

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

DATE: Tuesday, February 21, 2012

TIME: 3:00-5:30 pm

PLACE: 2240 E. Gonzales Road, Suite 280, Oxnard CA 93036

AGENDA

Call to Order, Welcome and Roll Call

Public Comment / Correspondence

1. **Approve Minutes**
 - a. January 17, 2012 Meeting Minutes *Action Required*
2. **Accept and File CEO Update** *(verbal)* *For Information*
3. **Accept and File Financial Report**
 - a. January Financials *For Information*
4. **ACS Project Implementation** *For Discussion*
5. **External Monitor Services** *For Discussion*
6. **External Auditor Selection** *For Information*
7. **Salary Schedules** *For Information*
8. **Model Provider Contracts** *For Information*

Comments from Members

Adjourn

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

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 805/981-5320. 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

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

January 17, 2012
(Not official until approved)

CALL TO ORDER

Chair Greenia called the meeting to order at 3:09 p.m. in Suite 230 at the Ventura County Public Health Building located at 2240 E. Gonzales Road, Oxnard, CA 93036.

COMMITTEE MEMBERS PRESENT

Robert Gonzalez, MD, Ventura County Health Care Agency
Rick Jarvis, Private Hospitals / Healthcare System
Roberto S. Juarez, Clinicas del Camino Real, Inc.
Catherine Rodriguez, Ventura County Medical Health System

EXCUSED / ABSENT MEMBERS

Lanyard Dial, MD, Ventura County Medical Association

STAFF EX OFFICIO COMMITTEE MEMBERS

Earl Greenia, Chair, CEO
Sonia DeMarta, Vice-Chair, Interim CFO

ADDITIONAL STAFF IN ATTENDANCE

Traci R. McGinley, Clerk of the Board
Audra Lucas, Administrative Assistant
Candice Limousin, Human Resources Director
Guillermo Gonzalez, Government Affairs Director
Lyndon Turner, Sr. Financial Analyst

PUBLIC COMMENT

None.

1. APPROVAL OF MINUTES

a. November 28, 2011 Special Meeting Minutes

Committee Member Juarez moved to approve the minutes, Committee Member Jarvis seconded and the motion carried. **Approved 4-0.**

b. December 14, 2011 Meeting Minutes

Committee Member Gonzalez moved to approve the minutes, Committee Member Juarez seconded and the motion carried. **Approved 4-0.**

2. ACCEPT AND FILE CEO UPDATE

CEO Greenia Introduced Sonia DeMarta, Interim CFO. He also noted the presence of Ken Dixon and Adam Blodgett of ACS. CEO Greenia reported that when the Committee met in December there were more than 28,000 claims pended, it has been favorably reduced by 60%.

Ken Dixon of ACS advised the Committee that ACS has been able to reduce pended claims by changing processes, implementing technology upgrades, and hiring additional workers (with a plan of being staffed at that level through February).

There was discussion about unpaid claims. ACS and GCHP staff continue to meet with providers to reconcile claims and develop solutions. ACS explained how the claims queue is prioritized.

There was discussion regarding electronic claims submission, explanation of benefits, and direct deposit. Ken Dixon noted that both are on the "to-do" list.

In response to Committee Member Juarez's concern about Medi-Cal's payment of interest for late processing of claims, Interim CFO DeMarta responded that the interest is being paid.

3. ACCEPT AND FILE FINANCIAL REPORT

a. November and December Financials

Member status, December variances, CAP payments and medi-medi payments were discussed.

There was dialogue regarding the 2.19% budget decrease. CEO Greenia noted his preference to apply any cuts going forward only, rather than retroactively apply reductions to providers.

Sr. Financial Analyst Lyndon Turner expanded on the 10% reduction in new CAP rate. GCHP received the new actual rates from the State (column "New Cap Rate" on page 3a-16). The managed-care actuarial equivalent of the reduction is 2.19% for GCHP.

Accolades were given to Interim CFO DeMarta for preparing the reports in the requested format.

b. External Audit RFP Update

Interim CFO DeMarta indicated that RFPs were sent to five firms and three have responded, she will review the responses and develop a comparative matrix to evaluate the proposals. The RFP's cost estimates are \$20,000-\$25,000. The Committee suggested the item come before the Commission at the next meeting.

COMMENTS FROM COMMITTEE MEMBERS

Discussion was held by Committee Members Rodriguez and Gonzalez regarding the Executive Finance Committee Meetings conflicting with the Board of Supervisor's Meetings.

Committee Member Gonzalez commented on the Governor's budget, Healthy Families and Medi-Medi members. He also mentioned that he is being contacted by parents of disabled dependents with complaints that LVN in-home care requests have been denied by GCHP. CEO Greenia explained that if LVN in-home service is not medically necessary, it cannot be approved. GCHP has looked into specific members' requests and has approved LVN day services for those with the medical need. CEO Greenia asked the Committee Members to refer these types of calls to him. Further discussion was held as to possible organizations that may be of assistance in these situations. CEO Greenia noted that staff is working with these members and researching alternatives.

ADJOURN TO CLOSED SESSION - GC § 54957 - CEO Performance Evaluation

The Committee adjourned to Closed Session at 5:15 p.m.

RETURN TO OPEN SESSION

The Committee returned to open Session at 5:52 p.m. and announced that the Committee reviewed four evaluation tools and has selected one to recommend for use by the Commission. There was Committee consensus that Legal Counsel Tin Kin Lee and Human Resources Director Candice Limousin attend the next Closed Session.

ADJOURNMENT

Chair Greenia adjourned the meeting at 6:04 p.m.

GOLD COAST HEALTH PLAN
Executive Summary
January 2012 Financials

Membership

January membership decreased by 607 members to 100,636 compared to December membership of 101,243. Most of the decline (597) occurred in the Adult/Family category. This level is below budget by 1,059. Net positive retro-activity for January amounted to 3,782.

Revenue

Revenue for January came in above budget for the month and year-to-date:

- January gross Premium Revenue was \$1.3M above budget, and exceeded budget by \$7.9M year-to-date. Budgeted rates reflected the AB 97 adjustments and actual rates did not. However, on a net basis (allowing for a calculated reserve for the rate reduction), January Premium was still \$800K favorable and \$5.6M favorable year-to-date. The positive variance is largely due to the effect of retro-membership.
- Revenue in January was impacted by small changes in the Plan's member mix. When compared to budget, the changes contributed a favorable net effect of \$1.67 pmpm and \$0.52 pmpm year-to-date. Although a negative variance was seen in the Adult/Family category, gains in other higher pmpm categories helped to offset this loss and contributed to the overall favorable variance.
- In October, California Department of Health Care Services announced that the premium would be reduced retro-actively to July 1, 2011 as a result of the approval of the 10% provider rate reductions (AB 97) by CMS. The reduction to Plan Premium was approximately 2.2% or \$560,000 per month. Year-to-date, \$3.9 million had been accrued for future offsets. Payments have continued to come in at the original rates.

Health Care Costs

Total health care costs in January were \$21.6 million and \$149.2 million year-to-date. This compares to the forecast of \$21.7 million and \$149.4 million, respectively. Overall health care costs again followed budget, and experienced favorable variances in Pharmacy and Capitation.

- **Claims:** GCHP continued its progress in working through processing issues, sending out over \$32.3M in system claims payments during January. The Plan continued with a budget methodology in booking medical costs (adjusted for membership) until meaningful trends can be established. Total claims (ex-pharmacy) for January were \$17.9M, compared with \$17.4M per budget. Year-to-date, claims were \$125.0M, compared with \$122.7M per budget. The unfavorable variances were mainly due to retroactive membership increases.

- **Capitation:** Capitation continued to perform favorably as compared to budget. Capitation was budgeted based on total membership for the three aid categories (Adult/Family, Aged & Disabled). Not all members in these categories are required to select a capitated PCP. January capitation was \$638.7K as compared to a budgeted \$735.4K, and year-to-date was \$4.4M compared to \$4.8M.
- **Pharmacy:** Pharmacy again outperformed budget. The Plan's January expense of \$3.1M compared favorably to a budgeted \$3.6M, while a year-to-date \$19.8M yielded a positive variance of \$2.1M when compared to a budgeted \$21.9M. January pharmacy encounters increased by over 3,400 as compared with December, but January's cost per encounter dropped to \$44.57 from \$48.33 in the prior month.

General & Administrative Expenses

January general and administrative expenses were favorable to budget by \$216K for the month and \$348K year-to-date. Vendor costs represented 83% of total general and administrative expenses, while payroll costs represented 17%.

- ACS fees are based on a per member per month fee schedule. Year-to-date costs exceeded budget due to the increased membership and retro-adds.
- January CQS fees exceeded budget due to the unbudgeted addition of 5 RNs and Mailroom clerks.
- ScriptCare management fees were again significantly below budget as fees are based on utilization. The favorable utilization was reflected in the better than budgeted administrative expense. January PBM fees were \$32K below budget, and \$185K favorable, year-to-date.
- January Salaries and Benefits are favorable to budget for the month and year-to-date by \$128K and \$189K, respectively. Current payroll expenses declined from December by 11%. The savings were partially due to vacancies in senior management positions.
- Accounting, Printing and Postage were all well below budget due to timing issues. Certain expenses were anticipated in January but did not materialize. These items will be realized later in the year.
- Office Lease expense was below budget in January by \$13K. The original budget anticipated a move to a larger facility in January to accommodate a full staff.
- January's interest expense again represented interest paid to Providers for claims covering service dates extending back to July. Going forward, the company expects minimal interest expense on claims.

Balance Sheet

- Cash and cash equivalents as of January 31 were \$19.6 million. As progress has been made in processing claims, the cash balance has obviously been affected. Year-to-date the Plan has paid \$97.7 million in claims and capitation, converging with the forecasted amount of \$97.2 million through January. Due to a large check release on January 31, outstanding claims checks amounted to \$14.6 million.
- January's Medi-Cal Receivable balance included amounts due from the state for the current month amounting to \$24.4M, plus prior months' retroactive member increases of \$3.8M. Payment was received on February 1.
- Due to prior payment challenges, the plan had advanced interim payments to some providers. These advances continued to be applied against claims payments, and January's activity produced a 23% reduction.
- Incurred But Not Reported (IBNR)/Claims Payable as of January 31 was estimated at \$31.2 million (excluding \$1.9M in accrued pharmacy costs). Claims liability was estimated using budgeted per member per month amounts adjusted for membership plus retroactivity, less claims paid during the month. Claims paid in January amounted to \$32.3 million, reflecting another month of heightened processing activity connected with further reducing the backlog.
- Accrued Premium Reduction amounted to \$3.9 million and is the result of the reserve that GCHP continues to post for the mandated premium rate reduction. The reserve, representing 7 months of reduction retroactive to July 1, was set aside for anticipated future settlement. The amount added to the reserve in January was \$557K.
- Accrued Premium Tax Payable of \$523K reflected a single month of accrued MCO tax. The prior period tax (July through December) was settled in January. Going forward, quarterly payments will be made in accordance with state regulations.

Fund Balance

The Plan's fund balance at the end of January was \$7.4 million, primarily the result of the effects of membership retro-activity and favorable pharmacy management.

Tangible Net Equity

The Plan's required Tangible Net Equity (TNE) for January was \$2.9 million. According to the phased-in approach approved by the Department of Health Care Services, the Plan was required to attain 20% of the minimum required TNE (\$14.6M). As of January 31, the Plan's TNE of \$7.4 million exceeded the phase-in requirement by \$4.5 million.



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February 16, 2012

Sonia DeMarta
Chief Financial Officer
Gold Coast Health Plan
2220 East Gonzales Road, Suite 200
Ventura, CA 93036

RE: Review of Gold Coast Health Plan's Incurred But Not Paid Method

Dear Sonia:

At the request of Gold Coast Health Plan (GCHP), Milliman has reviewed GCHP's method for calculating historical liabilities for claims incurred but not yet paid (IBNP). In this letter, we present the results of our review of GCHP's IBNP method.

Background

The California Department of Health Care Services (DHCS) will audit GCHP's claim reserve projection method. Claim reserves are carefully scrutinized because their degree of adequacy is a key determinant in whether a health plan remains solvent. GCHP needs a reserve projection method that is accurate, and sufficiently easy to replicate on a regular basis.

GCHP hired Milliman to review their claim liability history and method for estimating IBNP. GCHP provided Milliman with historical data on members, and summaries of claims incurred and paid. We reviewed the data summaries and how they were compiled. Additionally, we visited the GCHP office to further discuss how claims are submitted, adjudicated, paid, and how information is recorded.

Review of IBNP Projection Methods

Based on our review, we understand that GCHP is using a "book to budget" method for projecting claims IBNP. We do not recommend that GCHP use a lag study method for these reserves, or other more traditional IBNP methods, due to the short period of time that GCHP has been in operation.

Using a lag study approach to estimating IBNP on these claims would probably not provide reasonably accurate results. Similarly, using an incurred claims approach (trended PMPM approach) will not be an appropriate method at this time because of the short historical period available for calculating incurred claims PMPM. Therefore, we support GCHP's decision to "book to budget."

The process for estimating IBNP using a “book to budget” approach is as follows:

1. Tabulate members and claims by month incurred.
2. Calculate the budgeted expected incurred claims PMPM based on the mix of members.
3. Calculate a "best estimate" of the total incurred claims in each month as:
(budgeted PMPM) x (members).
4. Subtract amounts incurred and paid as of the valuation date. Paid amounts include non-pharmacy FFS claims, capitation payments, and pharmacy claims.

The budgeted per member per month (PMPM) values come from the May 9, 2011 Pro Forma Exhibit HH3-b that Milliman developed using utilization and unit costs from fee-for-service (FFS) experience for the period April 2009 to March 2010, trended to the period July 2011 to June 2012. We also adjusted this historical data using certain medical management and trend assumptions. It is our understanding that DHCS reviewed these financial projections and ultimately approved them.

The term “best estimate” indicates we believe there is a 50% chance that the actual claims paid will be higher than our estimate, and a 50% chance that they will be lower than our estimate. We recommend that you hold an additional 2% to 4% to cover the administrative expense of paying the claims IBNP.

Attachment A shows the calculation of the estimated claims IBNP using the approach outlined above.

Ongoing Review of Claim Liability Projection Methods

The claim liability projection method that we reviewed is theoretically sound, and it appears that it would have provided reasonably accurate projections of liabilities in past months. However, as GCHP grows and changes, the methods may need to be refined, or may become inadequate. More traditional IBNP estimation methods will be more appropriate once GCHP has more historical data. Therefore, we recommend that GCHP periodically have an independent actuary review their claims experience and the sufficiency of their reserve estimation methods.

The claims triangle pattern for July and August 2011 incurred claims suggests that GCHP has not reached a point yet where the claims payments have slowed down, which is a concern since these claims are more than five months old. It is our understanding that ACS has communicated to GCHP that they have no claims in inventory older than sixty days as of January 31, 2012. Therefore, even though July 2011 is close to budget and August is over budget, we believe the projections to be reasonable estimates of the total incurred liabilities in these months.

Limitations of the Review

The claim liability projections that we have shown in this letter and attachment are estimates. Actual IBNP amounts will differ from our projections due to a variety of influences, including random fluctuation in the incidence of claims. The true IBNP amounts will only be known once all the claims have been paid. We recommend that GCHP continually monitor claims runout as it emerges, and adjust the projections accordingly.

In making our projections and our recommendations, we have relied on data and information provided by GCHP. Although we reviewed the data for reasonableness, we did not audit it for accuracy. If the data

were inaccurate or incomplete, our projections or recommendations may also be inaccurate or inappropriate.

Additional Comments

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and meet the qualification standards for performing the analysis in this letter.

Please call me if you have any questions, or need additional information (858-587-5302).

Sincerely,



Robert Cosway, FSA, MAAA
Principal and Consulting Actuary

Attachment A
Gold Coast Health Plan
Estimated Liability for Claims Incurred but Not Yet Paid (IBNP) as of 1/31/2012
Based on Claims Incurred 7/1/2011 or Later, and Paid through 1/31/2012

Claims Triangle (Non-Rx FFS)

Month of Service	Month Paid							Total
	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	
Jul-11	-	4,378,740	4,134,098	1,235,895	1,269,677	2,626,268	3,830,738	17,475,416
Aug-11	-	923,279	6,026,171	2,312,660	1,417,696	3,201,065	5,125,645	19,006,516
Sep-11	-	-	1,217,160	4,399,319	3,353,879	3,569,576	2,705,529	15,245,463
Oct-11	-	-	-	774,374	6,326,771	4,499,043	3,504,418	15,104,606
Nov-11	-	-	-	-	1,235,479	6,846,639	5,378,582	13,460,700
Dec-11	-	-	-	-	-	1,671,835	9,513,833	11,185,668
Jan-12	-	-	-	-	-	-	2,237,688	2,237,688
		5,302,019	11,377,429	8,722,248	13,603,502	22,414,426	32,296,434	93,716,058

Summary of Incurred Claims, Including Rx and Capitation Payments

Month of Service	Total			Total Claim Costs
	Non-Rx FFS	Total Capitation	Total Rx	
Jul-11	17,475,416	588,173	2,276,259	20,339,848
Aug-11	19,006,516	582,177	2,701,995	22,290,688
Sep-11	15,245,463	665,127	2,747,049	18,657,639
Oct-11	15,104,606	625,098	2,884,784	18,614,489
Nov-11	13,460,700	637,089	2,913,958	17,011,747
Dec-11	11,185,668	646,596	3,217,573	15,049,837
Jan-12	2,237,688	638,740	3,102,270	5,978,698
	93,716,058	4,383,000	19,843,888	117,942,945

Summary of Budgeted Costs

Month of Service	Member Count	PMPM Budget	Total Budget
Aug-11	105,543	207.51	21,901,511
Sep-11	105,300	207.89	21,891,018
Oct-11	105,181	208.80	21,961,399
Nov-11	104,403	209.26	21,847,387
Dec-11	103,458	209.43	21,667,385
Jan-12	100,636	210.82	21,215,892
			152,363,579

Estimated Liability for Claims Incurred but Not Yet Paid (IBNP) as of 1/31/2012

Month of Service	"Book to Budget" Estimated Claims IBNP
Jul-11	1,539,139
Aug-11	(389,177)
Sep-11	3,233,379
Oct-11	3,346,911
Nov-11	4,835,639
Dec-11	6,617,548
Jan-12	15,237,194
	34,420,634

**Gold Coast Health Plan
Balance Sheet
January 31, 2012**

ASSETS

Current Assets

Total Cash and Cash Equivalents	19,594,038
Medi-Cal Receivable	28,194,636
Provider Receivable	2,242,201
Other Receivables	27,460
Total Accounts Receivable	30,464,297
Total Prepaid Accounts	102,756
Total Other Current Assets	320,000

Total Current Assets **50,481,091**

Total Fixed Assets **97,799**

Total Assets **50,578,890**

LIABILITIES & FUND BALANCE

Current Liabilities

Incurred But Not Reported	22,690,256
Claims Payable	10,445,587
Capitation Payable	638,740
Accrued Premium Reduction	3,890,119
Accounts Payable	831,011
Accrued ACS	1,352,528
Accrued RGS	35,723
Accrued Premium Tax	523,306
Current Portion of Deferred Revenue	460,000
Accrued Payroll Expense	-
Current Portion Of Long Term Debt	500,000

Total Current Liabilities **41,367,270**

Other Long-term Liability	250,000
Deferred Revenue - Long Term Portion	1,571,667

Total Long-Term Liabilities **1,821,667**

Total Liabilities **43,188,936**

Beginning Fund Balance	(4,422,819)
Net Income Current Year	11,812,773

Total Fund Balance **7,389,954**

Total Liabilities & Fund Balance **50,578,890**

**Gold Coast Health Plan
Income Statement
Period Ended January 31, 2012**

	<u>NOV 2011</u>	<u>DEC 2011</u>	<u>JAN 2012</u>	<u>Budget</u>	<u>Variance Fav/(Unfav)</u>	<u>YTD</u>	<u>% of Rev</u>	<u>Budget</u>	<u>Variance Fav/(Unfav)</u>
Members (Member/Months)	101,174	101,243	100,636	101,695	(1,059)	709,662		711,618	(1,956)
Revenues									
Premium	26,051,388	26,543,927	26,093,935	24,737,749	1,356,186	181,734,420	101.99%	173,864,731	7,869,689
Reserve for Retro-Active Rate Reduction	(557,959)	(560,056)	(556,929)	-	(556,929)	(3,890,119)	-2.18%	(1,658,225)	(2,231,894)
Interest Income	15,968	16,814	18,094	14,843	3,251	83,291	0.05%	76,415	6,876
Miscellaneous Income	38,333	38,333	38,333	38,333	0	268,333	0.15%	268,331	2
Total Revenues	25,547,730	26,039,018	25,593,434	24,790,925	802,509	178,195,925	100.00%	172,551,252	5,644,673
MCO Tax	601,035	598,144	602,987	568,968	(34,019)	4,163,829	2.34%	3,997,922	165,907
Net Revenue	24,946,694	25,440,875	24,990,447	24,221,957	768,490	174,032,096	97.66%	168,553,330	5,478,766
Cost of Health Care									
<u>Capitation</u>	637,089	646,596	638,740	735,413	96,673	4,383,000	2.46%	4,776,231	393,231
<u>Claims</u>									
Inpatient FFS Expense	3,834,883	3,838,536	3,814,390	3,714,927	(99,463)	26,676,544	14.97%	26,160,220	(516,324)
LTC/SNF Expense	7,067,186	7,073,918	7,029,419	6,846,123	(183,296)	49,161,372	27.59%	48,218,170	(943,202)
Outpatient FFS Expense	2,259,228	2,271,359	2,178,213	2,179,329	1,116	15,649,557	8.78%	16,005,402	355,845
Laboratory and Radiology Expense	241,420	242,716	232,763	232,882	119	1,672,305	0.94%	1,544,286	(128,019)
Emergency Room Facility Services FFS	420,640	422,899	405,556	405,764	208	2,913,753	1.64%	3,640,094	726,341
Physician Specialty Services FFS	2,012,447	2,014,365	2,039,790	1,949,498	(90,292)	14,037,258	7.88%	13,757,192	(280,066)
Professional FFS Expense	-	-	-	-	-	121	0.00%	-	(121)
Other Medical Professional	209,958	210,158	212,811	203,390	(9,421)	1,464,503	0.82%	1,425,328	(39,175)
Pharmacy	2,913,958	3,217,573	3,102,270	3,559,333	457,063	19,843,888	11.14%	21,957,299	2,113,411
Reinsurance	92,928	92,131	92,131	92,543	412	649,348	0.36%	647,573	(1,775)
Other Fee For Service Expense	1,543,860	1,551,440	1,558,468	1,484,750	(73,718)	10,633,600	5.97%	9,382,203	(1,251,397)
Transportation FFS	307,837	309,490	310,704	296,950	(13,754)	2,146,277	1.20%	1,949,260	(197,017)
<u>Total Claims</u>	<u>20,904,345</u>	<u>21,244,585</u>	<u>20,976,515</u>	<u>20,965,489</u>	<u>(11,026)</u>	<u>144,848,525</u>	<u>81.29%</u>	<u>144,687,027</u>	<u>(161,498)</u>
Total Cost of Health Care	21,541,434	21,891,181	21,615,255	21,700,902	85,647	149,231,525	83.75%	149,463,258	231,733
Administrative Expenses									
Total Salaries Benefits and Compensation	367,354	387,971	346,120	474,171	128,051	2,527,435	1.42%	2,716,492	189,057
Total Travel and Training	2,106	1,354	1,805	16,030	14,225	27,421	0.02%	63,469	36,048
Outside Service - ACS	949,656	948,203	948,983	940,676	(8,307)	6,629,234	3.72%	6,551,475	(77,759)
Outside Service - CQS	191,197	191,152	190,229	173,948	(16,281)	1,302,327	0.73%	1,300,226	(2,101)
Outside Service - RGS	9,261	9,690	9,350	12,023	2,673	64,752	0.04%	70,127	5,375
Outside Service - Script Care	219,964	247,022	248,418	280,868	32,450	1,482,644	0.83%	1,667,247	184,603
Outside Services - Other	770	39,031	19,652	29,887	10,235	79,863	0.04%	73,004	(6,859)
Accounting & Actuarial Services	2,438	-	-	80,000	80,000	22,126	0.01%	113,445	91,319
Legal Expense	3,948	7,096	-	3,000	3,000	21,169	0.01%	29,667	8,498
Insurance	2,959	2,959	2,959	2,959	0	23,172	0.01%	23,175	3
Lease Expense -Office	13,040	13,040	13,089	26,080	12,991	91,329	0.05%	104,320	12,991
Consulting Services Expense	2,733	2,640	10,953	10,100	(853)	43,106	0.02%	56,463	13,357
Translation Services	1,440	3,253	483	1,397	914	7,482	0.00%	7,063	(419)
Advertising and Promotion Expense	13,226	406	-	9,658	9,658	153,602	0.09%	162,058	8,456
General Office Expenses	53,313	24,928	49,526	99,426	49,900	240,878	0.14%	221,724	(19,154)
Depreciation & Amortization Expense	1,461	1,461	1,806	1,461	(345)	10,570	0.01%	10,227	(343)
Printing Expense	(139,357)	2,014	5,720	37,500	31,780	18,074	0.01%	117,037	98,963
Shipping & Postage Expense	(148,599)	982	-	21,350	21,350	1,501	0.00%	43,654	42,153
Interest Exp	-	80,995	154,942	-	(154,942)	241,112	0.14%	5,175	(235,937)
Total Administrative Expenses	1,546,908	1,964,195	2,004,035	2,220,534	216,499	12,987,798	7.29%	13,336,048	348,250
Net Income	1,858,351	1,585,498	1,371,157	300,521	466,343	11,812,772	6.63%	5,754,024	4,898,783

