this section shall mean that GCHP paid within a 90 day period, in accordance with Section 2.5.6, ten (10) or more Complete Claims for which the Plan should have paid $15,000 or more in the aggregate or two (2) or more Complete Claims for which the Plan should have paid $75,000 or more in the aggregate.

9.4 RECOUPMENT --- GCHP shall recoup payments made to Plan when DHCS has determined that an individual was not eligible for Medi-Cal services and retroactively terminates the individual, including, without limitation, recouping any

payments made for a deceased Member. GCHP may also recoup overpayments to Plan, as well as unpaid Conlan reimbursements owed by Plan to GCHP Members, including offsetting any such amounts owed against Plan's claims submissions, in accordance with GCHP Policies. With respect to the recoupment for deceased, ineligible, or disenrolled individuals or Administrative Members, GCHP shall make reasonable efforts to provide Plan with written notice on or before the recoupment that specifies the names and Member number, the reason for the recoupment, and the monthly capitation and other amounts being recouped for each such individual, and shall provide Plan with supporting documentation and consider Plan's objections upon request by Plan. For any other recoupment, GCHP shall give Plan at least ten (10) days prior written notice specifying the reasons for recoupment and how it was calculated or such other, if greater, notice that is required by law or by other provisions of this Agreement. This clause shall not be construed to limit GCHP's right to recoup payment made to Plan on any other basis for which recoupment is appropriate or Plan's right to contest any recoupment or otherwise receive payment of all sums owed to Plan by GCHP.

9.5 ADDITIONAL PAYMENT --- GCHP reserves the right to pay Providers or Plan additional sums in any manner that GCHP deems at its discretion to be beneficial for GCHP's Members.

9.6 FEE-FOR SERVICE PAYMENT --- All Covered Services that are not Covered Medical Services and subject to the Capitated Payment, are authorized by GCHP, and are provided by Plan, will be compensated by GCHP at the lesser of the lowest allowable Fee-For-Service Payment or the rate agreed to by GCHP and the Plan..

9.7 LIMITATION ON GCHP'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Agreement, GCHP's obligation to pay Plan any payment shall be subject to GCHP's receipt of funding from the State.

9.8 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to GCHP within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Plan.

Section 10- Obligations of GCHP: Administrative

10.1 FINANCIAL SECURITY WITHHOLD --- GCHP may withhold from Plan an amount equal to one month of the monthly Capitation Payment if Plan or its Guarantor fails to meet the Financial Security Requirement set forth in Section 9.3 of this Agreement (Financial Security Withhold). GCHP may reduce the Plan's Capitation Payment from time to time should the Financial Security Withhold fall below an amount equal to one month of the monthly Capitation Payment. GCHP may increase the Financial Security Withhold in accordance with GCHP's Policy. In the event of Plan's insolvency or other continuing failure to timely pay Providers for Covered Services rendered to Members assigned to Plan, GCHP may use the

Financial Security Withhold in whole, or part, to pay Providers for Covered Services rendered to Members assigned to Plan.

10.2 COMPREHENSIVE PHYSICIAN AUDIT --- GCHP shall conduct and Plan shall agree to a full comprehensive compliance audit to be conducted at Plan administrative offices and/or Facilities annually, or as deemed necessary, by GCHP.

10.2.1 GCHP shall submit results of the Plan audit in writing to Plan. Plan may rebut and dispute audit findings pursuant to GCHP's Policies. Plan is responsible for implementing the corrective measures (if any). GCHP retains the right to publish data obtained from the audit. Plan acknowledges and agrees that GCHP may publish the audit data to Members and/or the general public without further notice to or consent from Plan.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, GCHP shall conduct an Encounter audit. The audit shall consist of GCHP requesting a percentage of each Plan's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Plan accurately reported all Encounters.

10.4 APPROVED DRUG LIST --- GCHP shall publish and maintain an Approved Drug List pursuant to GCHP Policies. The procedure for the Plan to request or require changes in the list shall be set forth in the GCHP Pharmacy Benefits Management Operations Manual or in other GCHP Polices.

10.5 REVIEW OF OFF-APPROVED DRUG LIST PRESCRIPTIONS --- GCHP shall review off-Approved Drug List prescriptions in a timely manner pursuant to GCHP Policies.

10.6 POLICIES AND PROCEDURES AVAILABILITY--- GCHP shall provide or make available for Plan copies of current GCHP Policies relevant to the provisions of this Agreement. Copies of current GCHP Policies relevant to the provisions of this Agreement may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the GCHP website.

10.7 MOU AVAILABILITY--- GCHP shall provide or make available for Plan copies of current MOUs entered into by GCHP that are binding on Plan. Copies of current MOUs entered into by GCHP that are binding on Plan may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the GCHP website.

10.8 INTERPRETATION OF MOUs --- GCHP shall provide or make available for Plan interpretation of MOUs entered into by GCHP that are binding on Plan. Interpretation of MOUs will identify duties, obligation and responsibilities of Plan.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Plan acknowledges and agrees that GCHP may release to Providers, Members and others without further notice to Plan, information and data relating to the performance of

Plan and its Network that GCHP determines, among other things, would contribute to Providers', Members', and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- GCHP has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Agreement, as provided in GCHP Policy. In the event that a time-frame or content requirement as to any complaint, grievance, appeal or other dispute set forth in this Agreement conflicts with a similar requirement in GCHP Policy, the requirements of this Agreement shall take precedence.

10.11 RISK ARRANGEMENTS DISCLOSURE --- GCHP shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 FINANCIAL RISK DISCLOSURE - On or before the effective date of any legislative or DHCS change in the definition of Covered Services or a reduction in the rates or other payments to GCHP under the State Contract that may materially affect either the Capitation Rate or the capitated or other delegated responsibilities under this Agreement, or if possible, at least thirty (30) days before such effective date GCHP shall disclose to Plan the factors that may change the Plan's Capitation Rate and/or financial risk assumed under the Agreement by providing to Plan the following information: a description of the changes in Covered Services, Capitation Rates, and other material factors affecting Plan's delegated responsibilities and the effective date of such change, if the factors and information is made available by the State to GCHP.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS - On the Agreement anniversary date each year, GCHP shall disclose to Plan the amount of Capitation Payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL - GCHP shall provide to Plan sufficient details to allow Plan to verify the accuracy and appropriateness of any deductions from capitation payments made by GCHP including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

Section 11- Obligations of GCHP: Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- GCHP shall approve all Plan, Member and Provider communications relating to termination of this Agreement, prior to distribution.

11.2 APPROVAL OF HEALTH NETWORK TERMINATION PLANS --- GCHP shall review and approve Plan termination plans at intervals and frequencies established by GCHP Policies.

11.3 RELEASE OF CAPITATION WITHHOLD --- GCHP shall release, to Plan, the capitation withhold, if there has been any, under Section 3.5.6 (Paid Claims and Encounter data), with the Plan's Capitation Payment due in the month following the date GCHP determines that the Plan has provided substantially all of the missing or incomplete data, or if this Agreement has terminated, not more than three (3)months following the date GCHP determines that the Plan has provided substantially all of the missing or incomplete data.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- GCHP shall release the Plan from its obligation to maintain the financial security requirement deposits, as described in Section 9.3, no less than twelve (12) months following the termination of this Agreement unless termination is the result of Plan insolvency. GCHP shall release the Plan from its obligation to maintain the financial security requirement deposits no less than eighteen (18) months following the termination of this Agreement if termination is the result of Plan insolvency.