**Gold Coast Health Plan
Income Statement PMPM
Period Ended January 31, 2012**

	<u>NOV 2011</u>	<u>DEC 2011</u>	<u>JAN 2012</u>	<u>Budget</u>	<u>Variance Fav/(Unfav)</u>	<u>YTD</u>	<u>Budget</u>	<u>Variance Fav/(Unfav)</u>
Members (Member/Months)	101,174	101,243	100,636	101,695	(1,059)	709,662	711,618	(1,956)
Revenues								
Premium	257.49	262.18	259.29	243.25	16.04	256.09	244.32	11.76
Reserve for Retro-Active Rate Reduction	(5.51)	(5.53)	(5.53)	-	(5.53)	(5.48)	(2.33)	(3.15)
Interest Income	0.16	0.17	0.18	0.15	0.03	0.12	0.11	0.01
Miscellaneous Income	0.38	0.38	0.38	0.38	0.00	0.38	0.38	0.00
Total Revenues	252.51	257.19	254.32	243.78	10.54	251.10	242.48	8.62
MCO Tax	5.94	5.91	5.99	5.59	(0.40)	5.87	5.62	0.25
Net Revenue	246.57	251.29	248.33	238.18	10.14	245.23	236.86	8.37
Cost of Health Care								
<u>Capitation</u>	6.30	6.39	6.35	7.23	0.88	6.18	6.71	0.54
<u>Claims</u>								
Inpatient FFS Expense	37.74	37.77	37.90	36.53	(1.37)	37.59	257.43	219.84
LTC/SNF Expense	69.55	69.61	69.85	67.32	(2.53)	69.27	474.50	405.23
Outpatient FFS Expense	22.23	22.35	21.64	21.43	(0.21)	22.05	157.50	135.45
Laboratory and Radiology Expense	2.38	2.39	2.31	2.29	(0.02)	2.36	15.20	12.84
Emergency Room Facility Services FFS	4.14	4.16	4.03	3.99	(0.04)	4.11	35.82	31.72
Physician Specialty Services FFS	19.80	19.82	20.27	19.17	(1.10)	19.78	135.38	115.60
Professional FFS Expense	-	-	-	-	-	0.00	-	(0.00)
Other Medical Professional	2.07	2.07	2.11	2.00	(0.11)	2.06	14.03	11.96
Pharmacy	28.68	31.66	30.83	35.00	4.17	27.96	216.07	188.11
Reinsurance	0.91	0.91	0.92	0.91	(0.01)	0.92	6.37	5.46
Other Fee For Service Expense	15.19	15.27	15.49	14.60	(0.89)	14.98	92.33	77.34
Transportation FFS	3.03	3.05	3.09	2.92	(0.17)	3.02	19.18	16.16
<u>Total Claims</u>	<u>205.71</u>	<u>209.06</u>	<u>208.44</u>	<u>206.16</u>	<u>(2.28)</u>	<u>204.11</u>	<u>1,423.82</u>	<u>1,219.71</u>
Total Cost of Health Care	211.98	215.42	214.79	213.39	(1.39)	210.29	1,470.82	1,260.53
Administrative Expenses								
Total Salaries Benefits and Compensation	3.63	3.83	3.44	4.66	1.22	3.56	3.82	0.26
Total Travel and Training	0.02	0.01	0.02	0.16	0.14	0.04	0.09	0.05
Outside Service - ACS	9.39	9.37	9.43	9.25	(0.18)	9.34	9.21	(0.13)
Outside Service - CQS	1.89	1.89	1.89	1.71	(0.18)	1.84	1.83	(0.01)
Outside Service - RGS	0.09	0.10	0.09	0.12	0.03	0.09	0.10	0.01
Outside Service - Script Care	2.17	2.44	2.47	2.76	0.29	2.09	2.34	0.25
Outside Services - Other	0.01	0.39	0.20	0.29	0.10	0.11	0.10	(0.01)
Accounting & Actuarial Services	0.02	-	-	0.79	0.79	0.03	0.16	0.13
Legal Expense	0.04	0.07	-	0.03	0.03	0.03	0.04	0.01
Insurance	0.03	0.03	0.03	0.03	(0.00)	0.03	0.03	(0.00)
Lease Expense -Office	0.13	0.13	0.13	0.26	0.13	0.13	0.15	0.02
Consulting Services Expense	0.03	0.03	0.11	0.10	(0.01)	0.06	0.08	0.02
Translation Services	0.01	0.03	0.00	0.01	0.01	0.01	0.01	(0.00)
Advertising and Promotion Expense	0.13	0.00	-	0.09	0.09	0.22	0.23	0.01
General Office Expenses	0.53	0.25	0.49	0.98	0.49	0.34	0.31	(0.03)
Depreciation & Amortization Expense	0.01	0.01	0.02	0.01	(0.00)	0.01	0.01	(0.00)
Printing Expense	(1.38)	0.02	0.06	0.37	0.31	0.03	0.16	0.14
Shipping & Postage Expense	(1.47)	0.01	-	0.21	0.21	0.00	0.06	0.06
Interest Exp	-	0.80	1.54	-	(1.54)	0.34	0.01	(0.33)
Total Administrative Expenses	15.29	19.40	19.91	21.84	2.43	18.30	18.74	0.44
Net Income	18.37	15.66	13.62	2.96	10.67	16.65	8.09	8.56

**Gold Coast Health Plan
Income Statement
Current Month vs. Prior Month**

	<u>DEC 2011</u>	<u>JAN 2012</u>	<u>Variance</u> Fav/(Unfav)	<u>% Variance</u> Fav/(Unfav)
Members (Member/Months)	<u>101,243</u>	<u>100,636</u>	<u>(607)</u>	
Revenues				
Premium	26,543,927	26,093,935	(449,993)	-1.70%
Reserve for Retro-Active Rate Reduction	(560,056)	(556,929)	(3,128)	0.56%
Interest Income	16,814	18,094	1,281	7.62%
Miscellaneous Income	38,333	38,333	-	0.00%
Total Revenues	<u>26,039,018</u>	<u>25,593,434</u>	<u>(445,584)</u>	<u>-1.71%</u>
MCO Tax	598,144	602,987	(4,844)	-0.81%
Net Revenue	<u>25,440,875</u>	<u>24,990,447</u>	<u>(450,428)</u>	<u>-1.77%</u>
Cost of Health Care				
<u>Capitation</u>	646,596	638,740	7,856	1.22%
<u>Claims</u>				
Inpatient FFS Expense	3,838,536.00	3,814,390.00	24,146	0.63%
LTC/SNF Expense	7,073,918.00	7,029,419.00	44,499	0.63%
Outpatient FFS Expense	2,271,359.00	2,178,213.00	93,146	4.10%
Laboratory and Radiology Expense	242,716.00	232,763.00	9,953	4.10%
Emergency Room Facility Services FFS	422,899.00	405,556.00	17,343	4.10%
Physician Specialty Services FFS	2,014,365.00	2,039,790.00	(25,425)	-1.26%
Other Medical Professional	210,158.00	212,811.00	(2,653)	-1.26%
Pharmacy	3,217,572.96	3,102,269.58	115,303	3.58%
Reinsurance	92,131.13	92,131.13	-	0.00%
Other Fee For Service Expense	1,551,440.00	1,558,468.00	(7,028)	-0.45%
Transportation FFS	309,490.00	310,704.00	(1,214)	-0.39%
<u>Total Claims</u>	<u>21,244,585</u>	<u>20,976,515</u>	<u>268,070</u>	<u>1.26%</u>
Total Cost of Health Care	<u>21,891,181</u>	<u>21,615,255</u>	<u>275,927</u>	<u>1.26%</u>

**Gold Coast Health Plan
Income Statement
Current Month vs. Prior Month**

	<u>DEC 2011</u>	<u>JAN 2012</u>	<u>Variance</u> Fav/(Unfav)	<u>% Variance</u> Fav/(Unfav)
Administrative Expenses				
Total Salaries Benefits and Compensation	387,971	346,120	41,851	10.79%
Total Travel and Training	1,354	1,805	(451)	-33.30%
Outside Service - ACS	948,203	948,983	(781)	-0.08%
Outside Service - CQS	191,152	190,229	923	0.48%
Outside Service - RGS	9,690	9,350	340	3.50%
Outside Service - Script Care	247,022	248,418	(1,396)	-0.57%
Outside Services - Other	39,031	19,652	19,379	49.65%
Accounting & Actuarial Services	-	-	-	0.00%
Legal Expense	7,096	-	7,096	100.00%
Insurance	2,959	2,959	-	0.00%
Lease Expense -Office	13,040	13,089	(49)	-0.38%
Consulting Services Expense	2,640	10,953	(8,312)	-314.84%
Translation Services	3,253	483	2,770	85.15%
Advertising and Promotion Expense	405	-	405	100.00%
General Office Expenses	24,928	49,526	(24,598)	-98.68%
Depreciation & Amortization Expense	1,461	1,806	(346)	-23.65%
Printing Expense	2,014	5,720	(3,706)	-184.01%
Shipping & Postage Expense	982	-	982	100.00%
Interest Exp	80,995	154,942	(73,947)	-100.00%
Total Administrative Expenses	<u>1,964,194</u>	<u>2,004,035</u>	<u>(39,841)</u>	<u>-2.03%</u>
Net Income	<u>1,585,499</u>	<u>1,371,157</u>	<u>(686,514)</u>	<u>-43.30%</u>

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

	<u>Dec 2011</u>	<u>Jan 2012</u>
Commission Fees	-	-
Committee/Advisory	500	-
Non-Capital - Furniture & Equip.	1,507	466
Non-Capital Equipment - Computer	-	2,239
Software Licenses	8,670	4,145
Repairs & Maintenance	35	-
Telephone Services/ Internet Charges	2,116	1,187
Utilities	-	-
Lease Expense -Equipment	-	-
Office & Operating Supplies	4,987	2,854
Bank Service Fees Expense	-	250
Bad Debt Expense	-	-
EE Recruitment	3,623	31,439
Prof Dues, Fees and Licenses	2,110	6,399
Subscriptions and Publications	1,381	549
Charitable Contributions and Donations	-	-
General Office Expenses	<u>24,928</u>	<u>49,526</u>

Gold Coast Health Plan
Fiscal Year July 1, 2011 - June 30, 2012
Reforecasted P & L - 02.13.12

DRAFT JAN '12 PRELIMINARY

	<u>Actual</u>															
	<u>Jul-11</u>	<u>Aug-11</u>	<u>Sep-11</u>	<u>Oct-11</u>	<u>Nov-11</u>	<u>Dec-11</u>	<u>Jan-12</u>	<u>Feb-12</u>	<u>Mar-12</u>	<u>Apr-12</u>	<u>May-12</u>	<u>Jun-12</u>	<u>7+5 Total</u>	<u>Approved 3+9</u>	<u>Var Fav/(Unfav)</u>	<u>% Change</u>
Enrollment-Members	102,033	101,487	101,470	101,619	101,174	101,243	100,636	100,661	100,686	100,711	100,737	100,762	1,213,220			
Retroactivity	-	2,202	3,351	3,626	3,805	3,836	3,782	3,868	3,862	3,860	3,859	3,860	39,911			
Member Months	102,033	103,689	104,821	105,245	104,979	105,079	104,418	104,529	104,548	104,571	104,596	104,622	1,253,130	1,220,476	32,654	2.7%
Average Membership													104,428	101,706	2,722	2.7%
<u>Revenue</u>																
Premium	25,231,919	25,578,699	25,934,155	26,300,397	26,051,388	26,543,927	26,093,935	25,507,024	25,511,528	25,517,069	25,523,012	25,529,188	309,322,241	297,646,272	11,675,969	3.9%
Reserve for Retro Rate Decrease	-	-	(1,658,225)	(556,951)	(557,959)	(560,056)	(556,929)						(3,890,119)	(1,658,225)	(2,231,894)	134.6%
Adjusted Revenue	25,231,919	25,578,699	24,275,931	25,743,446	25,493,429	25,983,871	25,537,006	25,507,024	25,511,528	25,517,069	25,523,012	25,529,188	305,432,122	295,988,047	9,444,074	3.2%
Interest Income	-	5,816	11,251	15,348	15,968	16,814	18,094	15,304	15,307	15,310	15,314	15,318	159,843	150,684	9,159	6.1%
Other Income	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	38,333	459,998	459,996	2	0.0%
Total Gross Revenue	25,270,252	25,622,849	24,325,515	25,797,127	25,547,730	26,039,018	25,593,434	25,560,661	25,565,168	25,570,712	25,576,659	25,582,839	306,051,964	296,598,728	9,453,236	3.2%
MCO Tax	591,954	587,426	585,154	597,129	601,035	598,144	602,987	586,662	586,765	586,893	587,029	587,171	7,098,349	6,844,898	253,451	3.7%
Net Revenue	24,678,298	25,035,423	23,740,361	25,199,998	24,946,694	25,440,875	24,990,447	24,973,999	24,978,403	24,983,819	24,989,630	24,995,668	298,953,615	289,753,830	9,199,785	3.2%
<u>Health Care Costs</u>																
Capitation	588,173	582,177	665,127	625,098	637,089	646,596	638,740	756,346	756,306	756,473	756,651	756,836	8,165,613	8,456,054	290,441	3.4%
<u>Claims</u>																
Inpatient	10,596,127	10,768,103	10,885,661	10,929,693	10,902,069	10,912,454	10,843,809	10,855,355	10,857,307	10,859,733	10,862,304	10,864,957	130,137,572	127,223,256	(2,914,315)	-2.3%
Outpatient	2,827,335	2,873,222	2,920,801	2,939,463	2,921,288	2,936,974	2,816,532	2,896,504	2,897,024	2,897,672	2,898,358	2,899,066	34,724,238	34,824,166	99,928	0.3%
Professional	2,160,039	2,195,217	2,219,060	2,228,037	2,222,405	2,224,523	2,252,601	2,212,883	2,213,281	2,213,775	2,214,299	2,214,840	26,570,960	25,955,036	(615,923)	-2.4%
Pharmacy	2,276,259	2,701,995	2,747,049	2,884,784	2,913,958	3,217,573	3,102,270	3,658,521	3,659,179	3,659,997	3,660,863	3,661,757	38,144,205	39,767,317	1,623,111	4.1%
Other	1,760,535	1,790,171	1,803,967	1,843,404	1,851,697	1,860,930	1,869,172	1,831,351	1,831,680	1,832,090	1,832,523	1,832,971	21,940,493	20,712,711	(1,227,782)	-5.9%
Reinsurance	92,850	92,353	92,338	94,616	92,928	92,131	92,131	95,122	95,139	95,160	95,182	95,206	1,125,156	1,110,633	(14,523)	-1.3%
Reinsurance Recoveries																
Total Claims	19,713,145	20,421,061	20,668,876	20,919,998	20,904,345	21,244,585	20,976,515	21,549,736	21,553,610	21,558,426	21,563,529	21,568,797	252,642,623	249,593,119	(3,049,503)	-1.2%
Total Health Care Costs	20,301,317	21,003,238	21,334,003	21,545,096	21,541,434	21,891,181	21,615,255	22,306,082	22,309,916	22,314,899	22,320,180	22,325,633	260,808,236	258,049,173	(2,759,062)	-1.1%
<u>Administrative Expenses</u>																
	1,762,708	1,596,607	1,919,616	2,193,728	1,546,909	1,964,194	2,004,035	2,308,154	2,148,894	2,134,553	2,208,503	2,139,688	23,927,590	24,225,120	297,530	1.2%
Net Income	2,614,273	2,435,577	486,741	1,461,174	1,858,351	1,585,499	1,371,157	359,763	519,592	534,368	460,946	530,347	14,217,789	7,479,537	6,738,252	90.1%

Gold Coast Health Plan
Fiscal Year July 1, 2011 - June 30, 2012
Reforecasted P & L - 02.13.12

DRAFT JAN '12 PRELIMINARY

	Actual															
	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	7+5 Total	Approved 3+9	Var Fav/(Unfav)	% Change
PMPM																
Revenue																
Premium	247.29	246.69	231.59	244.60	242.84	247.28	244.57	244.02	244.02	244.02	244.01	244.01	243.74	242.52	1.22	0.5%
Interest Income	-	0.06	0.11	0.15												
Other Income	0.38	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.37	0.38	(0.01)	-1.9%
Total Gross Revenue	247.67	247.11	232.07	245.11	243.36	247.80	245.11	244.53	244.53	244.53	244.53	244.53	244.23	243.02	1.21	0.5%
MCO Tax	5.80	5.67	5.58	5.67	5.73	5.69	5.77	5.61	5.61	5.61	5.61	5.61	5.66	5.61	0.06	1.0%
Net Revenue	241.87	241.45	226.48	239.44	237.64	242.11	239.33	238.92	238.92	238.92	238.92	238.91	238.57	237.41	1.15	0.5%
Health Care Costs																
Capitation	5.76	5.61	6.35	5.94	6.07	6.15	6.12	7.24	7.23	7.23	7.23	7.23	6.52	6.93	0.41	6.0%
Claims																
Inpatient	103.85	103.85	103.85	103.85	103.85	103.85	103.85	103.85	103.85	103.85	103.85	103.85	103.85	104.24	0.39	0.4%
Outpatient	27.71	27.71	27.86	27.93	27.83	27.95	26.97	27.71	27.71	27.71	27.71	27.71	27.71	28.53	0.82	2.9%
Professional	21.17	21.17	21.17	21.17	21.17	21.17	21.57	21.17	21.17	21.17	21.17	21.17	21.20	21.27	0.06	0.3%
Pharmacy	22.31	26.06	26.49	27.41	27.76	30.62	29.71	35.00	35.00	35.00	35.00	35.00	30.44	32.58	2.14	6.6%
Other	17.25	17.26	17.21	17.52	17.64	17.71	17.90	17.52	17.52	17.52	17.52	17.52	17.51	16.97	(0.54)	-3.2%
Reinsurance	0.91	0.89	0.91	0.91	0.89	0.88	0.88	0.91	0.91	0.91	0.91	0.91	0.90	0.91	0.01	1.3%
Reinsurance Recoveries	-	-														
Total Claims	193.20	196.95	197.18	198.77	199.13	202.18	200.89	206.16	206.16	206.16	206.16	206.16	201.61	204.50	2.90	1.4%
Total Health Care Costs	198.97	202.56	203.53	204.71	205.20	208.33	207.01	213.40	213.39	213.39	213.39	213.39	208.13	211.43	3.31	1.6%
Administrative Expenses	17.28	15.40	18.31	20.84	14.74	18.69	19.19	22.08	20.55	20.41	21.11	20.45	19.09	19.85	0.75	3.8%
Net Income	25.62	23.49	4.64	13.88	17.70	15.09	13.13	3.44	4.97	5.11	4.41	5.07	11.35	6.13	5.22	85.1%
Impact on TNE:																
Required TNE	13,838,478	14,137,004	14,297,004	14,431,989	14,512,627	14,619,993	14,664,626	14,766,195	14,845,502	14,909,294	14,961,820	15,005,907				
Phased in Requirement (20%)	-	-	-	-	-	-	2,932,925	2,953,239	2,969,100	2,981,859	2,992,364	3,001,181				
TNE Excess / (Deficiency)	(1,808,546)	627,031	1,113,773	2,574,946	4,433,298	6,018,797	4,457,028	6,996,478	7,500,209	8,021,818	8,472,259	8,993,788				
							50.4%	67.4%	70.5%	73.8%	76.6%	79.9%				

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

Cash Flow From Operating Activities	
Collected Premium	\$25,971,110
Miscellaneous Income	18,094
<u>Paid Claims</u>	
Medical & Hospital Expenses	(30,152,105)
Pharmacy	(3,015,926)
Capitation	(638,740)
Reinsurance of Claims	(92,131)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(536,540)
Repay Initial Net Liabilities	-
MCO Taxes Expense	(3,640,523)
Net Cash Provided by Operating Activities	(12,086,761)
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 by Investing/Financing	-
Net Cash Flow	<u><u>(12,086,761)</u></u>
Cash and Cash Equivalents (Beg. of Period)	31,680,799
Cash and Cash Equivalents (End of Period)	<u><u>19,594,038</u></u>
Adjustment to Reconcile Net Income to Net	
Cash Flow	
Net (Loss) Income	1,371,157
Depreciation & Amortization	(18,925)
Decrease/(Increase) in Receivables	760,352
Decrease/(Increase) in Prepaids & Other Current Assets	12,826
(Decrease)/Increase in Payables	1,761,912
(Decrease)/Increase in LT Liabilities	(80,000)
Purchase of fixed Assets	-
Changes in Withhold / Risk Incentive Pool	-
Change in MCO Tax Liability	(3,037,536)
Changes in Claims and Capitation Payable	(16,948,347)
Changes in IBNR	4,091,800
	<u>(12,086,761)</u>
Net Cash Flow from Operating Activities	<u><u>(12,086,761)</u></u>

**Gold Coast Health Plan
Statement of Cash Flows
Seven Months Ended January 31, 2012**

Cash Flow From Operating Activities	
Collected Premium	\$ 153,328,230
Miscellaneous Income	104,530
<u>Paid Claims</u>	
Medical & Hospital Expenses	(96,511,284)
Pharmacy	(16,896,276)
Capitation	(4,373,893)
Reinsurance of Claims	(557,217)
Reinsurance Recoveries	-
Payment of Withhold / Risk Sharing Incentive	-
Paid Administration	(12,520,228)
Repay Initial Net Liabilities	-
MCO Taxes Expense	(3,640,523)
Net Cash Provided by Operating Activities	-
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 by Investing/Financing	-
Net Cash Flow	<u><u>18,933,340</u></u>
Cash and Cash Equivalents (Beg. of Period)	660,697
Cash and Cash Equivalents (End of Period)	<u><u>19,594,038</u></u>
	<u><u>18,933,340</u></u>
Adjustment to Reconcile Net Income to Net Cash Flow	
Net (Loss) Income	11,772,555
Depreciation & Amortization	(10,161)
Decrease/(Increase) in Receivables	(30,455,143)
Decrease/(Increase) in Prepaids & Other Current Assets	(382,629)
(Decrease)/Increase in Payables	339,043
(Decrease)/Increase in LT Liabilities	(518,333)
Purchase of fixed Assets	-
Changes in Withhold / Risk Incentive Pool	-
Change in MCO Tax Liability	523,306
Changes in Claims and Capitation Payable	14,974,446
Changes in IBNR	22,690,256
	<u>18,933,340</u>
Net Cash Flow from Operating Activities	<u><u>18,933,340</u></u>

Gold Coast Health Plan
Premium Revenue Summary
31-Jan-12

Payment Month	Revenue	Membership Month																		Tot. Premium	Tot Mbrshp	Net Receivable
		Jul-11		Aug-11		Sep-11		Sep HYDE Pmt.	Oct-11		Nov-11		Dec-11		Dec HYDE Pmt.	Jan-12						
		Premium	Membership	Premium	Membership	Premium	Membership		Premium	Membership	Premium	Membership	Premium	Membership		Premium	Membership					
Jul-11	26,110,225	(24,558,575)	98,436	(627,796)	3,597	(396,514)	2,202	(56,473.53)	(216,723)	864	(84,440)	304	(60,505)	182	(800.08)	(38,345)	105	26,040,172	105,690	70,053		
Aug-11	26,130,448			(24,369,043)	97,249	(762,989)	4,238	(54,625.90)	(486,976)	2,487	(243,069)	913	(72,895)	335	(2,372.50)	(73,104)	316	26,065,074	105,538	65,374		
Sep-11	26,115,471					(24,378,798)	96,986	(51,646.77)	(805,057)	4,484	(475,374)	2,409	(213,440)	905	(5,072.77)	(98,945)	326	26,028,335	105,110	87,136		
Oct-11	26,186,161								(24,457,947)	97,060	(812,285)	4,559	(466,024)	2,383	(56,204.16)	(279,977)	844	26,072,437	104,846	113,724		
Nov-11	26,045,483										(24,518,766)	97,055	(715,580)	4,119	(54,378.43)	(477,247)	2,345	25,765,971	103,519	279,512		
Dec-11	25,832,434												(24,484,528)	96,976	(51,628.52)	(810,316)	4,267	25,346,472	101,243	485,962		
Jan-12	25,314,941														(24,438,020)	96,243	24,438,020	96,243	876,922			
Feb-12																						
Mar-12																						
Apr-12																						
May-12																						
Jun-12																						
Check Amount	\$ 181,735,163.88	\$ (24,558,575.10)	98,436	\$ (24,996,839.30)	100,846	\$ (25,538,300.25)	103,426	\$ (162,746.20)	\$ (25,966,703.55)	104,895	\$ (26,133,935.51)	105,240	\$ (26,012,971.66)	104,900	\$ (170,456.46)	\$ (26,215,953.21)	104,446	\$ 179,756,481.24	722,189	\$ 1,978,682.64		

Add back pm't received in Feb. 2012

Premium	26,160,928
Healthy Family	55,026
HYDE	-

Total Rec'bl at 1/31/2012

\$ 28,194,635.85

Gold Coast Health Plan
Monthly Restated Membership Report
July, 2011

<u>Aid Category</u>	Jul Current Month Membership	Aug Current Month Plus 1	Sep Current Month Plus 2	Oct Current Month Plus 3	Nov Current Month Plus 4	Dec Current Month Plus 5	Jan Current Month Plus 6	Feb Current Month Plus 7	Mar Current Month Plus 8	Apr Current Month Plus 9	May Current Month Plus 10	Jun Current Month Plus 11	Total Member Months
Adult/Family	72,291	75,465	77,362	78,091	78,327	78,457	78,516	78,541					544,759
Aged - Medi-cal	1,229	1,251	1,255	1,236	1,225	1,218	1,214	1,209					8,608
Disabled - Medi-Cal	7,716	7,782	7,847	7,895	7,913	7,938	7,962	7,983					55,320
Long Term Care - Medi-Cal	65	63	60	75	75	74	73	71					491
Aged - Dual	8,839	9,010	9,141	9,209	9,251	9,270	9,287	9,296					64,464
Disabled - Dual	7,220	7,361	7,452	7,483	7,494	7,504	7,510	7,512					52,316
Long Term Care - Dual	841	860	874	866	873	879	882	885					6,119
BCCTP	235	241	244	244	245	245	246	246					1,711
Total	98,436	102,033	104,235	105,099	105,403	105,585	105,690	105,743	-	-	-	-	733,788

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,516,387	9,934,213	10,183,934	10,279,899	10,310,966	10,328,079	10,335,846	10,339,137					10,339,137
Aged - Medi-cal	640,481	651,946	654,031	644,129	638,397	634,749	632,664	630,058					630,058
Disabled - Medi-Cal	6,425,808	6,480,772	6,534,903	6,574,877	6,589,867	6,610,687	6,630,674	6,648,163					6,648,163
Long Term Care - Medi-Cal	456,788	442,733	421,651	527,063	527,063	520,036	513,008	498,953					498,953
Aged - Dual	2,066,470	2,106,448	2,137,074	2,152,972	2,162,791	2,167,233	2,171,208	2,173,312					2,173,312
Disabled - Dual	1,424,650	1,452,473	1,470,429	1,476,546	1,478,716	1,480,689	1,481,873	1,482,268					1,482,268
Long Term Care - Dual	3,779,504	3,864,892	3,927,808	3,891,856	3,923,314	3,950,279	3,963,761	3,977,243					3,977,243
BCCTP	249,680	256,055	259,243	259,243	260,305	260,305	261,368	261,368					261,368
Abortion (Family/Adult Only)	52,772	55,089	56,474	57,006	57,179	57,274	57,317	57,335					57,335
Total	24,612,542	25,244,620	25,645,547	25,863,591	25,948,599	26,009,331	26,047,719	26,067,837	-	-	-	-	26,067,837

Less: Previous Cap Received	(24,516,187)	-											(24,516,187)
Retro Payments		(627,796)	(452,987)	(216,723)	(84,440)	(61,305)	(38,345)						(1,481,597)
Net Change due to Retro													
Activity	96,355	4,282	(52,061)	1,322	567	(574)	43	20,118					70,053

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	250.04	247.42	246.04	246.09	246.18	246.34	246.45	246.52					

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

Gold Coast Health Plan
Monthly Restated Membership Report
August, 2011

<u>Aid Category</u>	Aug Current Month Membership	Sep Current Month Plus 1	Oct Current Month Plus 2	Nov Current Month Plus 3	Dec Current Month Plus 4	Jan Current Month Plus 5	Feb Current Month Plus 6	Mar Current Month Plus 7	Apr Current Month Plus 8	May Current Month Plus 9	Jun Current Month Plus 10	Jul Current Month Plus 11	Total Member Months
Adult/Family	71,080	74,831	77,043	77,819	78,080	78,209	78,276						464,258
Aged - Medi-cal	1,223	1,256	1,239	1,225	1,199	1,204	1,190						7,313
Disabled - Medi-Cal	7,694	7,776	7,861	7,889	7,918	7,955	7,979						47,378
Long Term Care - Medi-Cal	65	63	67	77	70	68	65						410
Aged - Dual	8,891	9,072	9,194	9,270	9,317	9,340	9,362						55,555
Disabled - Dual	7,225	7,378	7,441	7,471	7,488	7,505	7,513						44,796
Long Term Care - Dual	835	861	875	882	896	902	904						5,320
BCCTP	236	250	254	254	254	255	254						1,521
Total	97,249	101,487	103,974	104,887	105,222	105,438	105,543	-	-	-	-	-	626,551

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,356,971	9,850,753	10,141,941	10,244,093	10,278,451	10,295,433	10,304,253						10,304,253
Aged - Medi-cal	637,354	654,552	645,692	638,397	624,847	627,453	620,157						620,157
Disabled - Medi-Cal	6,407,486	6,475,775	6,546,562	6,569,880	6,594,031	6,624,844	6,644,831						6,644,831
Long Term Care - Medi-Cal	456,788	442,733	470,843	541,118	491,926	477,871	456,788						456,788
Aged - Dual	2,078,627	2,120,943	2,149,465	2,167,233	2,178,221	2,183,599	2,188,742						2,188,742
Disabled - Dual	1,425,637	1,455,827	1,468,258	1,474,178	1,477,532	1,480,887	1,482,465						1,482,465
Long Term Care - Dual	3,752,540	3,869,386	3,932,303	3,963,761	4,026,678	4,053,642	4,062,630						4,062,630
BCCTP	250,743	265,618	269,867	269,867	269,867	270,930	269,867						269,867
Abortion (Family/Adult Only)	51,888	54,627	56,241	56,808	56,998	57,093	57,141						57,141
Total	24,418,035	25,190,212	25,681,173	25,925,335	25,998,552	26,071,750	26,086,875	-	-	-	-	-	26,086,875

Less: Previous Cap Received	(24,325,470)	-											(24,325,470)
Retro Payments		(762,989)	(541,602)	(243,069)	(75,267)	(73,104)							(1,696,031)
Net Change due to Retro													
Activity	92,565	9,189	(50,642)	1,093	(2,050)	94	15,125						65,374

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	251.09	248.21	247.00	247.17	247.08	247.27	247.17						

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

Gold Coast Health Plan
Monthly Restated Membership Report
September, 2011

<u>Aid Category</u>	Sep Current Month Membership	Oct Current Month Plus 1	Nov Current Month Plus 2	Dec Current Month Plus 3	Jan Current Month Plus 4	Feb Current Month Plus 5	Mar Current Month Plus 6	Apr Current Month Plus 7	May Current Month Plus 8	Jun Current Month Plus 9	Jul Current Month Plus 10	Aug Current Month Plus 11	Total Member Months
Adult/Family	70,750	74,804	76,948	77,698	77,915	78,037							385,402
Aged - Medi-cal	1,213	1,228	1,220	1,221	1,214	1,203							6,086
Disabled - Medi-Cal	7,696	7,779	7,831	7,881	7,918	7,947							39,356
Long Term Care - Medi-Cal	63	66	72	73	71	65							347
Aged - Dual	8,942	9,095	9,229	9,301	9,349	9,379							46,353
Disabled - Dual	7,236	7,379	7,444	7,465	7,488	7,506							37,282
Long Term Care - Dual	845	868	883	893	902	911							4,457
BCCTP	241	251	252	252	253	252							1,260
Total	96,986	101,470	103,879	104,784	105,110	105,300	-	-	-	-	-	-	520,543

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,313,530	9,847,199	10,129,435	10,228,165	10,256,731	10,272,791							10,272,791
Aged - Medi-cal	632,143	639,960	635,791	636,312	632,664	626,931							626,931
Disabled - Medi-Cal	6,409,152	6,478,273	6,521,578	6,563,218	6,594,031	6,618,182							6,618,182
Long Term Care - Medi-Cal	442,733	463,816	505,981	513,008	498,953	456,788							456,788
Aged - Dual	2,090,550	2,126,320	2,157,648	2,174,481	2,185,703	2,192,716							2,192,716
Disabled - Dual	1,427,808	1,456,024	1,468,850	1,472,994	1,477,532	1,481,084							1,481,084
Long Term Care - Dual	3,797,481	3,900,844	3,968,255	4,013,196	4,053,642	4,094,089							4,094,089
BCCTP	256,055	266,680	267,742	267,742	268,805	267,742							267,742
Abortion (Family/Adult Only)	51,648	54,607	56,172	56,720	56,878	56,967							56,967
Total	24,421,099	25,233,723	25,711,452	25,925,835	26,024,939	26,067,291	-	-	-	-	-	-	26,067,291

Less: Previous Cap Received Retro Payments **(24,330,618)** **(856,704)** **(475,374)** **(218,513)** **(98,945)** **(24,330,618)** **(1,649,537)**

Net Change due to Retro Activity 90,481 (44,080) 2,355 (4,130) 158 42,352 87,136

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	251.80	248.68	247.51	247.42	247.60	247.55							

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

**Gold Coast Health Plan
Monthly Restated Membership Report
October, 2011**

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total Member
<u>Aid Category</u>	Current Month Membership	Current Month Plus 1	Current Month Plus 2	Current Month Plus 3	Current Month Plus 4	Current Month Plus 5	Current Month Plus 6	Current Month Plus 7	Current Month Plus 8	Current Month Plus 9	Current Month Plus 10	Current Month Plus 11	Months
Adult/Family	70,777	74,881	76,966	77,635	77,873								307,355
Aged - Medi-cal	1,223	1,251	1,256	1,264	1,233								5,004
Disabled - Medi-Cal	7,714	7,764	7,839	7,903	7,938								31,444
Long Term Care - Medi-Cal	66	72	71	83	73								299
Aged - Dual	8,928	9,128	9,271	9,328	9,391								37,118
Disabled - Dual	7,256	7,397	7,452	7,479	7,506								29,834
Long Term Care - Dual	856	876	896	903	917								3,592
BCCTP	240	250	251	251	250								1,002
Total	97,060	101,619	104,002	104,846	105,181	-	-	-	-	-	-	-	415,648

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,317,084	9,857,335	10,131,804	10,219,871	10,251,202								10,251,202
Aged - Medi-cal	637,354	651,946	654,552	658,721	642,566								642,566
Disabled - Medi-Cal	6,424,142	6,465,782	6,528,241	6,581,539	6,610,687								6,610,687
Long Term Care - Medi-Cal	463,816	505,981	498,953	583,283	513,008								513,008
Aged - Dual	2,087,277	2,134,035	2,167,467	2,180,793	2,195,522								2,195,522
Disabled - Dual	1,431,754	1,459,576	1,470,429	1,475,756	1,481,084								1,481,084
Long Term Care - Dual	3,846,915	3,936,797	4,026,678	4,058,136	4,121,053								4,121,053
BCCTP	254,993	265,618	266,680	266,680	265,618								265,618
Abortion (Family/Adult Only)	51,667	54,663	56,185	56,674	56,847								56,847
Total	24,515,003	25,331,732	25,800,989	26,081,454	26,137,586	-	-	-	-	-	-	-	26,137,586

Less: Previous Cap Received	(24,409,372)												(24,409,372)
Retro Payments		(812,285)	(522,228)	(279,977)									(1,614,490)
Net Change due to Retro Activity	105,630	4,444	(52,971)	488	56,132								113,724

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	252.58	249.28	248.08	248.76	248.50								

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

**Gold Coast Health Plan
Monthly Restated Membership Report
November, 2011**

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Total Member
<u>Aid Category</u>	Current Month Membership	Current Month Plus 1	Current Month Plus 2	Current Month Plus 3	Current Month Plus 4	Current Month Plus 5	Current Month Plus 6	Current Month Plus 7	Current Month Plus 8	Current Month Plus 9	Current Month Plus 10	Current Month Plus 11	Months
Adult/Family	70,802	74,452	76,436	77,162									228,050
Aged - Medi-cal	1,239	1,267	1,282	1,269									3,818
Disabled - Medi-Cal	7,672	7,773	7,857	7,907									23,537
Long Term Care - Medi-Cal	74	70	69	76									215
Aged - Dual	8,905	9,106	9,266	9,343									27,715
Disabled - Dual	7,259	7,376	7,458	7,493									22,327
Long Term Care - Dual	864	885	906	909									2,700
BCCTP	240	245	245	244									734
Total	97,055	101,174	103,519	104,403	-	-	-	-	-	-	-	-	309,096

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,320,375	9,800,861	10,062,035	10,157,606									10,157,606
Aged - Medi-cal	645,692	660,284	668,101	661,327									661,327
Disabled - Medi-Cal	6,389,165	6,473,277	6,543,231	6,584,871									6,584,871
Long Term Care - Medi-Cal	520,036	491,926	484,898	534,091									534,091
Aged - Dual	2,081,900	2,128,892	2,166,298	2,184,300									2,184,300
Disabled - Dual	1,432,346	1,455,432	1,471,613	1,478,519									1,478,519
Long Term Care - Dual	3,882,868	3,977,243	4,071,618	4,085,101									4,085,101
BCCTP	254,993	260,305	260,305	259,243									259,243
Abortion (Family/Adult Only)	51,685	54,350	55,798	56,328									56,328
Total	24,579,060	25,302,570	25,783,898	26,001,384	-	-	-	-	-	-	-	-	26,001,384

Less: Previous Cap Received Retro Payments (24,474,667) (769,958) (477,247) (24,474,667) (1,247,205)

Net Change due to Retro Activity 104,393 (46,448) 4,081 217,486 279,512

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	253.25	250.09	249.07										

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

**Gold Coast Health Plan
Monthly Restated Membership Report
December, 2011**

<u>Aid Category</u>	Dec Current Month Membership	Jan Current Month Plus 1	Feb Current Month Plus 2	Mar Current Month Plus 3	Apr Current Month Plus 4	May Current Month Plus 5	Jun Current Month Plus 6	Jul Current Month Plus 7	Aug Current Month Plus 8	Sep Current Month Plus 9	Oct Current Month Plus 10	Nov Current Month Plus 11	Total Member Months
Adult/Family	70,684	74443	76370										150,813
Aged - Medi-cal	1,234	1286	1272										2,558
Disabled - Medi-Cal	7,699	7783	7863										15,646
Long Term Care - Medi-Cal	67	71	73										144
Aged - Dual	8,930	9130	9273										18,403
Disabled - Dual	7,257	7390	7456										14,846
Long Term Care - Dual	865	890	902										1,792
BCCTP	240	250	249										499
Total	96,976	101,243	103,458	-	-	-	-	-	-	-	-	-	204,701

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,304,842	9,799,677	10,053,347										10,053,347
Aged - Medi-cal	643,087	670,186	662,890										662,890
Disabled - Medi-Cal	6,411,650	6,481,605	6,548,228										6,548,228
Long Term Care - Medi-Cal	470,843	498,953	513,008										513,008
Aged - Dual	2,087,745	2,134,503	2,167,935										2,167,935
Disabled - Dual	1,431,951	1,458,195	1,471,218										1,471,218
Long Term Care - Dual	3,887,362	3,999,713	4,053,642										4,053,642
BCCTP	254,993	265,618	264,555										264,555
Abortion (Family/Adult Only)	51,599	54,343	55,750										55,750
Total	24,544,072	25,362,792	25,790,573	-	-	-	-	-	-	-	-	-	25,790,573

Less: Previous Cap Received (24,494,295) (24,494,295)
Retro Payments (810,316) (810,316)

Net Change due to Retro Activity 49,777 8,405 427,781 485,962

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	253.09	250.51	249.29										

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

Gold Coast Health Plan
Monthly Restated Membership Report
January, 2012

<u>Aid Category</u>	Jan Current Month Membership	Feb Current Month Plus 1	Mar Current Month Plus 2	Apr Current Month Plus 3	May Current Month Plus 4	Jun Current Month Plus 5	Jul Current Month Plus 6	Aug Current Month Plus 7	Sep Current Month Plus 8	Oct Current Month Plus 9	Nov Current Month Plus 10	Dec Current Month Plus 11	Total Member Months
Adult/Family	69,948	73,846											73,846
Aged - Medi-cal	1,256	1,291											1,291
Disabled - Medi-Cal	7,721	7,799											7,799
Long Term Care - Medi-Cal	72	71											71
Aged - Dual	8,895	9,102											9,102
Disabled - Dual	7,239	7,393											7,393
Long Term Care - Dual	865	882											882
BCCTP	247	252											252
Total	96,243	100,636	-	-	-	-	-	-	-	-	-	-	100,636

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,207,955	9,721,087											9,721,087
Aged - Medi-cal	654,552	672,792											672,792
Disabled - Medi-Cal	6,429,972	6,494,929											6,494,929
Long Term Care - Medi-Cal	505,981	498,953											498,953
Aged - Dual	2,079,562	2,127,957											2,127,957
Disabled - Dual	1,428,399	1,458,787											1,458,787
Long Term Care - Dual	3,887,362	3,963,761											3,963,761
BCCTP	262,430	267,742											267,742
Abortion (Family/Adult Only)	51,062	53,908											53,908
Total	24,456,212	25,259,916	-	-	-	-	-	-	-	-	-	-	25,259,916

Less: Previous Cap Received Retro Payments	(24,382,994)	-											(24,382,994)
Net Change due to Retro Activity	73,218	803,703											876,922

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	254.11	251.00											

Data Source: 820 File - Assumes this information is available in the 820 File.

Months in the column headers should state the month and year e.g 07/12, 6/12, 5/12 etc

Gold Coast Health Plan
Monthly Restated Membership Report
January, 2012

<u>Aid Category</u>	Feb Current Month Membership	Mar Current Month Plus 1	Apr Current Month Plus 2	May Current Month Plus 3	Jun Current Month Plus 4	Jul Current Month Plus 5	Aug Current Month Plus 6	Sep Current Month Plus 7	Oct Current Month Plus 8	Nov Current Month Plus 9	Dec Current Month Plus 10	Jan Current Month Plus 11	Total Member Months
Adult/Family	70,015												-
Aged - Medi-cal	1,262												-
Disabled - Medi-Cal	7,707												-
Long Term Care - Medi-Cal	65												-
Aged - Dual	8,952												-
Disabled - Dual	7,264												-
Long Term Care - Dual	855												-
BCCTP	238												-
Total	96,358	-	-	-	-	-	-	-	-	-	-	-	-

<u>Aid Category</u>	Current Month Capitation Paid	Current Month Minus 1 Capitation Paid	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	9,216,775	-	-	-	-	-	-	-	-	-	-	-	-
Aged - Medi-cal	657,679	-	-	-	-	-	-	-	-	-	-	-	-
Disabled - Medi-Cal	6,418,313	-	-	-	-	-	-	-	-	-	-	-	-
Long Term Care - Medi-Cal	456,788	-	-	-	-	-	-	-	-	-	-	-	-
Aged - Dual	2,092,888	-	-	-	-	-	-	-	-	-	-	-	-
Disabled - Dual	1,433,332	-	-	-	-	-	-	-	-	-	-	-	-
Long Term Care - Dual	3,842,421	-	-	-	-	-	-	-	-	-	-	-	-
BCCTP	252,868	-	-	-	-	-	-	-	-	-	-	-	-
Abortion (Family/Adult Only)	51,111	-	-	-	-	-	-	-	-	-	-	-	-
Total	24,371,064	-	-	-	-	-	-	-	-	-	-	-	-

Less: Previous Cap Received
Retro Payments

Net Change due to Retro Activity

-	-	-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-	-	-

<u>Aid Category</u>	Current Month Rates	Current Month Minus 1 Capitation Rates	Current Month Minus 3 Capitation Paid	Current Month Minus 4 Capitation Paid	Current Month Minus 5 Capitation Paid	Current Month Minus 6 Capitation Paid	Current Month Minus 7 Capitation Paid	Current Month Minus 8 Capitation Paid	Current Month Minus 9 Capitation Paid	Current Month Minus 10 Capitation Paid	Current Month Minus 11 Capitation Paid	Current Month Minus 12 Capitation Paid	Total Capitation Paid
Adult/Family	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64	131.64
Aged - Medi-cal	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14	521.14
Disabled - Medi-Cal	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79	832.79
Long Term Care - Medi-Cal	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51	7027.51
Aged - Dual	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79	233.79
Disabled - Dual	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32	197.32
Long Term Care - Dual	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06	4494.06
BCCTP	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47	1062.47
Abortion (Family/Adult Only)	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Total	252.92	#DIV/0!											

Line	Priority	Description	Status	Expected Completion	Estimated Addtl Cost
1	1	Provider User Guide for Portal	Active	2/15/12	\$6,500
2	1	Implement Vision Management Group	Active	3/1/12	\$20k
3	1	Clinicas Contract	Active	TBD	\$500k
4	1	GCHP Urgent Care Policy	Active	2/29/12	TBD
5	1	Milliman Reporting Support	Active	TBD	TBD
6	1	Reports	Active	2/29/12	TBD
7	1	State Audit Action Items	Active	2/29/12	TBD
8	1	1099 Forms	Active	3/31/12	No Charge
9	1	Adjustments	Active	Ongoing	No Charge
10	1	Authorization matching	Active	3/30/12	No Charge
11	1	Claim resource and training	Active	2/29/12	No Charge
12	1	COB claims - eligibility enhancements	Active	2/29/12	No Charge
13	1	COB claims - mailroom fixes	Active	2/29/12	No Charge
14	1	iKA auth training session portal	Active	2/29/12	No Charge
15	1	Mailroom Scanner	Active	2/29/12	No Charge
16	1	Med Mgmt project and system changes	Active	6/1/12	No Charge
17	1	Pends	Active	2/29/12	No Charge
18	1	Portal administrator	Active	2/29/12	No Charge
19	1	Pricing Issues	Active	3/30/12	No Charge
20	1	Project Manager	Active	2/29/12	No Charge
21	1	Provider outreach and reconciliation	Active	Ongoing	No Charge
22	1	report roles	Active	2/29/12	No Charge
23	1	Retro billing - ACS membership true-up	Active	2/29/12	No Charge
24	1	Share of Cost	Active	2/29/12	No Charge
25	2	AB97 Provider Pricing Cuts	Hold	TBD	TBD
26	2	Claims payment and pricing - Coalition America review	Active	TBD	TBD
27	2	EOP changes	Active	TBD	TBD
28	2	FAME to 834 Conversion	Active	3/31/12	TBD
29	2	Implement 835	Active	3/30/12	TBD
30	2	Implement EFT	Active	TBD	TBD
31	2	Implement ICES	Active	TBD	TBD
32	2	Medi Medi Cross Over	Active	TBD	TBD
33	2	OIL/APL review	Active	TBD	TBD
34	2	PCP Auto-assignment Finalization	Active	TBD	TBD
35	2	Plan-to-Plan Contract Implementation	Not started	TBD	TBD
36	3	6A Replacement	Hold	TBD	TBD
37	3	820 File Processing - Member Reconciliation	Not started	TBD	TBD
38	3	Adult Day Care	Need Info	TBD	TBD
39	3	Allow attachments to auths on Portal	Not started	TBD	TBD
40	3	Allow manual capitation Adjustments	Not started	TBD	TBD
41	3	Co-Pay implementation	Not started	TBD	TBD
42	3	Implement 277U	Not started	TBD	TBD
43	3	Implement Positive Pay	Not started	TBD	TBD
44	3	Member portal	Not started	TBD	TBD
45	3	Migrant Workers - Monterey County	Not started	TBD	TBD
46	3	SPD	Not started	TBD	TBD

**BRG Health Analytics
Workplan for Gold Coast Health Plan**

Phase I: Initial Operational Assessment

Initial Review of Gold Coast's Financial Condition

- Interview senior management team
- Review financial forecast, projections and assumptions
- Review IBNR/accrual
- Review contracts and relationships with third party vendors
- Review provider advancements outstanding

Initial Review of Claims Adjudication Process

- Review current claims processing policies and procedures
- Conduct interviews with claims personnel to understand system and any potential claims adjudication issues
- Conduct interviews with ACS management responsible for Gold Coast contract
- Perform walk through of claims functions performed onsite

Prepare Detailed Workplan for Phase II Based on Initial Site Visit

*****Estimated professional hours between 110 and 120 and fees not to exceed \$49,950*****

**BRG Health Analytics
Gold Coast Health Plan Document and Data Request**

Phase I: Initial Operational Assessment

Initial Review of Gold Coast's Financial Condition

Organization chart, including roster of employees and job titles

Financial review

- 12/31/2011 financial statements
- 12/31/2011 trial balance
- 12/31/2011 detailed IBNR calculations with claims lags
- Monthly disbursement ledgers (for all accounts)
- Monthly bank statements (for all accounts)
- All documentation with regards to provider advancements, including provider advancements outstanding and reconciliation process

Contract with ACS for claims processing, including the contract with the affiliate check printing company

Initial Review of Claims Adjudication Process
--

Current claims processing policies and procedures

Claims tracking documentation

- Mail room claims receipt log
- Scanned claims transmittal log
- Claims adjudication reports, including any reports for denied, adjusted, or pending claims
- Claims payment ledgers
- Any reports used to audit claims payments
- Any reports used to monitor the accuracy and timeliness of claims payments

Data layout and data dictionary for ACS's IKA claims system, including but not limited to:

- Claims processing module(s)
- Membership/eligibility module(s)
- Provider module(s)
- List of codes and explanations for the codes used in the claims adjudication process, including but not limited to, adjustment codes, pending codes, denial codes

Data download of all claims records from IKA claims system from inception through present

- File should be a pipe ("|") delimited text (.txt) file with column headers
- File should include indicators for whether claim or claim line was paid, denied, pending or rejected
- File should include final version of claims only (e.g., if a claim was adjusted, only include the information on the ultimate adjudication rather than previous versions that no longer reflect the ultimate adjudication, *unless* the prior version(s) are required to make a determination on the final adjudication of the claim). For example, if a claim was originally paid at \$75 and was subsequently adjusted to pay at \$100, we need to be able to see that \$100 was ultimately paid. If this is reflected in the system as three records - one record of \$75, one record of -\$75 and one record of \$25, we would like the net result to be included as one record at \$100. If the claim is reflected on two records of \$75 and \$25, we would need both records to be able to determine that a total of \$100 was paid.

Data layout and data dictionary for the ICMS system used by Medical Management unit

Provider Contracts

- Hospital contracts with reimbursement schedules for 2011 through 2012
- List of contracted physicians from which contracts to be reviewed can be selected once on site
- Representative sample of contracts non-hospital, non-physician agreements for highest volume providers

February 7, 2012

Executive / Finance Committee
Ventura County Medi-Cal Managed Care Commission
dba Gold Coast Health Plan
2220 E. Gonzales Rd., Ste. 200
Oxnard, CA 93036

Attention Ms. Sonia DeMarta:

This letter is intended to communicate certain matters related to the planned scope and timing of our audit of Ventura County Medi-Cal Managed Care Commission (dba Gold Coast Health Plan) financial statements as of and for the period from inception through June 30, 2011.

Communication

Effective two-way communication between our firm and Gold Coast Health Plan's Executive / Finance Committee is important to understanding matters related to the audit and in developing a constructive working relationship.