11.5 RELEASE OF FINANCIAL SECURITY WITHHOLD --- GCHP shall release to Plan the remainder of the Financial Security Withhold, under Section 10.1, if any, no less than twelve (12) months following the termination of this Agreement unless termination is the result of Plan insolvency. GCHP shall release the remainder of the Financial Security Withhold, under Section 10.1, if any, no less than eighteen (18) months following the termination of this Agreement if termination is the result of Plan insolvency.

Section 12- Term, Termination and Modification of Contract Terms

12.1 TERM OF AGREEMENT --- This Agreement shall be effective on the date mutually agreed upon by the parties in writing following issuance of the Plan's Knox-Keene Act License by the Department of Managed Health Care, approval of GCHP's template plan-to-plan contract ("Template Contract") by DHCS, and conformance of this Agreement to the DHCS approved Template Contract ("Effective Date"), and approval of the Agreement by the VCMMC Commission. This Agreement shall have an initial term of two (2) years, commencing on the Effective Date, and it shall automatically renew for successive terms of two (2) years, unless earlier terminated in accordance with its terms, including but not limited to Sections 12.2 through 12.18, below.

12.2 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Plan fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Plan by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Agreement; (iv) engaging in prohibited marketing activities; (v) failing to comply with GCHP's Compliance Program, including participation status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Agreement; (viii) failure to ensure that all Minimum Standards, are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to GCHP Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Plan's Participating Providers to comply with Medi-Cal point of sale authorization system (CPAS) and other pharmacy requirements, if any, as determined by GCHP; (xii) failure to meet medical loss ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements; (xvi) failure to submit Encounter data pursuant to this Agreement and GCHP Policy; (xvii) a failure to perform an obligation or duty under the prior contract, if any, and/or failure to take corrective action related to any such obligation or duty in the time or manner required by GCHP, and (xviii) a violation of the Department of Managed Health Care's Risk Bearing Organization or other Knox-Keene Act finanical regulations, including reporting, auditing or corrective action plan compliance violations. GCHP may take any of the actions described below:

12.2.1 Corrective Action Plan (CAP) - GCHP may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Plan or any Subcontractor(s) is not in compliance with any provision of this Agreement. A CAP shall be required if GCHP receives a substantiated complaint or grievance related to the standard of care provided by the Plan or any Subcontractors. GCHP shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by GCHP, which may be approved as submitted, accepted with specific modifications, or rejected. GCHP may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

12.2.2 General Sanctions - Notwithstanding any request for a CAP, GCHP may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Plan is not in compliance with the provisions of this Agreement, GCHP Policies and minimum

performance requirements as established by GCHP. Such sanctions may only be imposed after the Plan has been afforded, at a minimum, the notice, written findings, and other rights set forth in 42 CFR Section 438.700.

12.2.2.1 All monetary fines are payable to GCHP within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to GCHP for any monetary fines within the thirty (30) calendar day period shall result in GCHP deducting the penalty plus the administrative fee from the Plan's Capitation Payment.

12.2.2.2 Plan may appeal GCHP's decision to impose a sanction, by filing a complaint pursuant to GCHP Policies. Plan shall exhaust this administrative remedy, including requesting a hearing according to GCHP Policy, before commencing a civil action.

12.2.3 Termination for Cause - Notwithstanding, and in addition to, any other provisions of this Agreement, GCHP may terminate this Agreement for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 12.2. If the breach is capable of being cured by the Plan, Plan shall be allowed not less than thirty (30) days' notice and opportunity to cure. If it accomplishes the cure within that time period or such other longer, if any, time period set forth in GCHP's notice, the notice of termination shall be of no effect. Plan may appeal GCHP's decision to terminate the Contract for cause by filing a complaint pursuant to GCHP Policies. Plan shall exhaust all administrative remedies before commencing any civil action.

12.2.3.1 In the event of a "Termination for Cause" as provided by this Section, GCHP may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. Plan shall be liable to GCHP for any excess costs for the provision of such similar supplies or services, for a maximum of 120 days from the date notice of termination was given. In addition, Plan shall be liable to GCHP for administrative costs or other damages incurred by GCHP in procuring such similar supplies or services, and GCHP shall also charge an administrative fee when paying a claim on behalf of Plan.

12.2.3.2 GCHP's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

12.3 TERMINATION FOR INSUFFICIENT GCHP MEDI-CAL ENROLLMENT --- GCHP reserves the right in accordance with GCHP's Policies to terminate the Plan in

the event that membership in the Plan under this Agreement falls below five-thousand (5,000) total Members at any time based upon three (3) month rolling average of Plan's membership.

12.4 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- Subject to Section 12.2.3, above, GCHP may terminate this Agreement immediately should Plan fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by GCHP.

12.5 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- GCHP may terminate this Agreement with thirty (30) days written notice should Plan fail for two or more consecutive quarters to comply with or be in compliance with medical loss ratio requirements established in this Agreement, after having been given written notice by GCHP that it was not in compliance with those ratios for at least two (2) quarters.

12.6 TERMINATION OF STATE CONTRACT --- GCHP may terminate this Agreement immediately upon termination of the State Contract.

12.7 TERMINATION UPON LOSS OF WAIVER --- This Agreement shall terminate immediately upon written notice from GCHP to Plan that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act.

12.8 TERMINATION FOR PLAN ORGANIZATION AND OPERATIONS STRUCTURE --- GCHP may terminate this Agreement immediately should Plan fail to comply with requirements for Plan's organization and operation structure established in this Agreement.

12.9 TERMINATION OR SANCTION FOR TERMINATION OR SANCTION OF THE PLAN PARTNER --- This Agreement shall terminate upon the termination of the contract of the other party in the Plan, if any. Notification of termination to any party in the Plan shall constitute notification of termination to all parties in the Plan and Subcontractors. GCHP may apply sanctions pursuant to this Agreement and GCHP Policies to all parties in the Plan independent of the party in the Plan whose action(s) caused sanctions to be applied by GCHP.

12.10 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred twenty (120) calendar days advance written notice to the other party prior to the effective date of such termination.

12.11 TERMINATION FOR PLAN INSOLVENCY --- If Plan becomes insolvent, Plan shall immediately advise GCHP, and GCHP shall have the right to immediately terminate the Agreement. In the event of the filing of a petition for bankruptcy by or against Plan or a principal Subcontractor, Plan shall assure that all Plan's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. GCHP shall have the right to withhold any and all amounts otherwise due to Plan until Plan fully discharges its obligations under the Contract. GCHP shall

also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Plan obligations have been met.

12.12 TERMINATION BY PLAN FOR CAUSE --- Plan may terminate this Agreement for cause upon thirty (30) calendar days' prior written notice to GCHP. Cause shall mean GCHP's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to Plan under this Agreement. Termination shall be effective at the end of the thirty (30) calendar day notice period, unless GCHP pays to Plan any such past due payments. Cause shall also mean any other material breach of this Agreement by GCHP, provided, however, if the breach is capable of being cured by GCHP, GCHP shall be allowed not less than thirty (30) days' notice and opportunity to cure. If it accomplishes the cure within that time period, or such longer time period, if any as is stated in the notice given by Plan, the notice of termination shall be of no effect.