Your insights may assist us in understanding Gold Coast Health Plan and its environment, in identifying appropriate sources of audit evidence, and in providing information about specific transactions or events. We will discuss with you your oversight of the effectiveness of internal control and any areas where you request additional procedures to be undertaken. We expect that you will timely communicate with us any matters you consider relevant to the audit. Such matters might include strategic decisions that may significantly affect the nature, timing and extent of audit procedures, your suspicion or detection of fraud, or any concerns you may have about the integrity or competence of senior management.

We will timely communicate to you any fraud involving senior management and other fraud that causes a material misstatement of the financial statements, illegal acts that come to our attention (unless they are clearly inconsequential), and disagreements with management and other serious difficulties encountered in performing the audit. We also will communicate to you and to management any significant deficiencies or material weaknesses in internal control that become known to us during the course of the audit. Other matters arising from the audit that are, in our professional judgment, significant and relevant to you in your oversight of the financial reporting process will be communicated to you in writing after the audit.

Independence

Our independence policies and procedures are designed to provide reasonable assurance that our firm and its personnel comply with applicable professional independence standards. Our policies address financial interests, business and family relationships, and non-audit services that may be thought to bear on independence. For example, without our permission no partner or professional employee of McGladrey & Pullen, LLP is permitted to own any direct financial interest or a material indirect financial interest in a client or any affiliates of a client. Also, if an immediate family member or close relative of a partner or professional employee is employed by a client in a key position, the incident must be reported and resolved in accordance with Firm policy. In addition, our policies restrict certain non-audit services that may be provided by McGladrey and Pullen, LLP and require audit clients to accept certain responsibilities in connection with the provision of permitted non-attest services.

The Audit Planning Process

Our audit approach places a strong emphasis on obtaining an understanding of how your business functions. This enables us to identify key audit components and tailor our procedures to the unique aspects of your business. The development of a specific audit plan will begin by meeting with you and with management to obtain an understanding of business objectives, strategies, risks and performance.

We will obtain an understanding of internal control to assess the impact of internal control on determining the nature, timing and extent of audit procedures, and we will establish an overall materiality limit for audit purposes. We will conduct formal discussions among engagement team members to consider how and where your financial statements might be susceptible to material misstatement due to fraud or error.

We will use this knowledge and understanding, together with other factors, to first assess the risk that errors or fraud may cause a material misstatement at the financial statement level. The assessment of the risks of material misstatement at the financial statement level provides us with parameters within which to design the audit procedures for specific account balances and classes of transactions. Our risk assessment process at the account-balance or class-of-transactions level consists of:

An assessment of inherent risk (the susceptibility of an assertion relating to an account balance or class of transactions to a material misstatement, assuming there are no related controls); and

An evaluation of the design effectiveness of internal control over financial reporting and our assessment of control risk (the risk that a material misstatement could occur in an assertion and not be prevented or detected on a timely basis by the company's internal control).

We will then determine the nature, timing and extent of tests of controls and substantive procedures necessary given the risks identified and the controls as we understand them.

The Concept of Materiality in Planning and Executing the Audit

In planning the audit, the materiality limit is viewed as the maximum aggregate amount of pretax misstatements, which if detected and not corrected, would cause us to modify our opinion on the financial statements. The materiality limit is an allowance not only for misstatements that will be detected and not corrected but also for misstatements that may not be detected by the audit. Our assessment of materiality throughout the audit will be based on both quantitative and qualitative considerations. Because of the interaction of quantitative and qualitative considerations, misstatements of a relatively small amount could have a material effect on the current financial statements as well as financial statements of future periods. At the end of the audit, we will inform you of all individual unrecorded misstatements aggregated by us in connection with our evaluation of our audit test results.

Our Approach to Internal Control Relevant to the Audit

Our audit of the financial statements will include obtaining an understanding of internal control sufficient to plan the audit and to determine the nature, timing and extent of audit procedures to be performed. An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weaknesses. Our review and understanding of the Company's internal control is not undertaken for the purpose of expressing an opinion on the effectiveness of internal control.

Executive / Finance Committee
Gold Coast Health Plan
February 7, 2012
Page 3

Timing of the Audit

We will perform audit fieldwork in February and/or March. We plan to conclude the audit in April of 2012. Management's adherence to its closing schedule and timely completion of information used by us in performance of the audit is essential to timely completion of the audit.

Closing

We will be pleased to respond to any questions you have about the foregoing. We appreciate the opportunity to be of service to Gold Coast Health Plan.

This communication is intended solely for the information and use of the Executive / Finance Committee and is not intended to be and should not be used by anyone other than these specified parties.

McGladrey & Pullen, LLP

A handwritten signature in cursive script that reads "Steve Draxler".

Steven J. Draxler, Partner
steve.draxler@mcgladrey.com
612.376.9590

Pay Grade Schedule

Title	Pay Grade	Minimum	Market Target	Maximum
Analyst, Senior Financial	M	\$79,754	\$103,680	\$127,606
Assistant, Administrative	E	\$42,429	\$51,975	\$61,521
Assistant, Clinical Operations	D	\$35,065	\$42,955	\$50,845
Assistant, Data Entry	C	\$28,980	\$35,500	\$42,020
Assistant, Grievance & Appeals	D	\$35,065	\$42,955	\$50,845
Chief Financial Officer	P	\$137,815	\$179,158	\$220,504
Chief Medical Officer	Q	\$185,000	\$200,000	\$230,000
Claims Auditor	J	\$46,154	\$60,000	\$72,846
Claims PR Research	J	\$46,154	\$60,000	\$73,846
Clerk of the Board/Executive Assistant	J	\$55,384	\$72,000	\$88,615
Compliance Specialist	K	\$55,384	\$72,000	\$88,615
Coordinator, Accounts Payable	D	\$35,065	\$42,955	\$50,845
Coordinator, Grievance & Appeals	J	\$46,154	\$60,000	\$73,846
Coordinator, Member Services Outreach	C	\$28,980	\$35,500	\$42,020
Director / Senior Director	O	\$114,845	\$149,299	\$183,753
Entry Level Positions (none at this time)	B	\$23,950	\$28,045	\$34,727
Health Educator	K	\$55,384	\$72,000	\$88,615
Manager, Care Coordination	M	\$79,754	\$103,680	\$127,606
Manager, Finance & Accounting	M	\$79,754	\$103,680	\$127,606
Manager, IT	N	\$95,704	\$124,416	\$153,127
Manager, Provider Relations	M	\$79,754	\$103,680	\$127,606
Manager, Systems	M	\$79,754	\$103,680	\$127,606
Project Specialist	L	\$66,462	\$86,400	\$106,338
Representative, Provider Relations	J	\$46,154	\$60,000	\$73,846
Technician, Desktop Support	E	\$42,429	\$51,975	\$61,521

Pay Grade	Minimum	Market Target	Maximum
B	\$23,950	\$28,045	\$34,727
C	\$28,980	\$35,500	\$42,020
D	\$35,065	\$42,955	\$50,845
E	\$42,429	\$51,975	\$61,521
F	Reserved for future use.		
G			
H			
I			
J	\$46,154	\$60,000	\$72,846
K	\$55,384	\$72,000	\$88,615
L	\$66,462	\$86,400	\$106,338
M	\$79,754	\$103,680	\$127,606
N	\$95,704	\$124,416	\$153,127
O	\$114,845	\$149,299	\$183,753
P	\$137,815	\$179,158	\$220,504
Q	\$185,000	\$200,000	\$230,000

Updated 2-17-2012

HOSPITAL SERVICES AGREEMENT

Between

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

And

This Agreement is made effective as of the _____ day of _____, 2011 (the “Effective Date”), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as “PLAN” and _____ (please print) licensed as a hospital by the State of California pursuant to the California Health and Safety Code, Sections 1250 et. seq., which is eligible to participate in the California Medi-Cal (Medicaid) Program, and meets applicable requirements under Titles XVIII and XIX of the Social Security Act, hereinafter referred to as “HOSPITAL”.

IN WITNESS WHEREOF, the subsequent Agreement between PLAN and HOSPITAL is entered into by and between the undersigned parties.

HOSPITAL:

PLAN:

Hospital Provider Name Above

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

Executed by:

Executed by:

Signature

Signature

Printed Name

Earl Greenia
Chief Executive Officer

Title

Date

Date

Address for Notices:

Address for Notices:

Gold Coast Health Plan
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-8294

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
HOSPITAL AGREEMENT
TABLE OF CONTENTS**

RECITALS3

SECTION 1 – DEFINITIONS4

SECTION 2 – QUALIFICATIONS, OBLIGATIONS AND COVENANTS8

SECTION 3 – SCOPE OF SERVICES13

SECTION 4 – EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES ..14

SECTION 5 – REIMBURSEMENT, ACCOUNTS REPORTING AND RECOVERIES15

SECTION 6 – RECORDS AND CONFIDENTIALITY18

SECTION 7 – INSURANCE AND INDEMNIFICATION22

SECTION 8 – GRIEVANCES AND APPEALS23

SECTION 9 – TERMS AND TERMINATION.....25

SECTION 10 – GENERAL PROVISIONS27

SECTION 11 - RELATIONSHIP OF PARTIES.....31

SECTION 12 – ADDITIONAL LEGAL REQUIREMENTS32

ATTACHMENT A – Information Regarding Officers, Owners, and Stockholders

ATTACHMENT B – Per Diem Reimbursement Rates

RECITALS

- A. WHEREAS, PLAN is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.
- B. WHEREAS, PLAN has entered into and maintains contracts with the State of California, Department of Health Care Services (the “ Medi-Cal Agreements”) in accordance with the requirements of W&I Code, Section 14200 et. seq.; Title 22, CCR, Section 53250; and applicable federal and State laws and regulations, under which Ventura County Medi-Cal Beneficiaries, assigned to PLAN as Members, receive all medical services hereinafter defined as "Covered Services", through the PLAN as a County Organized Health System (COHS).
- C. WHEREAS, HOSPITAL, is licensed in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, Sections 1250 et seq.) and the regulations promulgated pursuant thereto, is currently certified under Title XVIII of the Federal Social Security Act, complies with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, and has on its medical staff physicians who have contracted with PLAN to provide physician services to Medi-Cal Members enrolled in the PLAN Medi-Cal Managed Care Program
- D. WHEREAS, the PLAN desires to arrange for hospital and other services for its Medi-Cal Members, and HOSPITAL desires to provide Hospital and other services for such Medi-Cal Members.

NOW THEREFORE, in consideration of the foregoing recitals and the mutual promises and covenants herein, receipt and sufficiency of which are hereby acknowledged, the parties agree and covenant as follows:

SECTION 1 DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

- 1.1 Administrative Day. Any day in an acute care facility for which inpatient care is not required, for whose care has been approved by the PLAN as such.
- 1.2 Administrative Member. Medi-Cal Members enrolled with PLAN who have not been assigned to a Primary Care Physician for administrative reasons.
- 1.3 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.

- 1.4 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.
- 1.5 Authorization Request Form (ARF). The form approved by PLAN for the provision of specified Covered Services set forth in the Provider Manual.
- 1.6 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.
- 1.7 Capitation Payment. The prepaid monthly amount that PLAN pays to Primary Care Physician (PCP) as compensation for those Covered Medical Services which are set forth in Attachment C, attached to and incorporated within the PCP Medical Services Agreement with PLAN.
- 1.8 Case Managed Members. Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care.
- 1.9 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.
- 1.10 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.
- 1.11 Complex Case. Members requiring comprehensive care management and coordination of services. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex psychosocial 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.
- 1.12 Contract Year. The 12-month period following the effective date of this Agreement between HOSPITAL and PLAN 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 PLAN operational date will apply.
- 1.13 County Organized Health System (COHS). A plan serving either a single or multiple county areas.
- 1.14 Covered Medical Services. Those Covered Services that are set forth in the Member Handbook some of which are to be provided to, or arranged for, Members by HOSPITAL, within the scope

of its licensure, pursuant to this Agreement and for which HOSPITAL is to be compensated by PLAN in accordance with Attachment B of this Agreement.

- 1.15 Covered Services. All Medically Necessary services to which Members are entitled from PLAN as set forth in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services. Covered Services includes Covered Medical Services.
- 1.16 DHCS. The State of California Department of Health Care Services.
- 1.17 Direct Referral Authorization Form (DRAF). The Plan's form, evidencing referral by PCP or Medical Director, or designee for initial specialist consultation or return follow-up with forty-five (45) days.
- 1.18 Eligible Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the PLAN 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.
- 1.19 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.
- 1.20 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.
- 1.21 Encounter Form. The UB04 or CMS1500 claim form used by HOSPITAL to report to the PLAN provision of Covered Services to Medi-Cal Members.
- 1.22 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the PLAN.
- 1.23 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.
- 1.24 Fee-For-Service Payment (FFS). (1) The maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by Plan and the HOSPITAL. All Covered Services authorized by PLAN pursuant to this Agreement will be compensated by PLAN as described in Attachment B.
- 1.25 Fiscal Year. The 12 month period starting July 1.
- 1.26 Governmental Agencies. Any agency that has legal jurisdiction over PLAN, Medi-Cal or Medicaid, such as: the Department of Managed Health Care ("DMHC"), DHCS, United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General.
- 1.27 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.

- 1.28 Identification Card. The card that is prepared by the PLAN which bears the name and symbol of PLAN and contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with PLAN or proof of Medi-Cal eligibility.
- 1.29 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.
- 1.30 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by PLAN to monitor the quality assurance and implement Quality Improvement Program of PLAN. Also called Chief Medical Officer.
- 1.31 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. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.
- 1.32 Medi-Cal Managed Care Program. The program that PLAN operates under its Medi-Cal Agreement with the DHCS for the Service Area.
- 1.33 Medi-Cal Provider Manual. The Medical Services Provider Manual of the DHCS, issued by the DHCS Fiscal Intermediary.
- 1.34 Medical Transportation. "Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, specially equipped 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.
- 1.35 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the PLAN.
- 1.36 Member Handbook. The PLAN 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 PLAN and the Medi-Cal Member.
- 1.37 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.
- 1.38 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.
- 1.39 Observation Day. A period of a minimum of 8 hours in duration during which services furnished by a hospital on the hospital's premises, including use of a bed and at least periodic monitoring by a hospital's nursing staff, which are reasonable and Medically

Necessary and appropriate to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician. In no instance shall PLAN pay for normal postoperative monitoring during a standard recovery period.

- 1.40 Operations Manual. The Manual of Operational Policies and Procedures for the PLAN Medi-Cal Managed Care Program. Also called Provider Manual.
- 1.41 Out-of-Area. The geographic area outside Ventura County.
- 1.42 Participating Referral Provider. Any health professional or institution contracted with PLAN that meets the Standards for Participation in the State Medi-Cal Program to render medical services to Medi-Cal Members.
- 1.43 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with PLAN and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program and who has contracted with PLAN to provide medical services to Medi-Cal members.
- 1.44 Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the PLAN. Such limit may be changed by mutual agreement of the parties.
- 1.45 Placement Day. A day that shall be approved by PLAN, when a Member is clinically stable for discharge and HOSPITAL performed "Sufficient Discharge Planning" (i.e. HOSPITAL has taken steps that include but are not limited to the following to discharge the Member from an inpatient status to a different level of care: 1) Communication with Member regarding home support if Member is able to be discharged home with home health and other supportive services, 2) Member transfer organizational processes to the post hospital facility or home discharge, including arranging for home healthcare and transportation, 3) when appropriate, communication with PLAN Utilization Management (UM) staff for assistance with home discharge, home health and other services), but the Member cannot be discharged for reasons outside of HOSPITAL'S control. Placement Day may also be expressed as a Placement Day Rate.

HOSPITAL staff shall contact PLAN's UM staff twenty-four (24) hours after the planned discharge date for authorization of Placement Days if HOSPITAL is unable to discharge the Member after Sufficient Discharge Planning efforts. If the discharge is planned for the weekend or a holiday, HOSPITAL staff shall contact PLAN staff the following business day. If Sufficient Discharge Planning efforts occurred, Placement Days shall be authorized to include any weekend or holiday. After receiving authorization from PLAN for Placement Days, HOSPITAL will bill PLAN using Revenue code 169 and will be reimbursed at the Placement Day Rate for each authorized day as specified in Attachment B of this Agreement.

- 1.46 Plan. The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission and serving Ventura County Medi-Cal Eligible Beneficiaries. Also called Gold Coast Health Plan.
- 1.47 Primary Care Physician or PCP. A physician duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; 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, and pediatricians but may or may not include Obstetrician-Gynecologists depending on their scope of practice.
- 1.48 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.
- 1.49 Primary Hospital. Any hospital located within Ventura County that has entered into an Agreement with the PLAN.
- 1.50 Provider Manual. The Plan's Manual describing operational policies and procedures relevant to Providers. Also called Operations Manual.
- 1.51 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.
- 1.52 Referral Physician. Any qualified physician, duly licensed in California who meets the Standards of Participation, has been enrolled in the State Medi-Cal Program in accordance with Article 3, Title 22, CCR. Exception to this requirement must be authorized by Plan CEO and/or Medical Director. A Referral Physician must have an Agreement with PLAN or authorized by a subcontracted Plan provider. Primary Care Physician may refer any Member for consultation or treatment to a Referral Physician.
- 1.53 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.
- 1.54 Service Area. The County of Ventura.
- 1.55 Treatment Authorization Request or TAR or Prior Authorization. The PLAN's form for the provision of inpatient Non-Emergency Services as set forth in the Provider Manual.
- 1.56 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).
- 1.57 Utilization Management Program. The program(s) approved by PLAN, which are designed to review and monitor the utilization of Covered Services. Such program(s) are set forth in the PLAN's Provider Manual.

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

SECTION 2
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

- 2.1 HOSPITAL is responsible for:

- 2.1.1 Provision of Covered Services. HOSPITAL shall provide to Members those Covered Services that are Medically Necessary which HOSPITAL is licensed to provide and customarily provides to all HOSPITAL patients. Those services which HOSPITAL customarily provides but which are specifically excluded from this Agreement, if any, are described in Section 4. HOSPITAL will perform such hospital services in an economic and efficient manner consistent with professional standards of medical care generally accepted by the medical community. Any Primary Care Physician or Specialist Physician who admits or treats a Medi-Cal Member in HOSPITAL must be a member in good standing of HOSPITAL'S organized medical staff with appropriate clinical privileges to admit and treat such Medi-Cal Member. HOSPITAL is responsible for coordinating the provision of Covered Services with the Member's assigned Primary Care Physician.
- 2.1.2 Admission and Transfer of Medi-Cal Members. Upon receipt of prior authorization from PLAN or its designee, HOSPITAL shall admit Medi-Cal Members in accordance with its admission protocols and community standards. In the event that a Medi-Cal Member is transferred to or from HOSPITAL to another hospital that is a Participating Hospital, HOSPITAL will complete all transfer and authorization forms requested by PLAN, and as necessary, to ensure the continuity of care of the Medi-Cal Member.
- 2.1.3 Referral and Authorization. Except for Emergency Services, HOSPITAL will provide Hospital Services to Medi-Cal Members only when HOSPITAL has received an appropriate prior written authorization for such Services from PLAN or its designee.
- 2.1.4 Plan Policies and Procedures Compliance. HOSPITAL will comply with the policies and procedures approved by PLAN for the provision of Covered Services under the Medi-Cal Managed Care Program. HOSPITAL agrees to comply with all policies and procedures set forth in the PLAN Provider Manual. The Provider Manual is available through the PLAN website at www.____.org. PLAN may modify the Provider Manual from time to time.
- 2.1.5 Standards: HOSPITAL shall:
- (a) Standards of Care. Provide Covered Services to Members that are Medically Necessary that are the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.

- (b) Licensure. Maintain in good standing the license and accreditation of its facility or facilities in accordance with Section 1250 et seq. of the Health and Safety Code and the licensing regulations contained in Title 22 and 17 of the California Code of Regulations. HOSPITAL agrees to remain certified under Title XVIII of the Federal Social Security Act, and shall notify PLAN immediately if any action of any kind is initiated against HOSPITAL which could result in (a) the suspension or revocation of its license; or (b) the suspension or loss of accreditation, or (c) the imposition of any sanction against HOSPITAL under the Medicare or Medi-Cal Programs; or (d) the material impairment of its ability to provide hospital services hereunder. HOSPITAL shall provide PLAN with evidence of such licensure and accreditation upon execution of this Agreement.
- (c) Officers, Owners, and Stockholders. Be responsible for providing upon execution of this Agreement the information regarding officers, owners and stockholders as set forth in Attachment A, attached to and incorporated herein.
- (d) Facilities, Equipment and Personnel. Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement.
- (e) Hospital Privileges. Use its best efforts in granting HOSPITAL privileges in accordance with its medical staff bylaws for qualified Participating Providers affiliated with PLAN.
- (f) Medical Records. Ensure that a medical record will be established and maintained for each Medi-Cal Member. Each Medi-Cal Member's medical record will be established upon the Medi-Cal Member's first visit. The record will contain that information normally included in accordance with generally accepted HOSPITAL practices and standards prevailing in the professional community. HOSPITAL will facilitate the sharing of medical information with other providers subject to all applicable laws and professional standards regarding the confidentiality of medical records. HOSPITAL will make such records available to authorized PLAN personnel and its designees in order for PLAN to conduct its Quality Improvement and Utilization Management Programs.
- (g) Cultural and Linguistic Services. HOSPITAL shall provide services to Members in a culturally, ethnically and linguistically appropriate manner. HOSPITAL shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. HOSPITAL shall comply with Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate

with Plan by providing any information necessary to assess compliance. HOSPITAL is responsible for providing interpretive services. However, if HOSPITAL unable to meet a member's interpretive needs, HOSPITAL may utilize the PLAN's telephonic language assistance program, if available. If HOSPITAL does not utilize Plan's telephonic interpreters, however, Contractor shall provide or arrange for interpreter services for Members at all service locations at both medical and non-medical points of contact, at no additional cost to PLAN and at no cost to Members.

2.1.6 Participation in Quality Improvement and Utilization Management Programs. HOSPITAL will cooperate and participate in PLAN'S Quality Improvement and Utilization Management Programs and will comply with the policies and procedures associated with these Programs. This includes participation in facility reviews, chart and access audits and focused reviews.

- (a) HOSPITAL will participate in the development of corrective action plans for any areas that fall below PLAN standards and ensuring medical records are readily available to the PLAN staff as requested.
- (b) HOSPITAL recognizes the possibility that PLAN, through the utilization management and quality improvement process, may be required to take action requiring consultation with its Medical Director or with other physicians prior to authorization of services or supplies or to terminate this Agreement.
- (c) In the interest of program integrity or the welfare of Members, PLAN may introduce additional utilization controls as may be necessary.
- (d) In the event of such change, a thirty (30) day notice will be given to the HOSPITAL. HOSPITAL will be entitled to appeal such action to the Quality and Utilization Advisory Committee, (QUAC), the Physician Advisory Group and then to the PLAN Board of Commissions.

2.1.7 HOSPITAL will apply standards established by PLAN's Quality Improvement and Utilization Management Programs in determining appropriate referrals, length of stay and discharge planning in a manner to affect the goals set forth in program descriptions and work plans of both programs.

2.1.8 Actions Against HOSPITAL. HOSPITAL will adhere to the requirements as set forth in the PLAN Provider Manual and notify PLAN by certified mail within five (5) days of HOSPITAL's learning of any action taken which results in restrictions on HOSPITAL's provision of services regardless of the duration of the restriction or exclusion from participation in the Medi-Cal Program in accordance with the Standards of Participation.

2.1.9 Data Requirements. HOSPITAL shall:

- (a) Financial and Accounting Records. Maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Upon PLAN written request, HOSPITAL will furnish to PLAN an annual Balance Sheet and Profit and Loss Statement prepared in accordance with generally accepted accounting principles consistently applied and, if available, the annual audit report of an independent certified public accountant.
 - (b) Encounter and Claims Data. Provide encounter and claims data for all services for each Medi-Cal Member visit and hospitalization. Such data will be provided by HOSPITAL to PLAN in a form acceptable to PLAN and DHCS at no cost, at least monthly, on a UB-04 Claim Form, other claim forms as may be designated by PLAN or by electronic transfer. All forms (data) submitted should contain the data elements as outlined in the PLAN Provider Manual.
 - (c) Reports. Submit reports as required by PLAN or DHCS.
- 2.1.10 Compliance with Member Handbook. HOSPITAL acknowledges that HOSPITAL is not authorized to make nor will HOSPITAL make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook. HOSPITAL will comply with existing State and federal regulations promulgated hereto pertaining to the issuance of explanations of benefits under the Medi-Cal Managed Care Program to Medi-Cal Members as outlined in the Member Handbook.
- 2.1.11 Promotional Materials. HOSPITAL consents to be identified as a hospital in written materials published by PLAN, including without limitation, the provider directory and marketing materials prepared and distributed by PLAN.
- 2.1.12 Domestic Partners. Any HOSPITAL licensed in accordance with California Health & Safety Code Section 1250 will ensure that Medi-Cal Members are permitted to be visited by the Medi-Cal Member's domestic partner, the children of the Medi-Cal Member's domestic partner, and the domestic partner of the Medi-Cal Member's parent or child.
- 2.1.13 HOSPITAL is not obligated hereunder to provide Members with inpatient, outpatient or emergency services that are not currently maintained by HOSPITAL due to religious or other reasons as of the effective date of this Agreement.
- 2.1.14 HOSPITAL will retain the right, within its sole discretion, to alter, enlarge, reconstruct, modify, or shut down all or any part of its facilities, provided

however, that written notice of any action described herein, which would materially affect the services available to Members hereunder, will be given to PLAN at least sixty (60) days prior to implementation of such change, and PLAN will have the right to terminate this Agreement upon providing HOSPITAL with thirty (30) days prior written notice in accordance with Section 9 of this Agreement.

2.1.15 Hospital Admission. Hospital agrees to notify PLAN Utilization Management Department within twenty-four (24) hours of all in-patient admissions.

2.1.16 Concurrent Review. HOSPITAL will cooperate with PLAN in conducting concurrent review of in-patient services provided to members. PLAN UM nurses may conduct onsite review in addition to HOSPITAL UM Staff providing periodic updates of member's medical condition to PLAN. HOSPITAL agrees to retrospective review of members medical records when concurrent review was not available. Hospital agrees to use nationally recognized criteria, PLAN UM guidelines developed and approved by the Quality/Utilization Advisory Committee (Q/UAC) and applicable laws and regulations, including, without limitation, California Code of Regulations Title 22, to determine appropriateness of all admission as well as in the determination of medical necessity for the continuation of all hospital stays.

2.1.17 Discharge Planning. HOSPITAL will continue to be responsible for discharge planning and will cooperate with PLAN discharge planning efforts.

2.1.18 Grievances and Appeals. HOSPITAL will cooperate with PLAN in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the Medi-Cal Member grievance policy and procedure set forth in the PLAN Provider Manual, and Quality Improvement Program.

2.2 PLAN is responsible for:

2.2.1 Administration and Provision of Data. PLAN shall perform all administrative, accounting, enrollment, eligibility verification and other functions necessary or appropriate for the operation, administration and marketing of the PLAN and consistent with the terms of this Agreement. PLAN shall provide HOSPITAL with management information and data reasonably necessary to carry out the terms and conditions of this Agreement and for the operation of the PLAN.

2.2.2 Enrollment and Eligibility Verification. PLAN shall enroll Members in accordance with applicable State and Federal Laws and the Medi-Cal Agreement. PLAN shall determine the identity and eligibility of all Members. Upon request by HOSPITAL, either before or after providing Hospital Services to Members, PLAN shall verify that a Member is eligible for benefits under the PLAN in accordance with procedures set forth in the Provider Manual.

- 2.2.3 Quality Assurance and Utilization Management Programs. PLAN shall establish and maintain a Quality Assurance Program, including a Quality Assurance Committee, for the purpose of evaluating, monitoring and improving the quality of clinical care and services provided to Members by HOSPITAL and other Participating Providers. The Quality Assurance Program shall be established and operated in accordance with applicable State and Federal Laws and the standards of applicable Accreditation Organizations. PLAN shall also establish and maintain a Utilization Management Program to provide for prior authorization for referrals for Covered Services and admissions for HOSPITAL Services, concurrent utilization review for HOSPITAL Services, and retrospective utilization review for Emergency Services and Urgently Needed Services. The Utilization Management Program shall be established and operated in accordance with applicable State and Federal Law and the standards of applicable Accreditation Organizations.

SECTION 3 **SCOPE OF SERVICES**

- 3.1 Access to Covered Service. HOSPITAL will provide Medically Necessary Covered Services on a readily available and accessible basis 24-hours a day in accordance with PLAN policies and procedures as set forth in the PLAN Provider Manual. HOSPITAL agrees to render quality medical services consistent with community standards of care to Medi-Cal Members.
- 3.2 Confirmation of Eligibility. Prior to rendering services to Medi-Cal Members, HOSPITAL will confirm Medi-Cal Members' eligibility by a) accessing the PLAN web-based eligibility, b) checking the PLAN automated eligibility telephone service and/or c) contacting PLAN member services department directly. If patient holds himself out to be a Medi-Cal Member, HOSPITAL will attempt to verify eligibility by following the above procedures. If HOSPITAL is unable to verify the purported Medi-Cal Member's eligibility, HOSPITAL will render any Urgent Care necessary. At the first available opportunity, HOSPITAL will again attempt to verify eligibility.
- 3.3 Emergency Services. HOSPITAL will provide Emergency Services to Medi-Cal Member's in accordance with PLAN policies and procedures, as set forth in the PLAN Provider Manual, and Utilization Management Program.
- 3.3.1 PLAN will reimburse HOSPITAL for treatment and services rendered by HOSPITAL's Emergency Department hereunder in accordance with Attachment B of this Agreement and in accordance with PLAN Provider Manual policies and procedures.
- 3.3.2 HOSPITAL will notify the Medi-Cal Member's assigned Primary Care Physician immediately upon treatment and PLAN within 24-hours of treatment or next business day in accordance with PLAN Provider Manual, policies and procedures and Utilization Management Program.

3.3.3 HOSPITAL and PLAN understand that authorization is not required prior to rendering Emergency Services by HOSPITAL'S Emergency Department physician(s).

SECTION 4

EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

- 4.1 Services Not Payable. Medi-Cal Members in need of services, which are not Covered Services, as described in the Member Handbook, will not be eligible for reimbursement by the PLAN.
- 4.2 Services Neither Covered nor Compensated. Subject to those exclusions from Covered Services as set forth in the Medi-Cal Agreement, HOSPITAL understands that HOSPITAL will not be obligated to provide Medi-Cal Members with, and the PLAN will not be obligated to reimburse HOSPITAL for the following Excluded Services (for which PLAN does not receive capitation payment from the DHCS):
- (a) Dental Services, as defined in Title 22 CCR Section 51307 and Early Periodic Screening Diagnosis and Treatment supplement dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;
 - (b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.
 - (c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted: (i) outpatient mental health services within the Primary Care Physician's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health

history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.

- (d) Services provided by the California Children's Services ("CCS") program.
- (e) Services rendered in a State or Federal governmental hospital;
- (f) Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;
- (g) Fabrication of optical lenses;
- (h) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;
- (i) Direct Observed Therapy for tuberculosis;
- (j) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;
- (k) Childhood lead poisoning case management services provided by the Local Health Department;
- (l) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the State Medi-Cal Contract; and
- (m) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 United States Code ("USC") Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.
- (n) Other Services as may be determined by the DHCS and the PLAN, and as noticed to participating Hospital. In the event of such a change, a thirty (30) day notice will be given to the Hospital.

SECTION 5

REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES

5.1 Payment for Authorized Services Only. The PLAN will reimburse HOSPITAL for Medically Necessary Covered Services, after prior-authorization is received from PLAN or its designee (for non-emergent Covered Services), in conformance with the Provider Manual and the schedule in Attachment B of this Agreement.

5.1.1 PLAN and HOSPITAL agree that PLAN is responsible for payment of emergency services, and that, except for emergencies, HOSPITAL shall not be entitled to reimbursement for any Covered Services provided to a Member unless HOSPITAL has obtained the necessary authorization from PLAN in accordance with PLAN's Provider Manual policies and procedures.

- 5.1.2 The Member's attending physician will determine the need for acute care in accordance with usual standards of medical practice in the community nationally recognized criteria, PLAN Utilization Management (UM) guidelines developed and approved by the Quality and or Utilization Committee and California Department of Health and Welfare Code of Regulations Title 22.
 - 5.1.3 Member's attending physician will determine the Medically Necessary course of treatment to be provided in the HOSPITAL.
 - 5.1.4 Nothing in this Agreement is intended to create (nor shall it be construed to create) any right by PLAN or by PLAN's Participating Providers (except in their capacity as Members of HOSPITAL's medical staff) to interfere with the method(s) by which HOSPITAL or attending physicians render services hereunder.
 - 5.1.5 Notwithstanding anything to the contrary set forth in this Agreement, PLAN may reduce the rates or other compensation payable to HOSPITAL at any time or from time-to-time during the term of this Agreement as determined by PLAN to reflect implementation of State or federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Covered Services, or changes in rates implemented by the DHCS, CMS or any other governmental agency providing revenue to PLAN, or any other change that results in decreases to the rates or level of funding paid to PLAN. The amount of such adjustment shall be determined by PLAN and need not be in proportion to or in the same amount as the decrease to the rates or level of funding paid to PLAN. All other rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same. Notwithstanding anything to the contrary set forth in this Agreement, PLAN's obligation to pay HOSPITAL any payment amount hereunder shall be subject to PLAN's corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to PLAN, as applicable.
- 5.2 Claims Submission. HOSPITAL shall submit a complete UB-04 form or submit complete data through electronic transfer, in accordance with the Provider Manual and Attachment B of this Agreement. Reimbursement will be made within thirty (30) days of receipt of an uncontested claim which is accurate, complete and otherwise in accordance with the PLAN provider manual. All claims for Covered Services must be submitted to the PLAN within six (6) months from the date that service was provided. If for any reason it is determined that PLAN overpaid HOSPITAL, PLAN may deduct monies in the amount equal to the overpayment from any future payments to HOSPITAL.
- 5.1.1 A summary report will accompany each check identifying the Medi-Cal Members who received Covered Services from HOSPITAL and the appropriate amount of reimbursement disbursed per Medi-Cal Member.

- 5.1.2 HOSPITAL agrees not to submit separate claims for reimbursement for Medi-Cal Members who receive outpatient and emergency medical services during the same calendar day as in-patient admission of the Medi-Cal Member to the HOSPITAL.
- 5.2 Entire Payment. HOSPITAL will accept from PLAN compensation as payment in full and discharge of PLAN's financial liability for Covered Services provided to eligible PLAN Members by HOSPITAL, and will be reimbursed as listed hereunder in those amounts set forth and in the manner and at the times as specified in Attachment B of this Agreement and in accordance with PLAN Provider Manual policies and procedures. HOSPITAL will look only to PLAN for such compensation. PLAN has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to PLAN are reduced by DHCS.
- 5.3. Medi-Cal Member Hold Harmless. HOSPITAL will not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal Member, or from other persons on behalf of the Medi-Cal Member, for any service included in the Medi-Cal program's Covered Services in addition to a claim submitted to the PLAN for that service. Furthermore, HOSPITAL will hold harmless the State of California and Medi-Cal Members in the event PLAN cannot or will not pay for services provided by HOSPITAL under this Agreement.
- 5.4 Coordination of Benefits. Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. HOSPITAL must bill the primary carrier before billing PLAN for reimbursement of Covered Services and, with the exception of authorized share of cost payments, will at no time seek compensation from Medi-Cal Members of the DHCS. The HOSPITAL may look to the Medi-Cal Member for non-covered services.
- 5.4.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the PLAN Provider Manual.
- 5.4.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005.
- 5.4.3 HOSPITAL will make best efforts to report to PLAN the discovery of third party insurance coverage for a Medi-Cal Member within five (5) business days of discovery.
- 5.4.4 HOSPITAL will recover directly from Medicare for reimbursement of medical services rendered. Medicare payments will be reported to the PLAN on the UB04 encounter form or electronic transfer tape as indicated in the Provider Manual.
- 5.5 Third Party Liability Tort. In the event that HOSPITAL provides services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State

of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by HOSPITAL pursuant to the terms of this Agreement.

5.5.1 HOSPITAL will cooperate with the DHCS and PLAN in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.

5.5.2 HOSPITAL will make best efforts to report to PLAN the discovery of third party tort action for a Medi-Cal Member within five (5) business days of discovery.

5.6 Subcontracts

5.6.1 All subcontracts between HOSPITAL and HOSPITAL's subcontractors pertaining to the provision of Covered Services under this Agreement ("Subcontractors") will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Agreement with the DHCS, Health and Safety Code Section 1340 et seq.; Title 28, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.

5.6.2 All such subcontracts and their amendments will become effective only upon written approval by PLAN and DHCS (to the extent DHCS approval is required) and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the HOSPITAL. HOSPITAL will notify DHCS and PLAN when any subcontract is amended or terminates. HOSPITAL will make available to PLAN and Governmental Agencies, upon request, copies of all agreements between HOSPITAL and Subcontract(s) for the purpose of providing Covered Services.

5.6.3 All agreements between HOSPITAL and any Subcontractor will require Subcontractor to comply with the following:

(a) Records and Records Inspection. Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least ten (10) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to HOSPITAL and PLAN all reports required by HOSPITAL, PLAN or DHCS.

(b) Surcharges. Subcontractor will not collect a Surcharge for Covered Services for a PLAN Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the PLAN Member within fifteen (15) days of the occurrence and will notify PLAN of the action taken. Upon notice of any Surcharge, PLAN will take appropriate action consistent with the terms of

this Agreement to eliminate such Surcharge, including, without limitation, repaying the Medi-Cal Member and deducting the amount of the Surcharge and the expense incurred by PLAN in correcting the payment from the next payment due to HOSPITAL.

- (c) Notification. Notify DHCS (to the extent DHCS notification is required) and PLAN in the event the agreement with Subcontract is amended or terminated. Notice will be given in the manner specified in Section 10.4 (Notices) below.
- (d) Assignment. Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS (to the extent DHCS approval is required) and PLAN.
- (e) Additional Requirements. Be bound by the provisions of Section 9.7 (Survival of Obligations After Termination), and Section 7 (Hospital Indemnification), and any other provisions of this Agreement that state that they apply to subcontractors.

SECTION 6

RECORDS AND CONFIDENTIALITY

- 6.1 Maintenance of Records. HOSPITAL shall maintain books, charts, documents, papers, reports, management information systems, procedures and records (including, but not limited to, financial, accounting, and administrative records, patient medical records, encounter data, prescription files, laboratory results, subcontracts and Authorizations) and supporting documentation related to Members and Services provided hereunder to Members both medical and non-medical, to the cost thereof, to the manner and amount of payments, including payments received from Members or others on their behalf, to the manner in which HOSPITAL administers its daily business, and to the financial condition of HOSPITAL (“Records”). Records include notes, documents, reports and other information related to Provider disputes and determinations. Records also include all Medi-Cal 35-file paid claims data and any other records that are customarily maintained by HOSPITAL for purposes of verifying claims information and reviewing appropriate utilization of Services, including but not limited to the quantity and quality of Services. HOSPITAL shall maintain Records in accord with applicable state and federal requirements and obligations of the Membership Contracts, including but not limited to Title 28 CCR Section 1300.80(b)(4), 42 USC Section 1396a(w) and privacy and confidentiality requirements. HOSPITAL shall maintain Records in accord with the general standards applicable to that book or record keeping, and shall ensure that an individual is responsible for securing and maintaining such Records. Records shall be legible, current, organized, accurate, comprehensive, and kept in a secure location with detail (i) consistent with appropriate medical and professional practice and prevailing community standards, (ii) which permits effective internal professional review and external medical audit process, and (iii) which facilitates an adequate system for follow-up treatment. The Member’s medical record shall reflect (i) whether the Member has

executed an advance directive, (ii) the language needs of the Member, and (iii) any request for, offer of and refusal of language interpretation services. The Provider Manual outlines additional Medical Records requirements. HOSPITAL shall be fully bound by the requirements in Title 42 of the Code of Federal Regulations, relating to the maintenance and disclosure of Member Records received or acquired by federally assisted alcohol or drug programs. HOSPITAL shall preserve Records for the longer of (i) ten (10) years after termination of this Agreement, and (ii) the period of time required by state and federal law and Membership Contracts, including the period required by, to the extent applicable, the Knox Keene Act and Regulations, and by the Medicare and Medi-Cal programs, unless a longer period is stipulated. If there is any litigation, claim, negotiation, audit, review, examination, evaluation, or other action pending at the end of such period, then HOSPITAL shall retain said Records until such action is completed.

- 6.2 Access to and Copies of Records. PLAN and its authorized agents shall have access to and may inspect the Records, subject to reasonable request and notification requirements, and subject to any legal requirements regarding confidentiality. HOSPITAL shall transmit Record information by fax when requested. HOSPITAL shall provide copies of Records to PLAN upon request, at no charge for the first copy and at five cents (\$.05) per page for any additional copies. HOSPITAL shall, subject to any legal requirements regarding confidentiality, provide access to Records and other information as required by Government Officials and accrediting organizations. Medical Records for Members shall be available to providers at Member encounters as set forth in Title 28 CCR Section 1300.67.1 (c). Members shall have access to their Medical Records, and where legally appropriate, may receive copies of, amend, or correct their Medical Records. HOSPITAL shall provide any notice to, or obtain any consent from, Members or, as appropriate, persons authorized to consent on behalf of Members, as may be required by any applicable federal or State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the California Medical Information Act (“CMIA”), regarding the receipt, use and disclosure of Protected Health Information and Medical Information, as those terms are defined in HIPAA and CMIA respectively.
- 6.3 Copies of Clinical Information. For all Members receiving Services, HOSPITAL will promptly forward copies of initial consultation reports upon completion of consult, and summaries of patient care or patient results upon completion of patient care or discharge, to the Member’s Primary Care Physician. HOSPITAL shall provide copies of such clinical information to the Primary Care Physician at no charge.
- 6.4 Disclosure to Government Officials. HOSPITAL shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, HOSPITAL shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Health Plan Employer Data Information Set (“HEDIS”) auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the County of Ventura, the

U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, "Government Officials") as may be necessary for compliance by PLAN with the provisions of all state and federal laws and contractual requirements governing PLAN, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at HOSPITAL's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. HOSPITAL shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by HOSPITAL related to this Agreement.

6.5 Reporting

6.5.1 HOSPITAL shall supply PLAN or PLAN's designated agent with periodic reports and information pertaining to (i) Services provided to Members by HOSPITAL or its subcontracted health care providers, (ii) Provider directory and network information, and (iii) HOSPITAL's financial resources, on such forms and within such times as requested by PLAN, and which will enable PLAN to meet all federal and state legal and contractual reporting requirements. HOSPITAL shall also supply PLAN with other reports as reasonably requested. If HOSPITAL is a Federally Qualified Health Center, the Medi-Cal program requires that it keep a record of the number of visits by Medi-Cal Members separate from fee-for-service Medi-Cal beneficiaries.

6.5.2 HOSPITAL certifies and warrants that all reports, invoices, papers, documents, books of account, instruments, data, information, forms of evidence and other Records submitted to Plan or Government Officials pursuant to this Agreement are current, accurate, timely, true, complete and in full compliance with legal and contractual requirements, and do not contain any material misrepresentations or omissions. HOSPITAL shall immediately notify PLAN if any of HOSPITAL's certifications and warranties cease to be true at any time during the term of this Agreement.

6.6 Confidentiality of Information

6.6.1 Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, Code of Federal Regulations, Section 431.300 and following and Section 14100.2 of the 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 Agreement and pertaining to Members shall be

protected by HOSPITAL from unauthorized disclosure. HOSPITAL and its employees, agents, and subcontractors shall protect from unauthorized disclosure 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 HOSPITAL, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

- 6.6.2 With respect to any identifiable information concerning any such Medi-Cal Member or person that is obtained by HOSPITAL, HOSPITAL, its employees, agents and subcontractors (i) will not use any such information for any purpose other than carrying out the express terms of HOSPITAL's obligations under this Agreement, (ii) will promptly transmit to PLAN all requests for disclosure of such information except Member requests for Medical Records in accordance with applicable law, and (iii) will not disclose except as specifically permitted by this Agreement, any such information to any party other than PLAN or DHCS, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 and following, Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder, and (iv) will, at the expiration or termination of this Agreement, return all such information to PLAN or maintain such information according to written procedures sent to PLAN by DHCS for this purpose. HOSPITAL shall provide a signed Declaration of Confidentiality in the format set forth in the Provider Manual, prior to the Effective Date.
- 6.6.3 HOSPITAL shall comply with all federal, state and local laws which provide for the confidentiality of Records and other information. HOSPITAL shall not disclose any confidential Records or other confidential information received from PLAN or Government Officials or prepared in connection with the performance of this Agreement, unless PLAN or Government Officials specifically permits HOSPITAL to disclose such Records or information. HOSPITAL shall promptly transmit to PLAN any and all requests for disclosure of such confidential Records or information. HOSPITAL shall not use any confidential information gained by HOSPITAL in the performance of this Agreement except for the sole purpose of carrying out HOSPITAL's obligations under this Agreement. HOSPITAL shall comply with California Welfare and Institutions (W & I) Code Section 10850 and 45 CFR Section 205.50, and all other applicable provisions of law which provide for the confidentiality of records and prohibit their being opened for examination for any purpose not directly connected with the administration of public social services. Whether or not covered by such sections, confidential medical or personnel records and the identities of clients and complainants shall not be disclosed unless there is proper consent to such disclosure or a court order requiring disclosure. Confidential information gained by HOSPITAL from access to any such records, and from contact with its clients and complainants, shall be used by HOSPITAL only in connection with its conduct of the program under this Agreement.

6.6.4 HOSPITAL shall protect the security and confidentiality of all eligibility and enrollment data and all other personal information and protected health information about Members in accordance with the Information Practices Act, Civil Code Section 1798 et seq., and all other applicable State and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the regulations promulgated thereunder. All financial, statistical, personal, technical and other data and information relating to the State’s operations which are designated confidential by the State and which become available to HOSPITAL shall be protected by HOSPITAL from unauthorized use and disclosure. HOSPITAL shall not use any individual identifiable information or other confidential information for any purpose other than carrying out the provisions of this Agreement. Upon request by PLAN, HOSPITAL shall provide a copy of its policies and procedures for preserving the confidentiality of medical records, as outlined in California Health and Safety Code Section 1364.5. HOSPITAL shall make itself available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where HOSPITAL is a named adverse party.

SECTION 7 INSURANCE AND INDEMNIFICATION

- 7.1 Hospital Insurance. Throughout the term of this Agreement and any extension thereto, HOSPITAL will maintain appropriate insurance programs or policies as follows:
- 7.1.1 Each participating HOSPITAL covered by this Agreement will secure and maintain, at its sole expense, liability insurance, or other risk protection programs, in the amounts of at least ONE MILLION DOLLARS (\$1,000,000) per person per occurrence and THREE MILLION DOLLARS (\$3,000,000) in aggregate, including "tail coverage" in the same amounts whenever claims made malpractice coverage is involved.
 - 7.1.2 Notification of PLAN by HOSPITAL of cancellation or material modification of the insurance coverage or the risk protection program will be made to PLAN at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to PLAN upon execution of this Agreement.
 - 7.1.3 General Liability Insurance. In addition to Subsection 6.1.1 above, HOSPITAL will also maintain, at its sole expense, a policy or program of comprehensive liability insurance (or other risk protection) with minimum coverage including and no less than Three Hundred Thousand Dollars (\$300,000) per person for HOSPITAL’S property together with a Combined Single Limit Body Injury and

Property Damage Insurance of not less than Three Hundred Thousand Dollars (\$300,000). Documents evidencing such coverage will be provided to PLAN upon request. The HOSPITAL will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PLAN.

- 7.1.4 Workers' Compensation. HOSPITAL'S employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to PLAN upon request. The HOSPITAL will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to PLAN.
- 7.2 Plan Insurance. PLAN, at its sole cost and expense, will procure and maintain a professional liability policy to insure PLAN and its agents and employees, acting within the scope of their duties, in connection with the performance of PLAN's responsibilities under this Agreement.
- 7.3 Hospital Indemnification. HOSPITAL shall indemnify and hold harmless PLAN its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of HOSPITAL and its officers, directors, agents, employees, agents and shareholders acting alone or in collusion with others. HOSPITAL also agrees to hold harmless both the State and Members in the event that PLAN cannot or will not pay for services performed by HOSPITAL pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

SECTION 8 **DISPUTE RESOLUTION**

- 8.1 Dispute Resolution. For disputes unresolved by the PLAN provider appeals process, PLAN and HOSPITAL agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, HOSPITAL shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").
- 8.2 Judicial Reference. The parties may mutually agree in writing (but shall not be obligated to agree) that a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code

of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation. For the avoidance of doubt, neither party shall be obligated or required to submit the Dispute to judicial reference, arbitration or any other alternative dispute resolution procedure.

- 8.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.
- 8.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Ventura, State of California.

SECTION 9 **TERM AND TERMINATION**

- 9.1 Initial Term and Renewal. This Agreement shall be effective as of the Effective Date and shall remain in effect for a term of one (1) year, and will thereafter renew automatically for one (1) year terms unless terminated sooner as set forth below.
- 9.2 Termination Without Cause. HOSPITAL or PLAN may terminate this Agreement without cause at any time upon providing the other party with ninety (90) days prior written notice.
- 9.3 Immediate Termination for Cause by PLAN. The PLAN may terminate this Agreement immediately by written notice to HOSPITAL upon the occurrence of any of the following events:
- 9.3.1 The suspension or revocation of HOSPITAL'S license; or
 - 9.3.2 HOSPITAL fails to meet PLAN Credentialing Criteria;

- 9.3.3 The discontinuance by HOSPITAL of the provision of Covered Services as confirmed and agreed by both parties hereto; or
- 9.3.4 If PLAN determines pursuant to procedures and standards adopted in its Utilization Management Program or Quality Improvement Program that HOSPITAL has provided or arranged for the provision of services to Medi-Cal Members which are not medically necessary or provided or failed to provide Covered Services in a manner which violates any provision of this Agreement or the PLAN Provider Manual; or
- 9.3.5 If PLAN determines that the continuation hereto constitute as a threat to the health, safety or welfare of any Medi-Cal Member; or
- 9.3.6 If PLAN determines that HOSPITAL has filed a petition for bankruptcy or reorganization, insolvency, as defined by law, or PLAN determines that HOSPITAL is unable to meet financial obligations as described in this Agreement; or
- 9.3.7 If HOSPITAL breaches Section 10.10 (Marketing Activity and Patient Solicitation) (such breach of said Section 10.10 shall not be subject to the cure specified in Section 9.4 (Termination for Cause with Cure Period)).
- 9.4 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3 (Immediate Termination for Cause by Plan) above of this Agreement, the non-breaching party may terminate this Agreement upon thirty (30) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach within twenty (20) days of receipt of this notice, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.
- 9.5 Continuation of Services Following Termination. Should this Agreement be terminated, HOSPITAL will, at PLAN's option, continue to provide Covered Services to Medi-Cal Members who are under the care of HOSPITAL at the time of termination until the services being rendered to the Medi-Cal Members by HOSPITAL are completed, unless PLAN has made appropriate provision for the assumption of such services by another hospital. HOSPITAL will ensure an orderly transition of care for Medi-Cal Members, including but not limited to the transfer of Member medical records. Payment by PLAN for the continuation of services by HOSPITAL after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to HOSPITAL of photocopying such records will be reimbursed by the PLAN at a cost not to exceed \$.10 per page.
- 9.6 Medi-Cal Member Notification Upon Termination. Notwithstanding Section 9.3 (Immediate Termination for Cause by PLAN), upon the receipt of notice of termination by either PLAN or HOSPITAL, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, PLAN at its option, may immediately inform

Medi-Cal Members of such termination notice.