12.13 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW --- GCHP reserves the right to modify or terminate the Agreement at any time when modifications or terminations are mandated by changes in federal and State laws, or as required under the State Contract and by changes in any requirements and conditions with which GCHP shall comply pursuant to the federally-approved waiver. This Agreement and any amendments hereto shall only be effective upon approval of DHCS, in necessary. GCHP shall notify DHCS of any amendments to this Agreement, if required.

12.14 MODIFICATION OF TERMS BY FINANCIAL AND CONTRACT INTERPRETATION BULLETINS --- GCHP reserves the right to issue periodic "Financial Bulletins" and "Contract Interpretation Bulletins" to Plan as necessary. These Bulletins shall interpret Agreement language, and shall not modify existing, or establish new, obligations and requirements upon Plan. Plan shall abide by and comply with these Bulletins.

12.15 PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN --- GCHP may establish key performance measures of Plan to set minimum contract performance thresholds and/or pay financial incentives to Health Network and Plan Groups. GCHP may take the following actions, at its sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Plan, terminate this Agreement, and establish Capitation Rates and other payments to Plan.

12.16 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Plan agrees as follows:

12.16.1 GCHP reserves the right to require Plan, upon notification from GCHP, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when GCHP deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Agreement.

12.16.2 GCHP requires that Plan Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable GCHP Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. GCHP may also require that Plan terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in GCHP Direct whether based on a credentialing, recredentialing and/or peer review decision.

12.17 TERMINATION FOR FAILURE TO MEET PERFORMANCE MEASURE REQUIREMENTS --- GCHP may terminate this Agreement pursuant to Section 12.2.3 in the event Plan fails to comply with or fails to be in compliance with performance requirements as established in the performance measure program.

12.18 NOTICE OF NON-RENEWAL --- In order for GCHP to facilitate Member transition to other health networks or Provider groups, Plan shall provide GCHP with an advance notice of non-renewal of the Agreement in accordance with Section 13.18 prior to the end date of the Agreement term in the event Plan elects not to participate in any extension period or new Agreement term.

Section 13- Miscellaneous

13.1 INTERPRETATION OF CONTRACT LANGUAGE --- This Agreement shall be interpreted in accordance with applicable law, including but not limited to the laws administered by the DHCS, the DMHC, and CMS.

13.2 INDEMNIFICATION --- Each party to this Agreement agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicted shall have occurred prior to the effective date of termination or completion.

13.3 INDEPENDENT CAPACITY OF PLAN --- GCHP and Plan agree that Plan and any agents or employees of Plan, in performance of this Agreement, shall act in an independent capacity, and not as officers or employees of GCHP.

13.4 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

13.5 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Agreement which such party believes is essential to the successful performance of this Agreement, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Agreement.

13.6 CHOICE OF LAW --- This Agreement shall be governed by the laws of the State of California. Plan shall be required to bring all legal proceedings against GCHP in State courts located in Ventura County, California. The State Contract shall be the guiding and controlling document when interpreting the terms of the Agreement.

13.7 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Agreement shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

13.8 SEVERABILITY --- If any provision of this Agreement is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Agreement shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

13.9 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

13.10 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

13.11 ASSIGNABILITY --- Except as specifically permitted hereunder, this Agreement is not assignable by the Plan, either in whole or in part, without the prior written consent of GCHP and DHCS, provided that GCHP's consent may be withheld in its discretion. For purposes of this Section and this Agreement, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Plan (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Plan (iii) the merger, reorganization, or consolidation of Plan with another entity with respect to which Plan is not the surviving entity; and/or (iv) a change in the management of Plan from management by persons appointed, elected or otherwise selected by the governing body of Plan (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

13.12 NO LIABILITY OF COUNTY OF VENTURA --- As required under Ordinance No. 4409, of the County of Ventura, State of California, GCHP and the Plan hereby acknowledge and agree that the obligations of GCHP under this Agreement are solely the obligations of GCHP. The County of Ventura, State of California, shall have no obligation or liability therefor.

13.13 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Agreement as Attachment E, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

13.14 DEBARMENT CERTIFICATION --- By signing this Agreement, the Plan agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

13.14.1 By signing this Agreement, the Plan certifies to the best of its knowledge and belief, that it and its principals:

13.14.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

13.14.1.2 Have not within a three-year period preceding this Agreement have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

13.14.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision 13.14.1.2 herein; and

13.14.1.4 Have not within a three-year period preceding this Agreement had one or more public transactions (federal, State or local) terminated for cause or default.

13.14.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

13.14.1.6 Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions and Subcontracts.

13.14.2 If the Plan is unable to certify to any of the statements in this certification, the Plan shall submit an explanation to GCHP.

13.14.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

13.14.4 If the Plan violates this certification, in addition to other remedies available to the federal Government, GCHP may immediately terminate this Agreement.

13.15 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Agreement, Plan certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Plan further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

13.16 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Plan agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

13.17 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION ---

13.17.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

13.17.2 Certification and Disclosure Requirements

13.17.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit 1, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.17.3 of this provision.

13.17.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

13.17.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 13.17.2.2 herein. An event that materially affects the accuracy of the information reported includes:

13.7.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

13.7.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

13.7.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

13.17.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 13.17.2.1 of this provision a

contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

13.17.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by GCHP. GCHP shall forward all disclosure forms to DHCS program contract manager.

13.17.3 Prohibition-Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

13.18 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, on the date of delivery if sent by Federal Express or other recognized overnight delivery service, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth on page one of this Agreement or such other address provided by notice.

13.19 INCORPORATION OF STATE CONTRACT PROVISIONS. --- The State Contract is incorporated in this Agreement by this reference, including those provisions cited in this Agreement as "State Contract Exhibit," and was received by Plan as acknowledged in Attachment M.

13.20 DUPLICATE ORIGINALS --- This Agreement may be executed in any number of counterpart copies, all of which shall constitute one and the same Agreement and each of which shall constitute an original, and shall become effective upon execution and delivery to GCHP and Plan.

ATTACHMENT A

FINANCIAL RESPONSIBILITY MATRIX FOR COVERED MEDICAL SERVICES

The purpose of the Matrix of Financial Responsibility is to identify how GCHP has allocated to the Plan components of the medical costs associated with the provision of Covered Services. That is, the Capitation Rates in this Agreement are based upon the Plan being financially responsible for the provision of Covered Services as indicated in this Matrix and as defined in Plan Provides.