- 9.7 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of HOSPITAL will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: a) Section 9.5, Continuation of Services Following Termination; b) Section 6, Records And Confidentiality; and, c) Section 7.3, HOSPITAL Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between HOSPITAL and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. HOSPITAL will assist PLAN in the orderly transfer of Medi-Cal Members to other Participating Hospitals.
- 9.8 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by PLAN, HOSPITAL will allow the copying and transfer of medical records of each Medi-Cal Member to the HOSPITAL assuming the Medi-Cal Member's care at termination. Such copying of records will be at PLAN's expense if termination was not for cause. PLAN will continue to have access to records in accordance with the terms hereof.
- 9.9 Termination or Expiration of Plan's Medi-Cal Agreement. In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, HOSPITAL will allow DHCS and PLAN to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, HOSPITAL will assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the HOSPITAL'S Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. In no circumstances will a Medi-Cal Member be billed for this service.
- 9.10 Interruption of Services. Should a substantial part of the services which HOSPITAL has agreed to provide hereunder be interrupted for a period in excess of thirty (30) days, PLAN shall have the right to terminate this Agreement upon providing ten (10) days prior written notice to HOSPITAL.
- 9.10.1 In the event the operations of HOSPITAL's facilities, or any substantial portion thereof, are interrupted by war, fire, insurrection, riots, the elements, earthquakes, acts of God, or without limiting the foregoing, any other cause beyond the control

of HOSPITAL, the HOSPITAL shall be relieved of its obligations with respect to the provisions of this Agreement (or such portions hereof which HOSPITAL is thereby rendered incapable of performing) for the duration of such interruptions.

9.10.2 Nothing contained herein shall be construed to limit or reduce PLAN's obligation to pay HOSPITAL for Medi-Cal Benefits rendered to Members prior to or subsequent to an event described herein.

SECTION 10

GENERAL PROVISIONS

10.1 Assignment. This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged or hypothecated in any way by the HOSPITAL and will not be subject to execution, attachment or similar process, nor will the duties imposed on HOSPITAL be set, contracted or delegated without the prior written approval of PLAN and DHCS (to the extent approval by DHCS is required).

10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS as may be required pursuant to the Medi-Cal Agreement. This Agreement may be amended by the PLAN upon thirty (30) days written notice to the HOSPITAL. No obligation under this Agreement or an Attachment hereto may be waived by any party hereto except by an instrument in writing in the form of an Amendment.

10.2.1 If the HOSPITAL does not give written notice of termination within sixty (60) days, as authorized by Section 10.4 (Notices), HOSPITAL agrees that any such amendment by PLAN will be a part of the Agreement.

10.2.2 Unless HOSPITAL or DHCS notifies PLAN that it does not accept such amendment, the amendment except as specified below, will become effective sixty (60) days after the date of PLAN's notice of proposed amendment.

10.2.3 Notwithstanding the foregoing, PLAN may amend this Agreement with prior written notice to HOSPITAL in order to maintain compliance with State and Federal Law and the Medi-Cal Agreement. Such amendment shall be binding upon HOSPITAL and shall not require the consent of HOSPITAL.

10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be

deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.

10.4.1 PLAN will notify DHCS in the event this Agreement is amended or terminated to the extent required by law or the Medi-Cal Agreement. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. A copy of the written notice will also be mailed as first-class registered mail to:

California Department of Health Care Services
Medi-Cal Managed Care Division
1501 Capitol Avenue, Ste. 71.4001
MS. 4407, P.O. Box 997413
Sacramento, CA 95899-7413

- 10.5 Entire Agreement. This Agreement, together with the Attachments and the PLAN Provider Manual, contains the entire agreement between PLAN and HOSPITAL relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.
- 10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 10.7 Governing Law. The laws of the State of California, the United States of America, and the contractual obligations of PLAN will govern the validity, construction, interpretation and enforcement of this Agreement. Any provision required to be in this Agreement by law, regulation, or the Medi-Cal Agreement will bind PLAN and HOSPITAL whether or not provided in this Agreement.
- 10.8 Treatment Alternatives. PLAN or HOSPITAL will not interfere with and will allow the physician-patient communication regarding appropriate treatment alternatives nor will a penalty be assessed to the physician for discussing medically necessary or appropriate medical care for the patient.
- 10.9 Reporting Fraud and Abuse. HOSPITAL is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to

believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by PLAN contracted physicians within 10 days to PLAN for investigation.

- 10.10 Marketing Activity and Patient Solicitation. HOSPITAL will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of PLAN and DHCS.
- 10.11 Direct Solicitation. HOSPITAL will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.
- 10.12 Nondisclosure and Confidentiality. HOSPITAL will not disclose the payment provisions of this Agreement except as may be required by law.
- 10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Medi-Cal Members for which HOSPITAL accepts responsibility hereunder, HOSPITAL reserves the right to provide hospital services to persons who are not Medi-Cal Members including Eligible Beneficiaries. Nothing contained herein will prevent HOSPITAL from participating in any other prepaid health care program.
- 10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one of which will be deemed an original, but all of which will constitute one and the same instrument.
- 10.15 HIPAA. HOSPITAL and PLAN each acknowledge that it is a “Covered Entity” as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the “HIPAA Privacy Rule”). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members’ individually identifiable health information. If the HOSPITAL identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to PLAN or Members, the HOSPITAL must notify PLAN’s Privacy Officer immediately.

SECTION 11 **RELATIONSHIP OF PARTIES**

- 11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent HOSPITAL from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, HOSPITAL will provide written assurance to PLAN that any

contract providing commitments to any other prepaid program will not prevent HOSPITAL from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.

- 11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of PLAN to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.
- 11.3. Relationship of HOSPITAL and Contracting Physicians. It is expressly understood and agreed that no Contracting Physician or other physician shall be entitled to admit, or treat, or prescribe for Medi-Cal Member in HOSPITAL if physician is not a Member in good standing of HOSPITAL's Medical Staff with appropriate clinical privileges to admit and treat Medi-Cal Members in HOSPITAL. Medical Staff membership and clinical privileges may be granted to Contracting Physicians by HOSPITAL's Governing Board, acting in conjunction with its Medical Staff, in accordance with the standards, procedures, and other provisions of HOSPITAL's Medical Staff Bylaws and the Rules and Regulations relating thereto which have been adopted by HOSPITAL's Medical Staff with the approval of said Board.
- 11.4 HOSPITAL Privileges of PLAN Participating Physicians. Nothing contained in this Agreement shall be construed to grant any greater rights to Participating Physicians with respect to the granting and retention of Medical Staff membership and privileges than are available to any other licensed physician; however, HOSPITAL agrees to consider, with all due speed, any and all applications for Medical Staff membership or privileges submitted by physicians wishing to become a Participating Physician, but prevented from doing so for lack of privileges at a Primary Hospital. HOSPITAL shall render such decisions within ninety (90) days of such application. If application is denied, HOSPITAL shall submit to applicant, in writing, an explanation of the reasons for such denials. HOSPITAL and any delegate performing the covenants of the HOSPITAL shall not deny medical staff membership or clinical privileges for reasons other than a physician's individual qualifications as determined by professional and ethical criteria, uniformly applied to all medical staff applicants and Members. Determination of medical staff membership or clinical privileges shall not be made upon the basis of:

11.4.1 The existence of a contract with the HOSPITAL or with others;

11.4.2 Membership in or affiliation with any society, medical group or teaching facility or upon the basis of any criteria lacking professional justification, such as sex, race, creed, disability, or national origin.

HOSPITAL shall henceforth notify PLAN when it revokes or modifies privileges of any physician who is also contracted with the PLAN. Written notification shall be submitted to the PLAN at the time of occurrence.

- 11.5 HOSPITAL does not waive the provisions of Evidence Code 1157 with regard to Medical Staff records

SECTION 12
ADDITIONAL LEGAL REQUIREMENTS

12.1 Compliance With Laws.

12.1.1 HOSPITAL represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives 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, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used for the acquisition, operation or maintenance of computer software in violation of copyright laws.

12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are \$100,000 or more, HOSPITAL certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of HOSPITAL, 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 the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are \$100,000 or more, HOSPITAL shall submit to PLAN the “Certification Regarding Lobbying” set forth in the Provider Manual. If any funds other than Federally 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 Agreement, HOSPITAL shall complete and submit to PLAN standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. HOSPITAL shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by HOSPITAL. HOSPITAL shall require that the language of this certification be included in all subcontracts at all tiers which exceed \$100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to PLAN.

- 12.1.3 HOSPITAL 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 Medicaid programs, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.
- 12.1.4 HOSPITAL shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by PLAN's Contract with the State of California for the provision of Medi-Cal Services. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. HOSPITAL shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by PLAN's Contract with the State of California for the provision of Medi-Cal Services.. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 12.1.5 If HOSPITAL 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, HOSPITAL, upon request, shall make available to PLAN its policies and procedures related to economic profiling used by HOSPITAL. The term "economic profiling" as used in this Section 7.1 (e) 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 7.1 (e) 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.

- 12.1.6 HOSPITAL shall immediately notify PLAN of (i) investigations of HOSPITAL in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. HOSPITAL shall comply with PLAN's antifraud plan, including its policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. HOSPITAL 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).
- 12.1.7 If required by Health and Safety Code Section 1375.4, (1) HOSPITAL shall meet the financial requirements that assist PLAN in maintaining the financial viability of arrangements for the provision of Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) HOSPITAL shall abide by PLAN's process for corrective action plans if there is a deficiency, and (3) PLAN shall disclose information to HOSPITAL that enables HOSPITAL to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), PLAN and HOSPITAL shall meet the requirements set forth in such Regulations. Members may request general information from PLAN or HOSPITAL about any bonuses or incentives paid by PLAN, if applicable.
- 12.1.8 HOSPITAL shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, HOSPITAL shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If HOSPITAL is required to file monthly financial statements with DMHC, then HOSPITAL shall simultaneously file monthly financial statements with DHCS. In addition, HOSPITAL shall file monthly financial statements with DHCS upon request.
- 12.1.9 If payments under this Agreement are in excess of \$100,000, HOSPITAL shall comply with the following provisions unless this Agreement is exempt under 40 CFR Section 15.5. (i) HOSPITAL shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) HOSPITAL shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as

amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

12.2 Nondiscrimination.

12.2.1 HOSPITAL shall not discriminate against Members or deny benefits to Members, on the basis of race, color, creed, religion, language, sex, gender, marital status, political affiliation, ancestry, sexual orientation, sexual preference, national origin, health status, age (over 40), physical or mental disability, medical condition (including cancer), pregnancy, childbirth, or related medical conditions, veteran's status, income, source of payment, status as a Member of PLAN, or filing a complaint as a Member of PLAN. Members may exercise their patient rights without adversely affecting how they are treated by HOSPITAL. HOSPITAL shall not condition treatment or otherwise discriminate on the basis of whether a Member has executed an advance directive. HOSPITAL shall fully comply with all federal, state and local laws which prohibit discrimination, including but not limited to, Title VI of the Civil Rights Act of 1964, Title 45 CFR Part 91 the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act of 1973, 42 U.S.C. Section 2000(d), 45 C.F.R. Part 80 and 84, Title 28 CFR Part 36, Title IX of the Educational Amendments of 1973, California Government Code Section 11135, California Civil Code Section 51 and rules and regulations promulgated thereto, and all other laws regarding privacy and confidentiality. HOSPITAL shall provide reasonable access and accommodation to persons with disabilities to the extent required of a health services provider under the Americans with Disabilities Act and regulations, guidelines issued pursuant to the ADA, any applicable state law, and the Medi-Cal Contract.

12.2.2 During the performance of this Agreement, HOSPITAL, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), mental disability, medical condition (including health impairments related to or associated with cancer for which a person has been rehabilitated or cured), marital status, political affiliation, age (over 40), sex, gender, sexual preference, sexual orientation, pregnancy, childbirth, or related medical conditions, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Contractor, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Contractor, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), and following) and the applicable regulations promulgated there under (California Code of Regulations, Title 2, Section 7285.0 and following). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section

12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

12.2.3 Federal Equal Opportunity Requirements.

- (a) HOSPITAL 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. HOSPITAL 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. HOSPITAL 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 HOSPITAL'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.
- (b) HOSPITAL will, in all solicitations or advancements for employees placed by or on behalf of HOSPITAL, 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.
- (c) HOSPITAL 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 HOSPITAL's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

- (d) HOSPITAL 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 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
- (e) HOSPITAL will comply with and 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 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.
- (f) In the event of HOSPITAL's 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 the Agreement 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 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.
- (g) HOSPITAL will include the provisions of subparagraphs (c)(1) through (c)(7) in every subcontract 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 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 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. HOSPITAL will take such action with respect to any subcontract 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 HOSPITAL becomes involved in, or is threatened with litigation by a subcontractor as a result of such direction by DHCS, HOSPITAL 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.

ATTACHMENT A

DISCLOSURE FORM (Welfare and Institutions Code Section 14

_____ TAX I.D. # _____
Name of Hospital

The undersigned hereby certifies that the following information regarding the Hospital is true and correct as of the date set forth below:

Form of Hospital (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

If a proprietorship, Co-Owner(s). If a partnership, partners.

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

Stockholders owning more than ten percent (10%) of the stock of the Provider:

Major creditors holding more than five (5) percent of Provider debt:

If not already disclosed above, is Hospital, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

Dated: _____

Signature: _____

Name: _____

(Please type or print)

Title: _____

(Please type or print)

**ATTACHMENT B
PER DIEM REIMBURSEMENT**

A. HOSPITAL Inpatient Service Reimbursement

- (1) Plan shall pay HOSPITAL one hundred percent (100%) of the following all-inclusive rates per day for admissions.
 - (a) Acute Medical/Surgical Day
 - (b) ICU Day/CCU
 - (c) Neonatal Critical Care Day
 - Level C
 - Level B
 - (d) Obstetrics Common Day
 - (e) Obstetrical Common Day (including mother & baby)
 - (f) Boarder Baby Day
 - (g) Pediatric Day
 - (h) Administrative Day
 - (i) Observation Day
 - (j) Placement Day
- (2) The all-inclusive per diem rates, as described above, are to be the only payments made by PLAN to HOSPITAL for inpatient services provided to eligible PLAN members except where otherwise provided hereunder.

B. Hospital Outpatient, Home Health Care, Physical Therapy, Speech Therapy, Occupational Therapy, and Emergency Room Reimbursement.

The PLAN shall pay HOSPITAL for those Outpatient Services, excluding physician services, provided to eligible PLAN Members, and for which approved claims have been submitted by HOSPITAL at 100% of the prevailing Medi-Cal fee-for-service rates as determined by the state of California Department of Health Care Services.

MEDICAL SERVICES AGREEMENT

Between VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

And PRIMARY CARE PHYSICIAN

This Medical Services Agreement (this "Agreement") is made effective as of the _____ day of _____, 20__ (the "Effective Date"), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as "Plan," and _____ (please print) ("Primary Care Physician"), a physician licensed to practice medicine in the State of California pursuant to California Business and Professions Code, Division II, Chapter 5, Section 200 et. seq., who is eligible to participate in the California Medi-Cal (Medicaid) program, and who meets applicable requirements under Titles XVIII and XIX of the Social Security Act.

IN WITNESS WHEREOF, the subsequent Agreement between Plan and Primary Care Physician is entered into by and between the undersigned parties.

Primary Care Physician:

Plan:

(List Primary Care Physician Name Above)

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

Executed by:

Signature

Signature

Printed Name

Printed Name

Title

Title

Date

Date

Address for Notices:

Address for Notices:

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
PRIMARY CARE PHYSICIAN MEDICAL SERVICE AGREEMENT**

TABLE OF CONTENTS

RECITALS 3

SECTION 1 ó DEFINITIONS 3

SECTION 2 ó QUALIFICATIONS, OBLIGATIONS AND COVENANTS 8

SECTION 3 ó SCOPE OF SERVICES 13

SECTION 4 ó EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES..... 17

SECTION 5 ó PAYMENTS 19

SECTION 6 ó MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES 20

SECTION 7 ó INSURANCE AND INDEMNIFICATION 25

SECTION 8 ó GRIEVANCES AND APPEALS 26

SECTION 9 ó TERM, TERMINATION, AND AMENDMENT 27

SECTION 10 ó GENERAL PROVISIONS..... 29

SECTION 11 ó RELATIONSHIP OF PARTIES 32

Attachment A ó Primary Care and Referral Physician Case Management Protocol..... 34

Attachment B ó Monthly Capitation Table..... 45

Attachment C ó Scope of Capitated Services 46

Attachment D ó Officers, Owners, and Stockholders..... 49

Attachment E ó Primary Care Physician Contracted Location(s) 50

RECITALS

- A. WHEREAS, Plan is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.
- B. Whereas Plan has entered into and maintains contracts (the "Medi-Cal Agreements") with the State of California, Department of Health Care Services in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975 at Health and Safety Code, Section 1340 et. seq.; Title 10, CCR, Section 1300 et. seq.; W&I Code, Section 14200 et. seq.; Title 22, CCR, Section 53250; and applicable federal and State laws and regulations, under which Ventura County Medi-Cal Beneficiaries, assigned to Plan as Members, receive all medical services hereinafter defined as "Covered Services", through the Plan.
- C. Whereas Plan will arrange for Covered Services for its Medi-Cal Members under the case management of designated Primary Care Physicians chosen by or assigned to Members.
- D. Whereas PCP will participate in providing Covered Services to Medi-Cal Members and will receive payment from Plan for the rendering of those Covered Services.
- E. Whereas Primary Care Physician desires to provide primary care services for such Medi-Cal Members.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the parties set forth in this Agreement agree and covenant as follows:

SECTION 1 – DEFINITIONS

As used in this agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

- 1.1 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.
- 1.2 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 Special Case Managed Members.
- 1.3 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.
- 1.4 Capitation Payment. The prepaid monthly amount that Plan pays to Primary Care Physician as compensation for capitated primary care services the scope of which is defined in Attachment C, attached to and incorporated herein.

- 1.5 Case Managed Members. Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care.
- 1.6 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.
- 1.7 Contract Year. The 12-month period following the effective date of this Agreement between Primary Care Physician and Plan 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 Plan operational date will apply.
- 1.8 County Organized Health System (COHS). A plan serving either a single or multiple county areas.
- 1.9 Covered Services. All Medically Necessary services to which Members are entitled from Plan as set forth in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services.
- 1.10 DHCS. The State of California Department of Health Care Services.
- 1.11 Eligible Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the Plan 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.
- 1.12 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.
- 1.13 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.
- 1.14 Encounter Form. The CMS-1500 claim form used by Primary Care Physician to report to the Plan provision of Covered Services to Medi-Cal Members.
- 1.15 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the Plan.
- 1.16 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.
- 1.17 Fee-For-Service Payment (FFS). (1) the maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by contractor and the provider. All Covered Services that are not Capitated Services, as described in Attachment C, authorized by Plan pursuant to this Agreement will be compensated by Plan at the lowest allowable Fee-For-Service rate unless otherwise identified in Attachment C of this Agreement.

- 1.18 Fiscal Year. The 12 month period starting July 1.
- 1.19 Governmental Agencies. The Department of Managed Health Care (öDMHCö), DHCS, United States Department of Health and Human Services (öDHHSö), United States Department of Justice (öDOJö), and California Attorney General and any other agency which has jurisdiction over Plan or Medi-Cal (Medicaid).
- 1.20 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.
- 1.21 Identification Card. The card that is prepared by the Plan which bears the name and symbol of Plan and contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with Plan or proof of Medi-Cal eligibility.
- 1.22 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.
- 1.23 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by Plan to monitor the quality assurance and implement Quality Improvement Activities of Plan.
- 1.24 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. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.
- 1.25 Medi-Cal Managed Care Program. The program that Plan operates under its Medi-Cal Agreement with the DHCS for the Service Area.
- 1.26 Medi-Cal Provider Manual. The Medi-Cal Services Provider Manual of the DHCS, issued by the DHCS Fiscal Intermediary.
- 1.27 Medical Transportation. "Medical transportation services" means 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.
- 1.28 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the Plan and who will be required to select a Primary Care Provider. Also referred to as öCase Managed Memberö or öLinked Member.ö An Administrative Member is an eligible Medi-Cal Beneficiary who is eligible by an aid code that only provides limited coverage, limited duration or a specific set of services and such Member would not be required to select a Primary Care Provider. Examples include: Dual Eligibles under Medicare and Medi-Cal where Medicare is primary; Breast, Cervical Cancer and Treatment Program eligibles; Share of Cost eligibles; Emergency Services coverage only eligibles; etc. Administrative Members will be identified as such on their Gold Coast Health Plan I.D. card while regular Members will have their Primary Care Provider listed on their I.D. cards.

- 1.29 Member Handbook. The Plan 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 Plan and the Medi-Cal Member.
- 1.30 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.
- 1.31 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.
- 1.32 Operations Manual. The Manual of Operational Policies and Procedures for the Plan Medi-Cal Managed Care Program.
- 1.33 Other Services. Vision Care and other covered services not included in the Specialty Care and Inpatient Hospital Services sub-accounts, as described in this Agreement.
- 1.34 Out-of-Area. The geographic area outside Ventura County.
- 1.35 Out-of-Plan. Non-contracted providers located inside or outside of Ventura County.
- 1.36 Plan. The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission and serving Ventura County Medi-Cal Eligible Beneficiaries.
- 1.37 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with Plan and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program and who has contracted with Plan to provide medical services to Medi-Cal members.
- 1.38 Physicians' Advisory Committee. The committee of physicians composed of contracting Physicians by the Plan for the purpose of advising the Ventura County Medi-Cal Managed Care Commission. Physicians who serve on this committee must be Board Certified and practice in Ventura County.
- 1.39 Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the Plan. Plan agrees that additional Members will not be permitted to select or be assigned to that Primary Care Physician. Such limit may be changed by mutual agreement of the parties.
- 1.40 Primary Care 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.
- 1.41 Primary Care Physician (PCP). A Physician or Physicians who have executed an Agreement with Plan to provide Primary Care Services. The physician must be duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; 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.

- 1.42 Primary Care Physician Account. A specific account set up in the name of the Primary Care Physician by Plan against which the agreed upon capitation amount will be credited and against which claims for Members of that Primary Care Physician will be debited.
- 1.43 Primary Care Services. Those services defined in Attachment C and 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.
- 1.44 Primary Hospital. Any hospital affiliated with Primary Care Physician that has entered into an Agreement with the Plan.
- 1.45 Participating Referral Provider. Any health professional or institution contracted with Plan that meets the Standards for Participation in the State Medi-Cal Program to render medical services to Medi-Cal Members.
- 1.46 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.
- 1.47 Referral Authorization Form or RAF. The form or number evidencing a referral by PCP or Medical Director, or designee, to render specific non-emergency Covered Services to Members.
- 1.48 Referral Physician. Any qualified physician, duly licensed in California who meets the Standards of Participation, has been enrolled in the State Medi-Cal Program in accordance with Article 3, Title 22, CCR. Exception to this requirement must be authorized by Plan CEO and/or Medical Director. The Physician has executed an Agreement with Plan, to whom a Primary Care Physician may refer any Member for consultation or treatment. Also called Participating Referral Physician.
- 1.49 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.
- 1.50 Service Area. The County of Ventura.
- 1.51 Administrative Member. Medi-Cal Member enrolled with Plan who has not been assigned to a Primary Care Physician for administrative reasons.
- 1.52 Treatment Authorization Request or TAR. "TAR" means the Treatment Authorization Request form approved by Plan for the provision of Non-Emergency Services. Those Non-Emergency Services that require a Treatment Authorization Request form.
- 1.53 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).

- 1.54 Utilization Management Program. The program(s) approved by Plan, which are designed to review and monitor the utilization of Covered Services.
- 1.55 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

SECTION 2 - QUALIFICATIONS, OBLIGATIONS AND COVENANTS

2.1 Primary Care Physician is responsible for and shall:

- 2.1.1 Standards of Care. Provide Covered Services for those complaints and disorders of Case Managed Members that are within Primary Care Physician's professional competence, with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.
- 2.1.2 Licensure. Warrant that Primary Care Physician has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license to practice medicine or osteopathy in the State of California to provide the Covered Services which are to be provided under the terms of this Agreement. Warrant that the Primary Care Physician has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by Plan. Warrant that the Primary Care Physician has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in the Medi-Cal Program in accordance with the program Standards of Participation as contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations.
- 2.1.3 Comprehensive Primary Care Services. Provide the Medically Necessary comprehensive level of health care for their assigned patients usually rendered in ambulatory settings by general practitioners, family practitioners, pediatricians, Obstetrician-Gynecologists, internists and mid-level practitioners practicing within the Service Area. This type of care emphasizes caring for the Case Managed Member's general health needs as opposed to specialists focusing on specific needs.
- 2.1.4 Referrals.
- a. Supervising, coordinating, and providing primary medical care to Case Managed Members; initiating referrals for specialist care; maintaining the continuity of patient care; education of Case Managed Members regarding appropriate health prevention measures; and the appropriate maintenance of medical records, including, as necessary, admission to institutional care and referral to specialists and the coordination of these and other types of care through diverse resources.
 - b. Except in an Emergency, Primary Care Physician shall not refer a Member to any physician, hospital or other provider of health care services without first securing prior authorization from Plan. Primary Care Physician shall comply with the referral procedures set forth in the Case Management Protocols which are included as Attachment A and the Operations Manual, in effect at the time of referral and shall not directly or indirectly engage in self-referral or any other method of referral not specifically authorized by the Case Management Protocols

and the Operations Manual in effect. Should a Primary Care Physician fail or refuse to comply therewith, Plan may, in addition to any other right or remedy under this Agreement, retain from any amount owed to Primary Care Physician an amount equal to the amount of money paid by Plan to the non-qualified Participating Referral Provider.

- d. In addition, Primary Care Physician shall not render Primary Care Services to Members assigned to another Primary Care Physician, nor provide Covered Services that fall outside those listed in Attachment C, without prior authorization from Plan if service being provided requires prior authorization.