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Abortions 0-12 weeks:				
Professional	Yes			
Facility	Yes			
Abortions 13+ weeks:				
Professional	Yes			
Facility	Yes			
Acupuncture	No			Not a covered benefit
Adult Day Healthcare Services	No			Not a covered benefit
AIDS/HIV:				
Professional	Yes			
Facility	Yes			
Allergy:				
Testing	Yes			
Serum	Yes			
Ambulance:				
In-Area Emergency (Ventura County)	Yes			
Out-of Ventura County (OOA) Emergency	Yes			
Non-Emergency Medical Transportation	Yes			
Anesthesiologist/Nurse Anesthetist:				
Professional - Outpatient	Yes			
Professional – Inpatient	Yes			
Audiology:				

[1] If GCHP's obligation with respect to any of the Covered Services Plan is to provide is limited, for example, to a maximum number of days of certain types of at-home or inpatient care, then Plan's obligation has the same limitation. Any GCHP obligation under the State Contract in place as of the Effective Date of this Agreement with respect to any Medi-Cal covered service/procedure, including those labeled in this Matrix as "Carve out," shall be Plan's obligation for Members assigned by GCHP to Plan.

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Screening and Exam	Yes			
Behavioral Health				
Professional – Outpatient	Yes			Carve out
Professional - Inpatient	Yes			Carve out
Facility - Outpatient	Yes			Carve out
Facility - Inpatient	Yes			Carve out
Blood or Blood Products:				
Autologous Blood Donation	Yes			
Storage	No			Not a Medi-Cal benefit
California Children's Services (CCS)	Yes			Carve out
Cardiac Rehab (CORF and CARF):				
Outpatient – Professional and Facility	Yes			
Chemical Dependency Detox Inpatient	Yes			Carve out
Chemical Dependency Treatment – Outpatient	Yes			Carve out
Chemotherapy - Outpatient:				
Professional	Yes			
Medications	Yes			See Medication – Specialty Outpatient
Chemotherapy - Inpatient:				
Professional	Yes			
Facility	Yes			
Child Health and Disability Prevention	Yes			
Chiropractic Medicine:	Yes			Carve out
Circumcision - Medically Indicated:				
Professional	Yes			
Facility	Yes			
Dental Services:				
Elective	Yes			Carve out
Emergent – Trauma to natural teeth	Yes			Carve out
Anesthesiologist	Yes			If prior authorized as Medically Necessary and not elective
Facility	Yes			If prior authorized as Medically Necessary and not elective

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Diabetic Supplies – glucometer , test strips and lancets per Plan Formulary Medical Supplies (Attachment C)	Yes			
Dialysis, including hemodialysis, peritoneal and other				
Dialysis - Outpatient:				
O/P Professional and Facility	Yes			
O/P Medications	Yes			See Medication – Specialty Outpatient
Dialysis - Inpatient:				
I/P Facility	Yes			
I/P Professional	Yes			
Durable Medical Equipment:				
Outpatient	Yes			
Inpatient	Yes			
Emergency Services - Out of Ventura County				
Facility	Yes			
Attending Physician	Yes			
Anesthesiologist	Yes			
Pathology	Yes			
Radiology	Yes			
Consults	Yes			
Interpretations	Yes			
Emergency Services – In Ventura County:				
Facility	Yes			
Attending Physician	Yes			
Pathology	Yes			
Radiologist	Yes			
Consults	Yes			
Interpretations	Yes			
Employment Ins. Court ordered Physical	No			Not a covered benefit
Endoscopic Studies:				
Office procedure	Yes			
Professional	Yes			
Facility	Yes			
Experimental Procedures	No			Not a covered benefit

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Family Planning:				
Oral/Topical Contraceptives	Yes			
All Other Contraceptives	Yes			
Genetic Counseling	Yes			
Health Education – Non CPSP	Yes			
Hearing Aid Device	Yes			Carve Out
Home Health:				
Professional Services	Yes			
Infusion Therapy (including IV Antibiotics, TPN/PPN)	Yes			
Hospice Care – In Home	Yes			
Hospice Care – Facility-Based:				
Professional Services	Yes			
Facility	Yes			
Immunizations:				
Pediatric	Yes			
Adult	Yes			See Medication - Specialty Outpatient pharmaceuticals
Work/travel immunizations	No			Not a covered benefit
Infant Special Formula	Yes			
Infertility Services	No			Not a covered benefit
Inpatient Services:				
Facility	Yes			
Attending Physician	Yes			
Anesthesiologist	Yes			
Pathologist	Yes			
Radiologist	Yes			
Consults	Yes			
Interpretations	Yes			
Laboratory Services - Outpatient	Yes			
Lithotripsy:	Yes			
Professional	Yes			
Facility	Yes			
Long-Term Care - Inpatient	Yes			
Medical Supplies – Outpatient, Disposable	Yes			

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Medication – Specialty Outpatient:				
Injections/infusion – Professional (admin.)	Yes			
Injectable chemotherapeutic medications and injectable adjunct pharmaceutical therapies for side effects	Yes			
Injectable medications or blood products used for hemophilia-Admin. Only	Yes			
Injectable medications related to transplant services – Admin. Only	Yes			
Adult vaccines – Admin Only	Yes			
Self-Injectable medications (excluding insulin) – admin. only	Yes			
Pediatric Vaccines – admin. only	Yes			Cost of pediatric vaccines reimbursed to Physicians and clinics under state and federal programs
Other injectables administered in office under $250/dose	Yes			
Other injectables administered in office over $250/dose	Yes			
Medication (outpatient) (i.e. oral, topical medications dispensed by retail pharmacy)	Yes			
Mental Health: Medical History and Physical (H&P)	Yes			
Neonatology	Yes			
Nuclear Medicine:	Yes			
O/P Professional	Yes			
O/P Facility	Yes			
I/P Professional	Yes			
I/P Facility	Yes			
Radiopharmaceuticals	Yes			
Nutritional Counseling	Yes			
Obstetrical Services:				
California Comprehensive Perinatal Services Program (CPSP)	Yes			Carve Out
Alfa Fetal Protein (State Program)	Yes			Carve Out

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Amniocentesis	Yes			
Ultrasound – Outpatient	Yes			
Fetal Monitoring - Outpatient	Yes			
Fetal Monitoring-Professional	Yes			
Prenatal Care	Yes			
Postpartum Care	Yes			
I/P Facility	Yes			
Office Visits - All Specialties:				
Professional	Yes			
Supplies	Yes			
Optometry/Vision Care:				
Screening	Yes			Carve Out
Lenses	Yes			
Frames	Yes			
Dispense Fee – Lenses and frames	Yes			
Refractions	Yes			
Contact lenses – Medically Necessary	Yes			
Orthotics	Yes			
Ostomy Supplies	Yes			
Outpatient Diagnostic Services:	Yes			
Angiograms – Professional				
CT Scans – Professional				
2D Echo – Professional				
EEG – Professional				
EKG – Professional				
Mammography – Professional				
MRI – Professional				
PET Scans – Professional				
Thallium & Adenosine – Professional				
Ultrasound – Professional				
X-Ray – Professional				
Outpatient Surgery:	Yes			
Professional				
Facility				
Pathology (Clinical/Anatomical):	Yes			
All Outpatient				
I/P Professional				
Perinatology	Yes			

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Prayer and Spiritual Healing	No			Not a Medi-Cal benefit
Prosthetic Devices:				
Surgically Implanted	Yes			
Non-Surgically Implanted	Yes			
Radiation Therapy				
I/P Professional	Yes			
O/P Professional	Yes			
Reconstructive Surgery for the following conditions only:				
a. Due to accidental injury or to improve the function of a malformed body part b. Reconstructive Breast surgery is covered for mastectomy and to produce a symmetrical appearance				
Professional	Yes			
Facility	Yes			
Rehabilitation – (PT, ST, OT)				
Outpatient – Professional and Facility	Yes			
Skilled Nursing Facility/Sub-Acute Care(Up to 62 days):	Yes			
Specialty Care (Within Medical Group's Contracted Network)	Yes			
Specialty Care (Outside Medical Group's Contracted Network - Non-Emergent, Non-Complex Case)	Yes			
Sterilization (Tubal Ligation/Vasectomy):				
Professional	Yes			
Inpatient Facility	Yes			
Transfusion Services:				
Outpatient	Yes			
Inpatient	Yes			
Transplant – other than Kidney:				
Professional	Yes			
Facility	Yes			
Transplant – Kidney	Yes			

Service/Procedure	Medi-Cal Covered	GCHP-Covered	Plan Provides	Comments [1]
Urgent Care (Free Standing)				
In-Area	Yes			
Out of Ventura County	Yes			

ATTACHMENT B

DISCLOSURE FORM
(Welfare and Institutions Code Section 14452)

_____
Name of Provider

The undersigned hereby certifies that the following information regarding _____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than ten percent (10%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

_____

_____

Dated:_____ Signature:_____

Name:_____
(Please type or print)

Title:_____
(Please type or print)

Attachment C

Formulary Medical Supplies

The following medical supply items are provided through GCHP's pharmacy network:

	Item	Limitation
Respiratory Items		
	Inhaler Assist Devices	1/Year
	Nasal Aspirator	1/Year
	Peak Flow Meters, Non-Electric	1/Year
Contraceptive Items		
	Condoms	1 Box of 12/Month
	Diaphragms	1/Year
Diabetic Supplies		
	Blood Glucose Monitors	1 Every 3 Years
	Insulin Syringes	100/Month
	Lancets	100/Month
	Lancet Auto Injectors	2/Year
	Blood Glucose Test Strips	100/Month
	Urine Test Strips	100/Month
	Alcohol Pads	200/Month

ATTACHMENT D

Standard Reporting Requirements

Reports for Submission to GCHP	Submission Frequency
Quality Improvement Reports	
Credentialing Report	Monthly
QI Work Plan (ICE)	Annually
QI Program	Annually
QI Report (ICE)	Semi-Annual
QI Program Evaluation	Annually
QI/UM Policies and Procedures	Annually
Care Coordination Reports	
Case Management Census	Quarterly
Case Management Program Description	Annually
Organ Transplant List of New Members (Kaiser only)	Monthly
Organ Transplant Report (Kaiser only)	Monthly
PSS Birth Outcomes Data	Quarterly
UM Work Plan (ICE)	Annually
UM Denial Letters	Monthly
UM Denial Log	Monthly
UM Program	Annually
UM Program Evaluation	Annually
UM Quarterly Report (ICE)	Quarterly
Financial and Claims Reports	
Audited Financial Statements	Annually
GCHP Medical Loss Ratio (MLR) Report	Interim
GCHP Medical Loss Ratio (MLR) Report	Annually
Claims Third Party Liability/Other Health Coverage Reporting	Monthly
Claims Timeliness Reports	Monthly
Reinsurance Activity Report	Monthly
Risk Bearing Organization Report (RBO) Financial Survey Reports (Physician)	Quarterly
Risk Bearing Organization Report (RBO) Financial Survey Reports (Physician)	Annually
Risk Pool Settlement Calculations	Interim
Risk Pool Settlement Calculations	Annually
Risk Pool Agreements	Annually
Total Business Reports (Financial Statements) (Hospital/Physician report separately)	Quarterly
Other Reports	
Delegation and Subcontracting of Administrative Services	Annually
Provider Complaint Report	Quarterly
Participating Provider Contracts	Monthly
PCP Upload	Semi-Monthly
Encounter Data Files (Professional and Facility)	Monthly

Reports to Retain for On-Site Audit and to be Provided to GCHP Upon Request	
Cultural and Linguistic Services Status Report Staying Healthy Assessment Provider Training Report Organization Structure Report Provider Network Profile	For these reports, routine submission is not required. Reports should be available for auditing and if requested by GCHP, shall be submitted by the Health Network within 72 hours.

ATTACHMENT E

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and GCHP, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by GCHP.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT F

Capitation Rates
July 1, 2011 through June 30, 2012

Payments by GCHP to Plan for providing or arranging for Covered Services for Plan Members in accordance with the Agreement shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in GCHP Policies.

Groups	Aid Codes	Rate
Adult/Family	01, 02, 03, 04, 06, 08, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 45, 46, 47, 54, 59, 72, 82, 83, 0A, 3A, 3C, 3D, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4F, 4G, 4K, 4M, 5K, 7A, 7J, 7X, 8P, 8R	
Aged Duals	10,14,16,17,1E, 1H	
Aged	10, 14, 16, 17, 1E, 1H	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U	
Disabled Duals	20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y	
Disabled	20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y	
Long Term Care Duals	13, 23, 53, 63	
Long Term Care	13, 23, 53, 63	

If DHCS creates a new Aid Code that is split or derived from an existing Aid Code covered under this Agreement, and the Aid Code has a neutral revenue effect for the Plan, then the split Aid Code will automatically be included in the same Aid Code rate group as the original Aid Code covered under this Agreement. Plan agrees to continue providing Covered Services to the Members at the monthly Capitation Rate specified for the original Aid Code. GCHP shall confirm all Aid Code splits, and the rates of payment for such new Aid Codes, in writing to Plan as soon as practicable after such Aid Code splits occur.

The rates set forth above are derived from GCHP's DHCS Medi-Cal Managed Care rates for Contract Year 2011 – 2012. The rates applicable on the Effective Date shall be negotiated and mutually agreed to by the parties to reflect a derived amount of the DHCS rates paid to GCHP on the Effective Date of this Agreement, for example, GCHP's DHCS Medi-Cal Managed Care rates for Contract Year 2012-2013. .

ATTACHMENT G

MEDICAL SPECIALTY NETWORK ADEQUACY*

Physician Specialty	Minimum Providers Per 25,000 Members
AIDS/HIV	1
Allergy/Immunology	2
Anesthesiology	3
Cardiology	2
Dermatology	1
Endocrinology	2
Gastroenterology	2
General Surgery	2
Geneticists	1
Hematology-Oncology	2
Infectious Disease	1
Neonatology	1
Nephrology	2
Neurological Surgery	1
Neurology	1
Nuclear Medicine	1
OB-Gynecology	3
Ophthalmology	1
Orthopedic Surgery	1
Otolaryngology	1
Pain Management	1
Pediatric Allergy	1
Pediatric Cardiology	1
Pediatric Neurology	1
Pediatric Surgery	1
Pediatrics	5
Perinatology	1
Physical Medicine & Rehabilitation	2
Plastic Surgery	1
Podiatry	1
Pulmonology	2
Radiation Therapy	1
Radiology/Nuclear Medicine	1
Rheumatology	1
Thoracic / Vascular Surgery	1
Urology and Urological Surgery	1

* This chart is consistent with the CMS Medicare Advantage specialist- to-enrollee ratios for Ventura County as adjusted for a Medi-Cal population.