2.1.5 Case Management. Provide medical case management services to ensure the coordination of Medically Necessary health care services, ensure the provision of preventive services in accordance with established standards and periodicity schedules and ensure the continuity of care for Case Managed Members. Such medical case management services include health risk assessment, treatment plans, coordination of medical services, initiation and follow-up of all referrals, follow-up and monitoring of appropriate services and resources required to meet the Case Managed Member's health care needs.

- a. Primary Care Physician agrees to abide by the Case Management Protocols which are included as Attachment A to this Agreement and are incorporated herein by this reference and which may be amended by Plan from time to time with thirty (30) days notice to Primary Care Physician.
- b. Primary Care Physician agrees to abide by the Plan Operations Manual policies and procedures which may be amended from time to time by Plan with thirty (30) days notice to Primary Care Physician.
- c. Primary Care Physician and any Attending Physician or Referral Physician to whom the Primary Care Physician has delegated the authority by a referral to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.
- d. Subject to Section 2.1.4 above, Primary Care Physician has the right to refer Member to any Participating Referral Provider
- e. Referrals to contracting providers outside the County may be made only after authorization for such has been obtained from Plan Utilization Management Department.
- f. Primary Care Physician acknowledges that Plan's Medical Director will assist in the management of Catastrophic Cases. Primary Care Physician will fully cooperate with Plan's Medical Director by providing information that may be required in the transfer of a Case Managed Member into medical facilities designated by Plan for the care of Catastrophic Cases, including but not limited to, prompt notification of known or suspected Catastrophic Cases.

2.1.6 Accessibility and Hours of Service. Provide Covered Services to Case Managed Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Operations Manual during normal business hours at Primary

Care Physician's usual place of business and arranging for Emergency Services and Urgent Care Services seven days a week, twenty-four hours per day.

- 2.1.7 Hospital Privileges. Maintaining active medical staff privileges and being a member in good standing of the medical staff with at least one Primary Hospital contracting with Plan or having executed a formal agreement with another physician to admit and follow patients in the Primary Hospital.
- 2.1.8 Credentialing. Provide Plan with a completed credentialing form, will use best efforts to notify Plan in advance of any change in such information, and will successfully complete a facility site review, if deemed necessary by Plan in accordance with DHCS Medi-Cal Agreement.
- 2.1.9 Officers, Owners and Stockholders. Providing information regarding officers, owners and stockholders as set forth in Attachment D, attached to and incorporated herein.
- 2.1.10 Minimum and Maximum Number of Assigned Members. Accepting all of his/her current patients who become Case Managed Members and all Medi-Cal Members who select or who are assigned to Primary Care Physician for no more than the maximum number of Members established by the Physician Patient Load Limitation for whom the parties have mutually agreed to provide services hereunder. PCP may later change the number of Beneficiaries upon mutual agreement of PCP and Plan will notify Primary Care Physician of the number of Case Managed Members under Primary Care Physician's care and will notify Primary Care Physician when such a maximum number of Case Managed Members has been reached.
 - a. Primary Care Physician agrees to serve a maximum of 2,000 Members per full-time equivalent Primary Care Physician.
 - b. The maximum ratio for a non-physician medical practitioner under the supervision of a primary care physician will be 1:1000 members.
 - c. The number of non-physician medical practitioners who may be supervised by a single primary care physician is limited to the full-time equivalent of one of the following:
 1. Four (4) nurse practitioners
 2. Four (4) physician's assistants
 3. Four (4) non-physician medical practitioners in any combination which does not include more than three (3) nurse midwives or two (2) physician assistants.
 - d. Plan will prevent Beneficiaries from selecting the Primary Care Physician who is serving the maximum number of Members specified in this Agreement.
- 2.1.11 Actions Against Primary Care Physician. Primary Care Physician will adhere to the requirements as set forth in the Operations Manual and notify Plan by certified mail within five (5) days of Primary Care Physician's learning of any action taken which results in restrictions on Primary Care Physician staff privileges, membership,

employment for a medical disciplinary cause or reason as defined in the California Business & Professions Code, Section 805, regardless of the duration of the restriction or excluded from participating in the Medi-Cal Program in accordance with the Standards of Participation.

- 2.1.12 Financial and Accounting Records. Maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Reports - Submit reports as required by Plan or DHCS.
- 2.1.13 Compliance with Member Handbook. Primary Care Physician acknowledges that Primary Care Physician is not authorized to make nor will Primary Care Physician make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.
- 2.1.14 Promotional Materials. Primary Care Physician will consent to be identified as a Primary Care Physician in written materials published by Plan, including without limitation, marketing materials prepared and distributed by Plan and, display promotional materials provided by Plan within his/her office.
- 2.1.15 Primary Care Physician shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Agreements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Primary Care Physician shall also provide, as applicable, the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 2.1.16 Compliance with Plan Policies and Procedures. Primary Care Physician agrees to comply with all Plan policies and procedures, as may be modified from time to time by Plan in its sole discretion. In the event such Plan policies and procedures are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.
- 2.1.17 Cultural and Linguistic Services. Primary Care Physician shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. Primary Care Physician shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. Primary Care Physician shall comply with Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with plan by providing any information necessary to assess compliance. Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. Primary Care Physician has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures.

2.2 Plan is responsible for:

2.2.1 Member Assignment. Assigning Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician, following which such Members are thereafter referred to as a Case Managed Member.

- a. The Medi-Cal Member can select from the Primary Care Physicians contracting with Plan.
- b. The Medi-Cal Member will seek all medical services, except those outlined in Section 4 from their assigned Primary Care Physician.
- c. If the Medi-Cal Member does not select a Primary Care Physician, Plan will assign Members to a Primary Care Physician in a systematic manner as the Plan deems appropriate and/or in accordance with established protocol.

2.2.2 Listing. Plan or its designee will enter the name of each contracted Primary Care Physician onto a list or provider directory from which Medi-Cal Members may choose a Primary Care Physician. Such a list will contain the following information in order to allow for an appropriate Primary Care Physician selection procedure.

- a. Name
- b. Address(es)
- c. Office hours
- d. Scope of services (specialty)
- e. Member age and sex limitations, if any
- f. Clinic or medical group affiliation, if any
- g. Hospital Affiliation
- h. Language Capabilities
- i. Medical Specialty
- j. Board Certification Status (Optional)
- k. Medical School (Optional)

2.2.3 Payment for Authorized Service Only. The Plan will reimburse Physicians for Medically Necessary Covered Services that are properly authorized by the Plan Medical Director (or his/her designee) where the service is not included in Attachment C as a Primary Care Physician capitated service. The reimbursement for such excluded services is described in Section 4 of this Agreement.

2.2.4 Change of Primary Care Physician. Beneficiaries may change Primary Care Physicians in accordance with procedures established by the Plan.

- a. The PCP may request Plan to reassign a Medi-Cal Member to another Primary Care Physician if a satisfactory physician-patient relationship cannot be developed between the Primary Care Physician and the Medi-Cal Member.
- b. If Plan is unable to make such arrangements, Primary Care Physician will use his or her best professional judgment and continue to provide medical services to the Member according to Plan's policies and procedures and until Plan is able to effect a change of the Member's Primary Care Physician.

- c. Primary Care Physicians may not request Medi-Cal Member reassignment based on the medical condition requiring increased care.

2.3 Member Eligibility. Plan will notify PCP on or before the tenth (10th) of each month of those Members who are entitled to receive Covered Services from Primary Care Physician and for whom the Full Capitation is credited to the PCP's Account.

2.3.1 The notification will be provided via telephone, facsimile, mail or electronic media, to Primary Care Physician listing all pertinent data regarding the eligibility of Medi-Cal Members who have chosen or have been assigned to Primary Care Provider. Such data will be updated on or about the twenty-fifth (25th) of the each month.

2.3.2 Plan will maintain (or arrange to have maintained) records and establish and adhere to procedures as will reasonably be required to accurately ascertain the number and identity of Medi-Cal Members.

SECTION 3 - SCOPE OF SERVICES

3.1 Management of Care. With the exception of Excluded Services described in Section 4 of this Agreement, it is the responsibility of the Primary Care Physician to determine, to provide, to prescribe, and to manage Covered Services for Medi-Cal Members in accordance with professionally recognized standards and medical necessity.

3.1.1 Covered Services are as specified in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services.

3.1.2 Except as otherwise provided herein, it will be the responsibility of the Primary Care Physician to render or provide referral for Covered Services for each Medi-Cal Member which has been determined to be medically necessary and appropriate for the control of disease, illness, or disability.

3.1.3 Primary Care Physician will abide by Case Management Protocols, incorporated into the agreement as Attachment A and in conformance with Plan policies and procedures as set forth in the Plan Operations Manual.

3.2 Consultation with Medical Director. Primary Care Physician or any other provider may at any time seek consultation with Medical Director on any matter concerning the treatment of the Member.

3.3 Covered Services. Covered Services are covered under the California State Medi-Cal program and the Medi-Cal Agreement when they are necessary and appropriate for the care of that Member. Covered Services include but are not limited to:

3.3.1 Accessibility and Hours of Service. Provide Covered Services to Case Managed Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan Operations Manual during normal business hours at Primary Care Physician's usual place of business and will arrange for Emergency Services and Urgent Care Services at all other times. Any Emergency Services shall be subject to the terms set forth in the Provider Manual regarding Contracting and Non-Contracting Emergency Service Providers and Post-Stabilization. Primary Care

Physician will make suitable arrangements for personal contact with the Member, or for services by appropriate personnel in accordance with customary medical practice and with law.

- 3.3.2 Initial Health Assessments Within 120 Days. Ensure that all Case Managed Members assigned to Primary Care Physician are scheduled for an initial health assessment within 120 days after enrollment for Case Managed Members over the age of 21 years and as soon as possible for Case Managed Members under the age of 21 years, unless Primary Care Physician determines that their medical records are adequate and sufficiently current to allow for an assessment of the Case Managed Member's health status without such an assessment. At a minimum, an initial health assessment will include a medical history, weight and height data, and blood pressure. The assessment will also include those preventive health screens and tests set forth in the Plan Operations Manual; a discussion of appropriate preventive measures; and the provision for future follow-up appointments as indicated.
- 3.3.3 Referrals. Be responsible for supervising, coordinating, and providing primary medical care to Case Managed Members; initiating referrals for specialist care; for maintaining the continuity of patient care; education of Case Managed Members regarding appropriate health prevention measures; and the appropriate maintenance of medical records. All referrals to specialists are to be to Referral Physicians and to other professional or institutional providers who are Participating Referral Providers unless otherwise authorized in writing by Plan. Nothing herein will be construed to impose liability on Primary Care Physician for the clinical performance of any other physician, any hospital, or any other health care provider rendering health care services to the Case Managed Members without the knowledge of the Primary Care Physician.
- 3.3.4 Preventive Health Care. Provide Case Managed Members regular preventive health examinations and procedures, including but not limited to routine physical examinations, immunizations, and health screenings, in accordance with CHDP guidelines and with Preventive Health guidelines. Primary Care Physician will ensure that a CHDP appointment is made for the Case Managed Member to be examined within four weeks of request.
- 3.3.5 Facilities, Equipment and Personnel. Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement. Primary Care Physician agrees to provide at least 60 days notice to Plan prior to the opening of any new location and 90 days prior to the closing of any location.
- 3.3.6 Health Education. Offer Case Managed Members appropriate health education, including but not limited to, nutrition counseling, family planning and counseling, and accident prevention counseling.
- 3.3.7 Other Medically Necessary Services. Other necessary durable medical equipment rental, medical supplies, and medical transportation.
- 3.3.8 Interpreter Services. Arrange interpreter services as necessary for Members at all facilities.

All services and goods required or provided hereunder will be of quality consistent with community standards of care.

3.4 Prescription Drugs. Comply with the Plan drug formulary regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals, in conformance with generally accepted medical and surgical practices and standards prevailing in the professional community.

3.4.1 If for medical reasons, the Primary Care Physician believes a generic equivalent should not be dispensed, the Primary Care Physician agrees to obtain prior authorization from the Plan Pharmacy Director.

3.4.2 Primary Care Physician acknowledges the authority of Plan's participating pharmacists to substitute generics for trade name drugs, as specified in Section 4073 of the California Business & Professions Code, and Title 22 CCR Section 51313 unless otherwise indicated.

3.5 Non-Discrimination

3.5.1 Medi-Cal Members. Primary Care Physician will provide services to Medi-Cal Members in the same manner as such services are provided to other patients of Primary Care Physician, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Managed Care Program. Subject to the foregoing, Primary Care Physician will not subject Case Managed Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan or filing a complaint as a Member of Plan in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination will include but is not limited to: denying any Case Managed Member any Covered Service or availability of a Facility; providing to a Case Managed Member any Covered Service which is different, or is provided in a different manner or as a different time from that provided to other Members under this Contract except where medically indicated; subjecting a Case Managed Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Case Managed Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered Services, treating a Case Managed Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.

3.5.2 For the purpose 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 genes include, but are not limited to, Tay-Sach trait, sickle-cell trait, Thalassemia trait, and X-linked hemophilia.

3.5.3 General Compliance. Pursuant to the requirements of this Section of the Medi-Cal Agreement, the Primary Care Physician will not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan, or filing a complaint as a Member of Plan and denial of family care leave. Primary Care Physician will ensure the evaluation and treatment of Primary Care Physician's employees and applicants for employment are free from discrimination and harassment. Primary Care Physician will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et. seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4, Chapter 5 are incorporated into this Agreement by reference and made a part hereof as set forth in full. Primary Care Physician will give notice of his obligations under this Section to labor organizations with which he has a collective bargaining or other agreement.

3.6 Quality Improvement and Utilization Management Programs

3.6.1 Primary Care Physician will participate in Plan's Quality Improvement and Utilization Management Programs, including credentialing and recredentialing, peer review and any other activities required by Plan, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. This includes participation in office reviews, chart and access audits and focused reviews. In addition, the Primary Care Physician will participate in the development of, and implement, corrective action plans for any areas that fall below standards and ensuring medical records are readily available to staff as requested.

- a. In the interest of program integrity or the welfare of Members, Plan may from time to time introduce additional utilization controls as may be necessary as determined by Plan.
- b. In the event of such change, a thirty (30) day notice will be given to the Primary Care Physician.
- c. The standards and requirements shall include, without limitation:
 1. Healthcare Quality Measures: patient satisfaction, patient access, emergency room utilization, grievance response compliance, credentialing issues, and health education compliance.
 2. HEDIS measures including but not limited to: childhood immunizations, breast cancer screening, cervical cancer screening, well child visits and lead screening.
 3. Encounter Data Compliance - Timely and accurate encounter data submission which meets expected volume thresholds.
 4. Utilization Management ó Aggregate claims expenses related to all Members assigned to Primary Care Physician for each review period

should be within an acceptable range either above or below the average costs of Primary Care Physician's peers. This measure is intended to monitor that there is no over utilization and/or under utilization of specialist, hospital or ancillary services. Plan may periodically review Primary Care Physician's compliance with the foregoing, which review will include a minimum of two (2) quarters of data for the purposes of evaluating such compliance. Non-compliance with the foregoing by Primary Care Physician may result, at Plan's sole option (i) in the modification by Plan of Primary Care Physician compensation schedules; (ii) offset or deduction, in whole or in part, from the compensation otherwise due Primary Care Physician for the services in question, according to the policies of the Plan and as required by Plan; and/or (iii) termination of this Agreement.

SECTION 4 - EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

- 4.1 Exclusions. Members in need of services which are not Covered Services as described in the Member Handbook, will not be reimbursed by the Plan. However, the Primary Care Physician will continue to coordinate the Medi-Cal Member's medical care or refer the Medi-Cal Member for the following services in accordance with generally accepted medical and surgical practices and standards prevailing in the professional community, and in conformance with Plan policies and procedures.
- 4.2 Services Neither Covered nor Compensated. Subject to those exclusions from Covered Services as set forth in the Medi-Cal Agreement, Primary Care Physician understands that Primary Care Physician will not be obligated to provide Medi-Cal Members with, and the Plan will not be obligated to reimburse Primary Care Physician for, the following Excluded Services (for which Plan does not receive capitation payment from the DHCS):
- (a) Dental Services, as defined in Title 22 CCR Section 51307 and Early Periodic Screening Diagnosis and Treatment supplement dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;
 - (b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.
 - (c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted: (i) outpatient mental health services within the Primary Care Physician's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii)

facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.

- (d) California Children's Services (CCS) are not covered in Ventura County
- (e) Services rendered in a State or Federal governmental hospital;
- (f) Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;
- (g) Fabrication of optical lenses;
- (h) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;
- (i) Direct Observed Therapy for tuberculosis;
- (j) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;
- (k) Childhood lead poisoning case management services provided by the Local Health Department;
- (l) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the State Medi-Cal Contract; and
- (m) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 United States Code (USC) Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.
- (n) Other services as may be determined by the DHCS and the Plan, and as noticed to participating PCPs. In the event of such a change, a thirty (30) day notice will be given to the PCP.

4.3 Restricted Services/Special Reimbursement

4.3.1 Primary Care Physician will ensure that services provided to Medi-Cal Members will be in conformance with the limitations and procedures listed in the Medi-Cal Provider Manual unless notified of modification to that policy by DHCS or Plan.

- a. The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization. These services shall be subject to the limitations specified therein.

4.3.2 Primary Care Physician referral and/or Plan authorization are not required for reimbursement by Plan to providers of the following services.

- a. The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.
- b. Family Planning Services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 Code

of Federal Regulations Section 441.20. Family Planning services are defined in the Provider Operation Manual and services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.

- 4.3.3 Primary care physician referral is not required for beneficiaries designated as Administrative Members.
- 4.3.4 California Children's Services (CCS) must be authorized by the Ventura County CCS Program.
- 4.3.5 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program.

SECTION 5 - PAYMENTS

- 5.1 Capitation Payment. Plan will pay a Capitation Payment to Primary Care Physician, by the 10th of each month, for Medi-Cal Members assigned to or for Medi-Cal Members who chose the Primary Care Physician based on the most current enrollment information as transmitted by the DHCS.
 - 5.1.1 A summary report will accompany each check identifying Members who are eligible for Primary Care Covered Services and appropriate amount of payment per Member.
 - 5.1.2 All designated Members will become eligible for Primary Care Covered Services on the first day of the month for which Capitation is paid to Primary Care Physician.
 - 5.1.3 The Full Capitation amounts for Primary Care Physician are set forth in Attachment B of this Agreement with the scope of capitated Primary Care Physician Services set forth in Attachment C of this Agreement.
- 5.2 Capitation Reconciliation and Adjustments.
 - 5.2.1 Within thirty (30) days of the receipt of the eligibility reports from DHCS, Capitation Payments will be reconciled and an appropriate adjustment of overpayments or underpayments will be made. In the event of termination of this Agreement, final settlement of all applicable payments will be made within one hundred twenty (120) days from the effective date of termination of this Agreement.
- 5.3 Fee-For-Service Payments (FFS). Reimbursement for the Primary Care Physician will be Medi-Cal fee for service rates for all properly documented and prior authorized, when required, for all non-capitated Medi-Cal Covered Services provided to:
 - 5.3.1 Members affiliated with the Primary Care Physicians and when the service is not a capitated service as listed in attachment C.
 - 5.3.2 Medi-Cal Members for prior authorized Covered Services not listed in Attachment C in accordance with Plan Operations Manual.

- 5.3.3 Administrative Members.
- 5.4 Claim Submission. The Primary Care Physician will obtain, complete, and submit CMS-1500 forms or submit through electronic transfer claims for all services rendered to Medi-Cal Members including capitated services.
- 5.4.1 All claims for reimbursement of Covered Services must be submitted to the Plan within six (6) months from the end of the month that service was provided.
- 5.4.2 Submission of a complete clean claim will be reimbursed within thirty (30) days after receipt.
- 5.4.3 CMS-1500 forms or electronic transfer are to be used for the submission of encounter data as documentation of Capitated Covered Services provided to Case Managed Members by the Primary Care Physician. The CMS-1500 forms or the submission by electronic transfer will be made by Primary Care Physician the 15th day of the month following the month of service during the term of this Agreement. All forms submitted should contain the data elements as outlined in the Operations Manual.
- 5.5 Entire Payment. Primary Care Physician accepts Capitation Payment as payment in full for Primary Care Covered Services as described in Attachment C herein. Primary Care Physician will not seek any Surcharges (copayment) from Case Managed Members for Covered Services under any circumstances except as may be required by State or federal law.
- 5.6.1 Except as otherwise provided herein, Primary Care Physician will accept such compensation as complete and full discharge of the liability of Plan and its Medi-Cal Members with respect to compensation for Covered Services.
- 5.6.2 Primary Care Physician will look only to Plan for such compensation. Plan has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to Plan are reduced by DHCS.
- 5.6 Payment for Services Provided to Special Case Managed Members. For Special Case Managed Members the attending physician will be reimbursed the prevailing Medi-Cal fee for service rates.
- 5.7 Notwithstanding anything to the contrary set forth in this Agreement, Plan may reduce the rates or other compensation payable to Primary Care Physician at any time or from time-to-time during the term of this Agreement as determined by Plan to reflect implementation of State or federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Covered Services, or changes in rates implemented by the DHCS, CMS or any other governmental agency providing revenue to Plan, or any other change that results in decreases to the rates or level of funding paid to Plan. The amount of such adjustment shall be determined by Plan. All other rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same. Notwithstanding anything to the contrary set forth in this Agreement, Plan's obligation to pay Primary Care Physician any payment amount hereunder shall be subject to Plan's corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to Plan, as applicable.

SECTION 6 - MEDICAL RECORDS, ACCOUNTS,

REPORTING AND RECOVERIES

- 6.1 Medical Record. Primary Care Physician shall ensure that a medical record will be established and maintained for each Medi-Cal Member who has received Covered Services. Each Medi-Cal Member's medical record will be established upon the first visit to Primary Care Physician. The record will contain information normally included in accordance with generally accepted medical and surgical practices and standards prevailing in the professional community.
- 6.1.1 Primary Care Physician will facilitate the sharing of medical information with other providers in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.
- 6.1.2 Primary Care Physician will ensure records are available to authorized Plan personnel in order for Plan to conduct its Quality Improvement and Utilization Management Programs. Plan shall have access to practitioner's medical records to the extent permitted by state law.
- 6.1.3 Primary Care Physician will ensure that medical records are legible.
- 6.1.4 Primary Care Physician will maintain such records for at least seven years from the close of the State's fiscal year in which this Agreement was in effect.
- 6.2 Records and Records Inspection.
- 6.2.1 Access to Records. Primary Care Physician will permit Plan's Medical Director, or officers or their designees, any agency having jurisdiction over Plan, including and without limitation the Governmental Agencies, to inspect the premises, records and equipment of Primary Care Physician and review all operational phases of the medical services provided to Case Managed Members.
- a. Primary Care Physician will make all of Primary Care Physician's books and records, and papers ("Records") relating to the provision of goods and services to Plan Members, to the cost of such goods and services, and to payments received by Primary Care Physician on their behalf available for inspection, examination and copying by Plan and all other state and federal agencies with jurisdiction over Plan or this Agreement, including without limitation, Governmental Agencies, at all reasonable times at Primary Care Physician's place of business or at such other mutually agreeable location in California.
 - b. Plan will pay for the cost of copying Records, not to exceed \$0.10 per page. The ownership of Records will be controlled by applicable law and this Agreement.
 - c. Primary Care Physician shall permit Plan, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review Primary Care Physician's work performed or being performed hereunder, Primary Care Physician's location(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy Records and any other books, accounts and materials relevant to the provisions of services under this Agreement. Primary Care Physician will provide all reasonable facilities, cooperation and assistance during such inspection and

reviews, including for the safety and convenience of the authorized representatives in the performance of their duties. Primary Care Physician shall allow such inspections and reviews for the Records retention time of seven years. The State reserves the right to conduct unannounced validation reviews to verify compliance with State and federal regulations and contract requirements.

6.2.2 Maintenance of Records. Primary Care Physician will maintain records in accordance with the general standards applicable to such book and record keeping and in accordance with applicable law, and Plan directives.

- a. Records will include all encounter data, working papers, reports submitted to Plan, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Members for a period of at least seven (7) years.
- b. All Records will be retained by Primary Care Physician for a period of at least seven (7) years from the close of the DHCS fiscal year in which this Agreement was in effect.
- c. Primary Care Physician's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.
- d. The Primary Care Physician will not charge the Member for the copying and forwarding of their medical records to another provider.

6.3 Disclosure to Government Officials. Primary Care Physician shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, Primary Care Physician shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Healthcare Effectiveness Data Information Set (HEDIS) auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the County of Ventura, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Quality Improvement Organizations (QIOs), their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, "Government Officials") as may be necessary for compliance by Plan with the provisions of all state and federal laws and contractual requirements governing Plan, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at Primary Care Physician's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. Primary Care Physician shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Primary Care Physician related to this Agreement.

6.4 Patient Confidentiality.

- a) Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et. seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted thereunder.
- b) For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Beneficiaries will be protected by the Primary Care Physician and his/her staff from unauthorized disclosure.
- c) Primary Care Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information.
- d) With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the Primary Care Physician, the Primary Care Physician (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the Plan all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than Plan, the federal government including the Department of Health and Human Services and Comptroller General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities the COHS program and contracts, without 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 thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the Plan or maintain such information according to written procedures sent the Plan by the Department of Health Care Services for this purpose.

6.4.1 All subcontracts between Primary Care Physician and Primary Care Physician's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Agreements, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.

6.4.2 All subcontracts and their amendments will become effective only upon written approval by Plan and DHCS and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the Primary Care Physician. Primary Care Physician will notify DHCS and Plan when any subcontract is amended or terminates. Primary Care Physician will make available to Plan and Governmental Agencies, upon request, copies of all agreements between Primary Care Physician and Subcontractor(s) for the purpose of providing Covered Services.