ATTACHMENT H

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
BUSINESS ASSOCIATE REQUIREMENTS

Whereas, _____ ("Associate" for the purpose of this Attachment) and Ventura County Medi-Cal Managed Care Commission, a public entity, doing business as Gold Coast Health Plan ("Plan", for purposes of this Attachment), will be providing Protected Information, as defined below, to each other which it has generated or received from its other contractors or persons submitting such information to it, both Associate and Plan agree to comply with the following requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and 45 CFR Parts 160 through 164 ("HIPAA Regulations") with respect to the Protected Information it receives from the other party. In addition, Associate agrees to include such provisions in all agreements between Associate and any health care providers from which Associate obtains usual or frequently used health care services on behalf of Plan Members.

1. Obligations of Associate.

(a) Permitted Uses and Disclosures. Associate shall not use or disclose Protected Information except as allowed under the Agreement and this Addendum. Associate shall not use or disclose Protected Information in any manner that would constitute a violation of the HIPAA Regulations if such use or disclosure is made by Plan, except that Associate may use Protected Information (i) for the proper management and administration of Associate and (ii) to carry out the legal responsibilities of Associate.

(b) Disclosures to Third Parties. To the extent that Associate discloses Protected Information to a third party, Associate shall obtain, prior to making any such disclosure, (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and (ii) an agreement from such third party to immediately notify Associate of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such breaches.

(c) Appropriate Safeguards. Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by this Attachment. Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities, which Associate shall provide to Plan upon Plan's request.

(d) Reporting of Improper Use or Disclosure. Associate shall report to Plan in writing of any use or disclosure of Protected Information not provided for or allowed by this Attachment within three (3) business days of the day in which Associate becomes aware of such use or disclosure.

(e) Associate's Agents. Associate shall ensure that any of its agents or subcontractors, to whom it provides Protected Information agree to the same restrictions and conditions that apply to Associate as provided for by this Addendum with respect to such PHI. Associate

shall implement and maintain sanctions against any agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

(f) Access to Protected Information by Plan Members. Associate shall make Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets available to Plan for inspection and copying within ten (10) business days of a request by Plan to enable Plan to fulfill its obligations to Plan Members under the HIPAA Regulations, including, but not limited to those contained in 45 CFR Section 164.524. If an individual requests such Protected Information directly from Associate or its agents or subcontractors, Associate shall notify Plan in writing within five (5) business days of the request. Associate understands and agrees that only the Plan, as the Covered Entity under HIPAA, has the right to deny access to Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets.

(g) Amendment of PHI by Plan Members. Within ten (10) business days of receipt of a request from Plan for an amendment of Protected Information or a record relating to an individual in a Designated Record Set, Associate or its agents or subcontractors shall make such Protected Information available to Plan for amendment and incorporate any such amendment to enable Plan to fulfill its obligations under the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526. If any individual requests an amendment of Protected Information directly from Associate or its agents or subcontractors, Associate shall notify Plan in writing within five (5) business days of the request. Associate understands and agrees that only the Plan, as the Covered Entity under HIPAA, has the right to deny amendment of Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets.

(h) Accounting Rights of Plan Members. Within ten (10) business days of notice by Plan of a request by a Plan Member for an accounting of disclosures of Protected Information allowed by the HIPAA Regulations, Associate and its agents or subcontractors shall make available to Plan the information required to provide an accounting of disclosures to enable Plan to fulfill its obligations under the HIPAA Regulations. Associate agrees to implement a process that allows for an accounting whereby information on uses and disclosures subject to an accounting are collected and maintained by Associate and its agents or subcontractors for at least six (6) years prior to the request, but not before the compliance date of the HIPAA Regulations. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Associate or its agents or subcontractors by a Plan Member, Associate shall within five (5) business days of a request forward it to Plan in writing. It shall be Plan's responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Sections 3(a) and 3(b) of this Addendum.

(i) Governmental Access to Books and Records. Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from Plan (or created or received by Associate on behalf of Plan), available to the Secretary of the U.S.

Department of Health and Human Services ("Secretary") or the Secretary's designee for purposes of determining compliance with the HIPAA Regulations. Associate shall provide to Plan a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.

(j) Minimum Necessary. Associate, or any of its agents or subcontractors, shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure.

(k) Data Ownership. Associate acknowledges that Associate has no ownership rights with respect to the Protected Information whether de-identified or otherwise.

(l) Retention of Protected Information. Notwithstanding Section 5(c) of this Addendum, Associate and its agents or subcontractors shall retain all Protected Information for the duration of the Agreement and shall continue to maintain the information required under Section 3(h) of this Attachment for a period of six (6) years after termination of the Agreement.

(m) Inspection of Policies, Procedures and Applicable Subcontracts. Within ten (10) business days of a written request by Plan, Associate and its agents or subcontractors shall allow Plan to inspect its policies, procedures and applicable subcontracts relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum.

(n) Special Provisions for EPHI:

(1) With respect to EPHI, implement Administrative, Physical, and Technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the EPHI that Associate creates, receives, maintains, or transmits on behalf of Plan as required by 45 CFR Part 164, Subpart C.
(2) With respect to EPHI, ensure that any agent, including a subcontractor, to whom Associate provides EPHI, agrees to implement reasonable and appropriate safeguards to protect the EPHI.
(3) With respect to EPHI, report to Plan any Security Incident of which Provider becomes aware.

2. **Obligations of Plan.**

(a) Maintenance of Safeguards. Plan shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Associate by Plan, in accordance with the standards and requirements of the HIPAA Regulations, until such PHI is received by Associate.

(b) Notification of Authorizations or Restrictions Placed by Plan Members. Plan shall promptly inform Associate of any authorizations and restrictions, and changes or withdrawals thereof placed by Plan Members on use or disclosure of their PHI to the extent that such authorizations or restrictions affect Associate's use or disclosure of PHI of such Plan Member.

(c) Plan to Provide Copies of Its Notice(s) of Privacy Practices. Plan shall provide Associate with copies of Plan's Notice(s) of Privacy Practices prepared in compliance with the HIPAA Regulations and made available to Plan Members.

3. **Termination.**

(a) Material Breach. A breach by Associate of any provision of this Attachment, as determined by Plan, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement by Plan.

(b) Associate to Take Reasonable Steps to Cure Breach. If Plan knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Attachment, Plan shall provide Associate immediate notice of Plan's discovery of such breach and Associate shall take reasonable steps to cure such breach within ten (10) business days of notice by Plan to the satisfaction of Plan, or Plan shall either (i) terminate the Agreement, if feasible; or (ii) if termination of the Agreement is not feasible, report Associate's breach or violation to the Secretary.

(c) Effect of Termination. Upon termination of the Agreement for any reason, Associate shall, if feasible, return or destroy all Protected Information or any copies thereof received from Plan that Associate or its agents or subcontractors still maintains in any form. Associate shall further certify in writing within thirty (30) days from the date of termination or expiration of the Agreement that all PHI has been returned or destroyed. If return or destruction is infeasible, Associate or its agents or subcontractors shall: (i) provide to Plan notification of the conditions that make return or destruction infeasible; (ii) continue to extend the protections of this Attachment to such information; and (iii) limit further use of such Protected Information to those purposes that make the return or destruction of such Protected Information infeasible.

4. **Amendment(s) to this Attachment.** The Parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Attachment may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. Plan may terminate the Agreement upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Addendum when requested by Plan pursuant to this Section or (ii) Associate does not enter into an amendment to this Addendum providing assurances regarding the safeguarding of PHI that Plan, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations or other applicable laws.

5. **Assistance in Litigation or Administrative Proceedings.** Associate shall make itself, and any of its agents, subcontractors, or employees assisting Associate in the performance of its obligations under the Agreement and this Attachment, available to Plan, at no cost to Plan, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Plan, its directors, officers or employees based upon an alleged violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Associate or any of its agents, subcontractors, or employees is a named adverse party.

6. Indemnification. Associate shall indemnify and shall hold Plan, or any of its employees, harmless from any and all claims, losses, damages, liabilities, costs, expenses, attorney's fees and liability to third parties arising from or in connection with any breach of this Attachment or from any negligence or wrongful acts or omissions, including failure to perform its obligations under the HIPAA Regulations, by Associate or any of its agents, subcontractors or employees. Associate's obligation to indemnify Plan shall survive the expiration or termination of this Addendum without regard to the reason of the expiration or termination.

7. **No Third Party Beneficiaries.** Nothing express or implied in this Attachment is intended to confer, nor shall anything herein confer, upon any person other than Plan, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8**. Disclaimer.** Plan makes no warranty or representation that compliance by Associate with this Attachment will be adequate or satisfactory for Associate's own compliance with HIPAA, the HIPAA Regulations, or other state and federal confidentiality of information laws including California Department of Health rules on restrictive disclosure of information relating to Medi-Cal beneficiaries. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of PHI.

9. Injunctive Relief. Notwithstanding any rights or remedies provided for in this Attachment, , Plan retains the right to seek injunctive relief to prevent or stop any unauthorized use or disclosure of PHI by Associate or any of its agents, contractors, subcontractors, or third parties that receives PHI from Associate.

10. Interpretation. The provisions of this Attachment shall prevail over any provisions in the Agreement that may conflict or be inconsistent with any provision in this Attachment. This Attachment and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and the HIPAA Regulations.

11. Non-Conflicting Provisions of Agreement to Remain Unchanged. All non-conflicting terms and provisions of the Agreement, as amended by any other previous amendments, shall remain unchanged.

ATTACHMENT I

ELECTRONIC DATA INTERCHANGE TRADING PARTNER AGREEMENT

A. This Trading Partner Agreement (TPA) sets forth the terms and conditions which will govern all Electronic Data Interchange (EDI) communications between the parties by direct digital or electronic transmissions in agreed upon formats as a means of accomplishing their business objectives, for their mutual benefit and in compliance with laws and regulations applicable to health claims-related EDI transactions.

B. GCHP and Plan enter into this TPA on the terms and condition(s) set forth herein below.

NOW THEREFORE, the parties, intending to be legally bound, agree as follows:

1. SCOPE OF THIS TRADING PARTNER AGREEMENT

A. This TPA sets forth those terms and conditions which will govern all EDI transactions between the parties that constitute any of the "HIPAA Transactions." A "HIPAA Transaction" is any of the transactions defined in 45 C.F.R. Part 162, Subparts K through R, as those regulations may be amended from time to time. This Agreement is not intended to be utilized for EDI transactions involving services or orders for goods which include services.

B. HIPAA Transactions Standards. Each party may electronically transmit to or receive from the other party any of the HIPAA Transactions. The parties agree that the standards specified the HIPAA Transactions Standards and Code Sets regulations or their official implementation guides (collectively, "HIPAA") shall govern and be used for the exchange of HIPAA Transactions between the parties. In addition, GCHP may from time to time issue Companion Guides to the ASC X12N Implementation Guides which clarifies and specifies the data content being requested when data is transmitted electronically to GCHP. The Companion Guide is not intended to convey information that in any way exceeds the requirements of usages of data expressed in the Implementation Guides. Companion Guides may be modified from time to time to be used in tandem with the X12N Implementation Guides, and are HIPAA compliant.

C. Third Party Service Providers. HIPAA Transactions may be transmitted electronically to each party either directly or through any third party service provider (“Vendor”) with which either party may contract, as mutually agreed upon between the parties. Either party may modify its election to use, not use or change a Vendor upon 30 days prior written notice to the other party. If either party uses one or more Vendors, the names and related information of such providers shall be set forth in Exhibit A to this TPA. Each party shall be responsible for the costs of any Vendor with which it contracts.

D. Systems Operations. Each party, at its own expense, shall provide and maintain the equipment, software services and testing necessary to effectively and reliably transmit and receive HIPAA Transactions. Each party shall pay its respective costs for the network services charges including, but not limited to, charges for maintaining an electronic mail box, connect time, and any minimum usage charges. Each party will also be responsible for all expenses it incurs for the

translations, formatting or sending and receiving communications over the network to the other party's electronic mail box. Each party shall provide, as its own expense, hardware equipment and software necessary to transmit and receive correspondence and HIPAA Transactions through the data transmission network.

E. Security Procedures. Each party shall properly use those security procedures which are reasonably sufficient to ensure that all transmissions of HIPAA Transactions are authorized, and to protect its business records and data from improper access.

F. Signatures. Each party shall adopt as its authorized signature an electronic identification consisting of symbols(s) or code(s) which are to be affixed to or contained in each HIPAA Transaction transmitted by such party ("Signature"). Each party agrees that any Signature of such party affixed to or contained in any transmitted HIPAA Transaction shall be sufficient to verify that such party originated such HIPAA Transaction. Each party shall inform the other in writing of the symbol(s) or code(s) which constitutes its Signature; such information shall be disclosed only to persons authorized to receive such information and such persons shall be approved by the other party. Neither party shall disclose to any unauthorized person the Signature of the other party. The Signature of any party may change from time to time, in order to protect its confidential character, by mutual agreement of the parties.

2. **TRANSMISSIONS**

A. Proper Receipt. HIPAA Transactions shall not be deemed to have been properly received, and no HIPAA Transaction shall give rise to any obligation, until accessible in the mail box of the agreed upon location as designated in Exhibit A hereto.

B. Verification. Upon proper receipt of any HIPAA Transaction, the receiving party shall promptly and properly transmit a functional acknowledgement in return.

C. Acceptance. When acceptance of a HIPAA Transaction is required, any such HIPAA Transaction which has been properly received shall not give rise to any obligation unless and until the party initially transmitting such HIPAA Transaction has properly received in return an acceptance of the HIPAA Transaction. HIPAA Transactions for which acceptance is required are those specified in Exhibit A.

D. Garbled Transmission. If either party receives a garbled transmission, the receiving party shall promptly contact the sender or the third party network to reject the garbled transmission and to request a resend of such transmission.

3. **TRANSACTION TERMS**

A. Terms and Conditions. The terms of this TPA shall prevail in the event of any conflict with any other terms and conditions applicable to any HIPAA Transaction, except that in the event of conflict between the terms of this Agreement and any provision of law applicable to any HIPAA Transaction, the provision of law shall prevail.

B. Confidentiality. The information contained in any HIPAA Transaction shall be considered confidential, and shall be protected by Company in accordance with the Business Associate Agreement in effect between the parties.

C. Validity and Enforceability. This TPA has been executed by the parties to evidence their mutual intent to create binding obligations pursuant to the electronic transmission and receipt of HIPAA Transactions. Any document or data properly transmitted pursuant to this Agreement shall be considered to be a "writing" or "in writing," and any HIPAA Transaction that contains, or to which there is affixed, a Signature ("Signed HIPAA Transaction") shall be deemed for all purposes to have been "signed" and to constitute an "original" when printed from electronic files or records established and maintained in the normal course of business.

D. The conduct of the parties pursuant to this Agreement, including the use of Signed HIPAA Transactions, shall, for all legal purposes, evidence a course of conduct accepted by the parties in furtherance of this Agreement. The parties agree not to contest the validity or enforceability of Signed HIPAA Transactions on the grounds that such HIPAA Transactions are not in writing and do not have affixed to them an original signature. Signed HIPAA Transactions, if introduced as evidence on paper in any judicial, arbitration, mediation or administrative proceeding, shall be admissible as between the parties to the same extent and under the same conditions as other business records originated and maintained in written form. Neither party shall contest the admissibility of copies of Signed HIPAA Transactions under either the business records exception to the hearsay rule or the best evidence rule on the basis that the Signed HIPAA Transactions were not originated or maintained in written form.

E. Neither party will liable to the other for any damage, loss, claim, suit or other action, or any liability whatsoever, arising out of, or resulting from mistakes, omissions, interruptions, delays, errors, or defects in the electronic transmission of HIPAA Transactions under this Agreement.

4. **MISCELLANEOUS**

A. Term. This TPA shall commence on upon execution, and shall continue until terminated by the parties in accordance with the terms and conditions specified herein.

B. Company agrees to submit test files as outlines in the GCHP Encounter Requirements Manual and or Companion Guide for all transactions covered within this TPA.

C. Termination. This TPA shall remain in effect for the term indicated in Section 4.A, or until terminated by either party with not less than 30 days prior written notice, which notice shall specify the effective date of termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any HIPAA Transactions of otherwise under this TPA prior to the effective date of termination. The provisions of Section 3.B, Confidentiality, shall survive any termination.

D. Severability. Any provision of this TPA which is determined by a court of competent authority to be invalid or unenforceable will be ineffective to the extent of such determination without invalidating the remaining provisions of this TPA or affecting the validity or enforceability of such remaining provisions.

E. Entire Agreement. This TPA, its Exhibit, the 35-Paid Claims Data Dictionary, the State Contract and the Business Associate Agreement between the parties constitute the complete agreement of the parties relating to rights granted and obligations imposed by this TPA and supersede all prior agreements, whether oral or written, with respect to such matters. No oral modification or waiver of any of the provisions of this Agreement shall be implied from the execution or delivery of this Agreement. This Agreement is for the benefit of, and shall be binding upon, the parties and their respective successors and assigns.

F. Governing Law. This TPA shall be governed by and interpreted in accordance with the laws of the State of California.

G. Force Majeure. No party shall be liable for any failure to perform its obligations in connection with any HIPAA Transaction where such failure results from any acts of God or other cause beyond such party‘s reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any HIPAA Transaction.

ATTACHMENT I

Exhibit A

LIST OF THIRD PARTY SERVICE VENDORS

TRANSMISSION MAIL BOX(ES)

HIPAA TRANSACTIONS REQUIRING ACCEPTANCE

ATTACHMENT J

DELEGATIONS AND DELINEATIONS OF RESPONSIBILITIES

J-1—QUALITY MANAGEMENT AND IMPROVEMENT DELINEATION

J-2—UTILIZATION MANAGEMENT DELINEATION

J-3—CASE MANAGEMENT DELINEATION

J-4—CREDENTIALING DELINEATION

J-5—HEALTH EDUCATION DELINEATION

J-6—DISEASE MANAGEMENT DELINEATION

ATTACHMENT K

SELECTION AND ASSIGNMENT OF MEMBERS

GCHP and Plan shall establish policies and procedures regarding how Members will be offered an opportunity to select Plan among other Health Networks offered to Members, on initial enrollment and periodically thereafter, and how they will select and be assigned to a Health Network or a PCP.

ATTACHMENT L

DE-DELEGATION PROCEDURES

1. Corrective Action

(a) In the event GCHP is dissatisfied with good cause with Plan's performance of delegated activities, GCHP may, after consultation with Plan, but in its sole discretion, modify Plan's status (with respect to all or a particular delegated activity) from "fully delegated" to "delegated with corrective action." Such notice of delegation with corrective action shall set forth the deficiencies perceived by GCHP in Plan's performance of delegated activities, and Plan shall have sixty (60) days, unless DHCS rules require less time, to correct such deficiencies to the reasonable satisfaction of GCHP. In the event such deficiencies are not corrected to the reasonable satisfaction of GCHP, GCHP may, in its sole discretion, immediately terminate this Agreement or extend the period given Plan to correct such deficiencies.

(b) In lieu of the notice of delegation with corrective action and opportunity to correct deficiencies, as set forth in Section 1(a) above, GCHP may also terminate the Agreement if GCHP determines, after consultation with Plan, that Plan either no longer substantially meets all delegation criteria or is not performing (or is reasonably not likely to perform) the delegated activities in full compliance with the delegation standards. In such event, GCHP shall give to Plan not less than thirty (30) days prior notice of such termination, and if Plan during such notice period cures such deficiencies to GCHP's reasonable satisfaction, GCHP shall withdraw such termination. However, if it is a "repeat offense," i.e., GCHP had given notice of failing to substantially meet one or more of the same delegation criteria or delegation sStandards within the previous twenty-four (24) months, then GCHP shall have the discretion to delay the termination pending up to three (3) months of continued compliance by Plan or proceed with the termination. If Plan is compliant with GCHP's delegation standards and/or so long as Plan is meeting the requirements of a GCHP corrective action, Plan's delegation status shall be retained.

EXHIBIT 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____

Name of Contractor Contract/Grant Number

_____ _____

Signature of Person Signing for Contract/Title Date

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415
1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB
0348-0046

contract grant cooperative agreement loan loan guarantee loan insurance	bid/offer/application initial award post-award	initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

	and Address of Prime: Congressional District, If known:
Congressional District, If known:	
	Federal Program Name/Description: CDFA Number, if applicable:
866197.1	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify: _____
Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature	
Value	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352.This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only

Authorized for Local Reproduction
Standard Form-LLL

866197.1 008792.1 860528.1 858934.6 858934.5 008792.1 858934.4 008792.1 858934.3 008792.1 858934.2 858934.1

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

ATTACHMENT M

ACKNOWLEDGEMENT OF STATE CONTRACT RECEIPT

Plan hereby acknowledges receipt of the State Contract.

Date of receipt: _____

Initials of authorized
representative of Provider: _____