6.4.3 All agreements between Primary Care Physician and any Subcontractor will be in writing and will require Subcontractor to comply with the following:

- a. Records and Records Inspection. Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least seven (7) years from the close of DHCS's fiscal year in which the Subcontract is in effect and submit to Primary Care Physician and Plan all reports required by Primary Care Physician, Plan or DHCS, and timely gather, preserve and provide

to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recovery for Litigation.

- b. Surcharges. Primary Care Physician will not make a Surcharge for Covered Services for a Case Managed Member or other person acting on their behalf. If a Surcharge erroneously occurs, Primary Care Physician will refund the amount of such Surcharge to the Case Managed Member within fifteen (15) days of the occurrence and will notify Plan of the action taken. Upon notice of any Surcharge, Plan will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Case Managed Member and deducting the amount of the Surcharge and the expense incurred by Plan in correcting the payment from the next payment due to Primary Care Physician.
- c. Notification. Notify DHCS and Plan in the event the Agreement with Primary Care Physician is amended or terminated. Notice will be given in the manner specified in Section 10.4 Notices.
- d. Assignment. Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS and Plan.
- e. Additional Requirements. Be bound by the provisions of Section 9.7, Survival of Obligations After Termination, and Section 7.5, 7.6 Hold Harmless.

6.5 Other Insurance Coverage. Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary. Primary Care Physician must bill Other Health Coverage (primary) carrier before billing Plan for reimbursement of covered services and, with the exception of authorized Medi-Cal share of cost payments, will at no time seek compensation from Medi-Cal Members or the DHCS. The PCP may look to the Member for non-covered services.

6.5.1 Coordination of Benefits. Primary Care Physician has the right to collect all sums as a result of Coordination of Benefits efforts for Covered Services provided to Medi-Cal Members with Other Health Coverage.

- a. The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the Plan Operations Manual.
- b. The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the DHCS Agreement with Plan
- c. Primary Care Physician shall report to Plan the discovery of third party insurance coverage for a Medi-Cal Member within 10 days of discovery.
- d. PCP will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the Primary Care Physician, but will be reported to the Plan on the encounter form or encounter tape.

6.6 Third Party Liability Tort. In the event that Primary Care Physician provides services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of

California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by Primary Care Physician pursuant to the terms of this Agreement.

- a. Primary Care Physician will cooperate with the DHCS and Plan in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workersø Compensation claims for Covered Services.
- b. Primary Care Physician shall report to Plan the discovery of third party insurance coverage for a Medi-Cal Member within 10 days of discovery.

SECTION 7 - INSURANCE AND INDEMNIFICATION

7.1 Insurance. Throughout the term of this Agreement and any extension thereto, Primary Care Physician will maintain appropriate insurance programs or policies as follows:

7.1.1 Each participating Primary Care Physician covered by this Agreement will secure and maintain, at its sole expense, liability insurance, or other risk protection programs, in the amounts of at least One Million Dollars (\$1,000,000) and Three Million Dollars (\$3,000,000) per person per occurrence/in aggregate, including "tail coverage" in the same amounts whenever claims made malpractice coverage is involved. Notification of Plan by Primary Care Physician of cancellation or material modification of the insurance coverage or the risk protection program will be made to Plan at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to Plan upon execution of this Agreement.

7.2 General Liability Insurance. In addition to Subsection 7.1 above, Primary Care Physician will also maintain, at its sole expense, a policy or program of comprehensive liability insurance (or other risk protection) with minimum coverage including and no less than Three Hundred Thousand Dollars (\$300,000) per person for Primary Care Physicianø property together with a Combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars (\$300,000). Documents evidencing such coverage will be provided to Plan upon request. The PCP will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.

7.3 Workersø Compensation. Primary Care Physicianø employees will be covered by Workersø Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to Plan upon request. The PCP will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.

7.4 Plan Insurance. Plan at its sole cost and expense, will procure and maintain a professional liability policy to insure Plan and its agents and employees, acting within the scope of their duties, in connection with the performance of Planø responsibilities under this Agreement.

7.5 Primary Care Physician Indemnification. Primary Care Physician shall indemnify and hold harmless Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Primary Care Physician and its officers,

directors, shareholders agents, employees and Subcontractors acting alone or in collusion with others. Primary Care Physician also agrees to hold harmless both the State and Members in the event that Plan cannot or will not pay for services performed by Primary Care Physician pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

- 7.6 Plan Indemnification. Plan shall indemnify and hold harmless Primary Care Physician, its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Plan and its officers, directors, shareholders agents, employees and Subcontractors acting alone or in collusion with others. The terms of this section shall survive the termination of this Agreement.

SECTION 8 - GRIEVANCES AND APPEALS

8.1 Appeals and Grievances.

- 8.1.1 PCP complaints, concerns, or differences, which may arise as a health care provider under contract with Plan will be resolved as outlined in the Appeals and Grievance policies as set forth in the Plan Operations Manual. Primary Care Physician and Plan agree to and will be bound by the decisions of Plan grievance and appeal mechanisms
- 8.1.2 Primary Care Physician will cooperate with Plan in identifying, processing and resolving all Member complaints and grievances in accordance with the Plan grievance procedure set forth in the Plan Operations Manual.

8.2 Responsibility

- 8.2.1 It is the responsibility of the Plan's Chief Executive Officer for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system. The Executive Director will be assisted in this process by the staff of Health Services and Provider Relations.

8.3 Dispute Resolution.

- 8.3.1 For disputes unresolved by the Plan provider appeals process, Plan and Primary Care Physician agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, Primary Care Physician shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").
- 8.3.2 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a

retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

8.3.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

8.3.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Ventura, State of California.

8.4 Peer Review and Fair Hearing Process. Providers determined hereto to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to the Plan Peer Review Committee. The Provider will be afforded an opportunity to address the committee. The Provider will be notified in writing of the Peer Review Committee Recommendations and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict or terminate the provider affiliation; to institute a monitoring procedure, or to implement continuing educational requirements.

8.5 Credentialing. A Credentialing Committee will review all provider files to determine whether a provider meets the Plan credentialing or recredentialing requirements. The Provider will be afforded an opportunity to address this committee if there is an adverse recommendation by the Committee regarding the provider's credentials. The Provider will be advised in writing of the Credentialing Committee's recommendation and notified of their rights to the Fair Hearing process. The Credentialing Committee can recommend denial of a provider's initial application or can deny the recredentialing of a current provider.

SECTION 9 - TERM, TERMINATION, AND AMENDMENT

9.1 Initial Term and Renewal. This Agreement shall be effective as of the Effective Date and shall remain in effect for a term of one (1) year, and will thereafter renew automatically for one (1) year terms unless terminated sooner as set forth below.

9.2 Termination Without Cause. Either party upon sixty (60) days prior written notice to the other party may terminate this Agreement without cause.

9.3 Immediate Termination for Cause by Plan. The Plan may terminate this Agreement immediately by written notice to the Primary Care Physician upon the occurrence of any of the following events:

9.3.1 The suspension or revocation of Primary Care Physician's license to practice medicine in the State of California; the suspension or termination of Primary Care Physician's membership on the active medical staff of any hospital; or the suspension, revocation or reduction in Primary Care Physician's clinical privileges at any hospital; or suspension from the State Medi-Cal Program; or loss of malpractice insurance; or failure to meet Plan's recredentialing criteria; or

9.3.2 Primary Care Physician's death or disability. As used in this Subsection, the term "disability" means any condition which renders Primary Care Physician unable to carry out his/her responsibilities under this Agreement for more than forty-five (45) working days (whether or not consecutive) within any 12-month period; or

9.3.3 If Plan determines, pursuant to procedures and standards adopted in its Utilization Management or Quality Improvement Programs, that Primary Care Physician has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of the Plan Operations Manual; or

9.3.4 If Plan determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member; or

9.3.5 If Plan determines that Primary Care Physician has filed a petition for bankruptcy or reorganization, insolvency, as defined by law and Plan determines that Primary Care Physician is unable to meet financial obligations as described in this Agreement; or the Primary Care Physician closes his / her office and no longer provides medically necessary services, or

9.3.6 If Primary Care Physician breaches Article 10.10, Marketing Activity and Patient Solicitation.

An immediate termination for cause made by Plan pursuant to this will not be subject to the cure provisions specified in Section 9.4 Termination for Cause with Cure Period.

9.4 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3, Immediate Termination for Cause by Plan above of this Agreement, the non-breaching party may terminate this Agreement upon twenty (20) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach during the twenty (20) day period, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.

9.5 Continuation of Services Following Termination. Should this Agreement be terminated, Primary Care Physician will, at Plan's option, continue to provide Primary Care and Covered Services to Medi-Cal Members who are under the care of Primary Care Physician at the time of termination if the primary care physician is willing to continue the care and accepts the Plan terms of payment and agrees to adhere to Plan policies and procedures. Medi-Cal Members are allowed to receive

ongoing care for a chronic or acute medical condition for up to 90 days after this Agreement has terminated. Members in their second or third trimester of pregnancy have access to Specialty care through the post partum period. Primary Care Physician will ensure an orderly transition of care for Case Managed Members, including but not limited to the transfer of Member medical records. Payment by Plan for the continuation of services by Primary Care Physician after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to the physician of photocopying such records will be reimbursed by the Plan at a cost not to exceed \$.10 per page.

- 9.6 Medi-Cal Member Notification Upon Termination. Notwithstanding Section 9.3, Immediate Termination for Cause by Plan, upon the receipt of notice of termination by either Plan or Primary Care Physician, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members Primary Care Physician will notify members 30 days prior to the effective date of termination. Plan at its option, may immediately inform Medi-Cal Members of such termination notice. Such Medi-Cal Members will be required to select another Primary Care Physician prior to the effective date of termination of this Agreement.
- 9.7 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of Primary Care Physician will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 9.5, Continuation of Services Following Termination; 2) Section 6.3.3a, Records and Records Inspection; and, 3) Section 7.5, Hold Harmless. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between Primary Care Physician and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. Primary Care Physician will assist Plan in the orderly transfer of Medi-Cal Members to the Primary Care Physician they choose or to whom they are referred. Furthermore, Primary Care Physician shall assist Plan in the transfer of care as set forth in the Provider Manual, in accordance with the Phaseout Requirements set forth in the Medi-Cal Contract.
- 9.8 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by Plan, Primary Care Physician will allow the copying and transfer of medical records of each Medi-Cal Member to the Physician assuming the Medi-Cal Member's care at termination. Such copying of records will be at Plan expense if termination was not for cause. Plan will continue to have access to records in accordance with the terms hereof.
- 9.9 Termination or Expiration of Plan's Medi-Cal Agreement. In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, Primary Care Physician will allow DHCS and Plan to copy medical records of all Medi-Cal Members, at DHCS's expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, Primary Care Physician will assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the Primary Care Physician's Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by

DHCS. Costs of reproduction of all such medical records will be borne by DHCS. In no circumstances will a Medi-Cal Member be billed for this service.

SECTION 10 - GENERAL PROVISIONS

- 10.1 Assignment. This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged or hypothecated in any way by the Primary Care Physician and will not be subject to execution, attachment or similar process, nor will the duties imposed on Primary Care Physician be set, contracted or delegated without the prior written approval of Plan and DHCS. Subcontractor's agreements that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
- 10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS. This Agreement may be amended by the Plan upon thirty (30) days written notice to the PCP.
- 10.2.1 If the PCP does not give written notice of termination within sixty (60) days, as authorized by Section 9.2, Primary Care Physician agrees that any such amendment by Plan will be a part of the Agreement.
- 10.2.2 Unless PCP, or DHCS notifies Plan that it does not accept such amendment, the amendment will become effective thirty (30) days after the date of Plan's notice of proposed amendment.
- 10.2.3 Amendments to the compensation, services or term provisions of this Agreement, will be forwarded to DHCS.
- 10.2.4 Notwithstanding the foregoing, Plan may amend this Agreement with prior written notice to Primary Care Physician in order to maintain compliance with State and Federal Law and the Medi-Cal Agreement. Such amendment shall be binding upon Primary Care Physician and shall not require the consent of Primary Care Physician.
- 10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.
- 10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.
- 10.4.1 Primary Care Physician will notify DHCS in the event this Agreement is amended or

terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. A copy of the written notice will also be mailed as first-class registered mail to:

California Department of Health Care Services
Medi-Cal Managed Care Division
1501 Capitol Avenue, Ste. 71.4001
MS. 4407, P.O. Box 997413
Sacramento, CA 95899-7413

- 10.5 Entire Agreement. This Agreement, together with the Exhibits and the Plan Operations Manual, contains the entire agreement between Plan and Primary Care Physician relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.
- 10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 10.7 Governing Law. The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of Plan. Any provision required to be in this Agreement by law, regulation, or the Medi-Cal Agreement will bind Plan and Primary Care Physician whether or not provided in this Agreement.
- 10.8 Affirmative Statement, Treatment Alternatives. Practitioners may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- 10.9 Reporting Fraud and Abuse. Primary Care Physician is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by Plan contracted physicians within 10 days to Plan for investigation.
- 10.10 Marketing Activity and Patient Solicitation. Primary Care Physician will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of Plan and DHCS.
- 10.10.1 Primary Care Physician will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.
- 10.10.2 During the period of this Agreement and for a one year period after termination of this Agreement, Primary Care Physician and Primary Care Physician's employees, agents or Subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which Primary Care Physicians render contracted services to Plan Members.
- 10.10.3 In the event of breach of this Section 10.10, in addition to any other legal rights to which it may be entitled, Plan may at its sole discretion, immediately

terminate this Agreement. This termination will not be subject to Section 9.4, Termination for Cause with Cure Period.

- 10.11 Nondisclosure and Confidentiality. Primary Care Physician will not disclose the payment provisions of this Agreement except as may be required by law.
- 10.12 Proprietary Information. With respect to any identifiable information concerning a Case Managed Member that is obtained by Primary Care Physician or its Subcontractors, Primary Care Physician and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to Plan all requests for disclosure of such information, except requests for medical records in accordance with applicable law; will not disclose any such information to any party other than DHCS without Plan's prior written authorization, except as specifically permitted by this Agreement or the Plan Medi-Cal Agreement with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Agreement; and, will, at expiration or termination of this Agreement, return all such information to Plan or maintain such information according to written procedures provided by Plan for this purpose.
- 10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Case Managed Members for which Primary Care Physician accepts responsibility hereunder, Primary Care Physician reserves the right to provide professional services to persons who are not Case Managed Members including Eligible Beneficiaries. Nothing contained herein will prevent Primary Care Physician from participating in any other prepaid health care program.
- 10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.
- 10.15 HIPAA. Primary Care Physician and Plan each acknowledge that it is a "Covered Entity" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the "HIPAA Privacy Rule"). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members' individually identifiable health information. If the Primary Care Physician identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to Plan or Members, the Primary Care Physician must notify Plan's Privacy Officer immediately.

SECTION 11 – RELATIONSHIP OF PARTIES

- 11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent Primary Care Physician from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, Primary Care Physician will provide written assurance to Plan that any contract providing commitments to any other prepaid program will not prevent Primary Care Physician from fulfilling its obligations to Medi-Cal Members

under this Agreement, including the timely provision of services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.

- 11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of Plan to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.
- 11.3 Physician-Patient Relationship. This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her Primary Care Physician. Primary Care Physicians will be responsible for maintaining the professional relationship with Case Managed Members and are solely responsible to such Case Managed Members for all medical services provided. Plan will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Case Managed Member resulting from the acts or omissions of Primary Care Physician.

**ATTACHMENT A
PRIMARY CARE AND SPECIALIST PHYSICIANS
CASE MANAGEMENT PROTOCOL
Table of Contents**

1.0 Primary Care and Specialist Physician Case Management Protocol 35

1.1 Definition of Case Management 35

1.2 Objectives 35

1.3 PCP Responsibilities 36

1.3.1 Responsibilities

1.3.2 Request For Change of Primary Care Physician

A. Physician Initiated

B. Member Initiated

C. Transfer Request During Active Treatment

1.4 Authorization of Services 38

1.4.1 General Procedure

1.4.2 Emergency Service Authorization

1.4.3 Non-Emergency Care Services

1.4.4 Eligibility Verification

1.4.5 Payment for Authorized Services

1.4.6 Second Medical Opinions

1.4.7 Other Coverage or Third Party Liability

1.5 Specialist Physician Responsibilities 40

1.5.1 Responsibilities

1.5.2 Patient Medical Record Data

1.5.3 Authorization for Additional Data Needs

1.5.4 Additional Consultation Treatment Authorization

1.6 Non Physician Medical Practitioners 42

1.7 Out-of-Area Service Claims 42

1.8 Twenty-Four Hour Case Management Coverage 43

1.9 Delegation of Treatment Responsibility 43

1.10 Utilization Controls 44

1.11 Production and Distribution of Case Management List 44

1.12 Monitoring and Evaluation 44

CASE MANAGEMENT PROTOCOL

1.0 Primary Care and Specialist Physician Case Management Protocol

1.1 Definition of Case Management

The California Department of Health Care Services defines case management as "Guiding the course of resolution of a personal medical problem (including the "problem" of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate times, in the most appropriate setting."

The following requirements are necessary for the case management system to function:

- 1.1.1 Medi-Cal beneficiaries (also referred to herein as "Members") are required to select a Primary Care Physician, or to be assigned to Primary Care Physician.
- 1.1.2 Participating Primary Care and Specialist Physicians are required to contract with the Plan for provision of the services at rates established by the Plan and by the Department of Health Care Services Medi-Cal fee-for-service program.
- 1.1.3 Through the referral process, Primary Care Physicians will control Member referral to all services except Emergency and Limited Services as defined in the Medical Service Agreement. Services for retroactive eligible Members and share of cost Members may be exempted from case management.
- 1.1.4 To facilitate accessibility of care to Members of the Plan, individual and group practice Primary Care Physicians, in private and public settings, will be geographically located throughout the county.
- 1.1.5 Providers must meet the Medi-Cal Program Standards of Participation and be credentialed by Plan or an entity that it has delegated the activity to in the formal process of a delegation agreement.

1.2 Objectives

The objectives of physician case management of Member's medical care are as follows:

- 1.2.1 To foster continuity of care and longitudinal provider/patient relationships for Medi-Cal beneficiaries (also referred to subsequently as "Members") in Ventura County.
- 1.2.2 To coordinate the care of Members in order to achieve satisfactory care results.
- 1.2.3 To contribute to the reduction in the use of hospital emergency rooms as a source of non-emergency, first-contact and urgent medicine by Members.
- 1.2.4 To reduce unnecessary referral of Members to specialty providers.
- 1.2.5 To discourage inappropriate use of pharmacy and drug benefits by Members.
- 1.2.6 To facilitate the Member's understanding and use of health promotion, disease prevention

practices, and early diagnostic services.

1.2.7 To provide a structure for Physicians to manage services to the Medi-Cal population by means of the following:

- A. Selection of medical specialists based upon quality of care and adherence to the case management system to promote the cost effective delivery of services.
- B. Reimbursement to Physicians through a payment structure based upon measurement of individual and group Physician utilization and quality of care performance.

1.2.8 To facilitate the smooth transition of members from one PCP to another when necessary.

1.3 PCP Responsibilities

1.3.1 The responsibilities of the PCP are the following:

- A. As specified in the Medical Service Agreement, to provide the scope of primary care services to health plan Members who have designated the Physician as his or her PCP.
- B. To refer all Medically Necessary non-emergency hospital and/or specialty services for each case managed Member, and to arrange for those services to be delivered by hospitals and Specialists who contract with the Plan. To refer Medically Necessary care to specialist for purposes continuity of care.
- C. To coordinate and direct appropriate care for Members by means of initial diagnosis and treatment, consultation with specialists, and follow-up of care to assess the results of the primary care, medication regimen and special treatment within the framework of integrated, continuous care.
- D. To record legibly and completely any information about patient visits, efforts to contact patients, treatment, referral and consultation reports in the medical record.
- E. To maintain a follow-up system of referrals to determine whether or not the Member obtained referral and the results of such referral.
- F. To facilitate and ensure patient quality of care by establishing procedures to contact Members when they miss appointments, requiring rescheduling for additional visits, or confirming referrals to a specialist for care.
- G. To maintain patient medical records for the Members consistent with standard medical practice and to make the individual patient medical records available upon request for audit/review by the staff of the Plan, the California Department of Health Care Services and the U.S. Department of Health and Human Services.
- H. To participate in and accept the Plan's continuing peer review of case managed and referred medical services.

- I. To participate in Plan Quality Improvement and Utilization Management Programs.
- J. To use as appropriate the appeal procedures for providers as established by Plan.
- K. To preserve the dignity of the Member.
- L. To maintain confidentiality of medical information about the Member.
- M. To coordinate Member discharge planning and referral to long term care with Plan staff.

1.3.2 Request for Change of PCP

- A. A Physician's request to transfer the Member to another PCP requires the approval of. Plan
- B. Such requests will be granted for the following reasons:
 - (1) Significant lack of cooperation, understanding and/or communication between doctor and patient. In such cases, the PCP and Plan will use their best efforts to provide the Member with the opportunity to be served by a PCP with whom a satisfactory physician-patient relationship can be developed. If the Plan is unable to make such arrangements and the Member is in active care, the PCP will continue to serve the Member according to the PCP's best professional judgment until the Plan is able to change the Member's PCP, a period not to exceed two months.
 - (2) Requests to transfer a Member to another PCP due to high cost or frequent visits will not be granted.
 - (3) The PCP must notify Provider Relations in writing regarding the PCP's desire to disenroll a Member in their practice. Complete documentation regarding the nature of the problem must be included with the request. Requests to disenroll a Member will be considered based on criteria outlined in Plan Operations Manual.
 - (4) Requests will be reviewed and PCP will be notified of the decision. Once the PCP has been notified of the disenrollment, it is expected that the PCP will notify the Member in writing regarding the PCP's decision to terminate the Member from their practice and that the PCP will no longer be responsible for the Member's medical care effective the date of the disenrollment. Plan will contact the patient to facilitate enrollment with a new PCP.
 - (5) Exceptions to this policy will be considered on a case by case basis.
 - (6) A Physician can cease providing care for a non-assigned Member when the Physician/patient relationship becomes unsatisfactory. In these cases, the Physician must notify the Member in writing that they will no longer

provide care for the Member. The Physician should assist the Member in choosing another Physician and transfer appropriate office medical records to that Physician.

- (7) A specialist physician can cease providing care for any member when the physician/patient relationship becomes unsatisfactory. In these cases, the specialist physician must notify both the PCP and the patient that they will no longer provide care to the patient. The PCP will refer the member to another specialist care for treatment if specialist care still is necessary.

1.3.3 Member Requests for change of PCP will be reviewed by Member Services Department.

1.3.4 Change of PCP requests from Members during active treatment requires special review by the Medical Director. Normally, such requests will not be granted until the treatment plan is completed. However, if the new PCP is willing to accept the transfer of the Member in active care, the request will be granted.

1.4 Authorization of Services

1.4.1 General Procedure

- A. Plan will pay for properly prior authorized claims only according to the specific contract terms with each Physician, hospital, and other provider. Providers should obtain the identification information from the Member. The Member should have a Plan ID Card with the name and telephone number of the PCP and a Medi-Cal card.
- B. All PCPs will use Plan authorization procedures whenever referring a Member to a Specialist.
- C. Specialists must obtain a Referral Authorization Form (RAF) from the PCP in order to be paid for the care given. Exceptions are as follows:
 - (1) Emergency care, DME, medical supplies, routine radiology including ultrasound, and laboratory services do not require a Referral Authorization Form (RAF).
 - (2) The following services do not require a formal referral or completion of a RAF by the PCP.
 - a. Family planning services involving delaying and preventing pregnancy, vasectomy, tubal ligation, STD diagnosis and treatment, abortions, pregnancy testing and HIV testing, when provided by a family planning provider;
 - (3) Obstetrical Services do not require a formal referral or completion of a RAF by the PCP unless services are accessed outside the county.
- D. The referring Physician must complete the original and attached copies of the RAF. The eligibility of the Member and number of visits, services and/or period

of service to be rendered must appear in the proper location on the RAF.

- E. The PCP files his/her copy and the respective reports in the patient's medical record.
- F. Specialist or other provider retains the specified copy for his/her file.
- G. When submitting claims, the RAF or TAR authorization number should be indicated on the claim form.

1.4.2 Emergency Service Notification

- A. Emergency services are defined in the Physician Agreement as those health services required for and Emergency Medical Condition, which is defined as 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.
- B. Emergency services rendered at hospitals do not require prior authorization.
- C. When a Member presents with an emergency condition to the Emergency Department, the attending physician/hospital must do the following:
 - (1) Verify Member eligibility, as well as PCP or Member status.
 - (2) Notify the PCP or alternate provider as soon as possible, but not later than 24 hours following service.
- D. When a Member with an emergency condition is admitted for in-patient services, the attending Physician/hospital will notify the PCP and Plan within 24 hours of the admission.

1.4.3 Non-Emergency Services Authorization

- A. When a Member reports to a hospital emergency room or urgent care facility for a non-emergency medical condition, the ER or urgent care report or face sheet shall be forwarded to the PCP within twenty-four (24) hours, or next business day, subsequent to rendering services.

1.4.4 Eligibility Verification

- A. PCP's, Specialists, and ancillary providers must verify both Medi-Cal eligibility of the Member and the assignment of PCP for the month of service. This verification is necessary for all service authorizations.

The PCP should consult the monthly list of Members furnished by Plan at the beginning of each month that designates Members for whom the Physician has assumed case management responsibility.

1.4.5 Payment For Authorized Services

- A. Payment for services rendered by a Specialist, Physician, hospital or other provider may not be claimed without the following:
 - (1) Eligibility verification of the Member for the month during which the service was or is to be rendered.
 - (2) A referral from the PCP or authorization from the Plan. If the claim is submitted without the prior authorization when required, the claim will be denied for no prior authorization.
- B. When submitting claims for authorized services, the referral number and/or authorization number must be indicated on the Medi-Cal claim form.

1.4.6 Second Medical Opinions

- A. Members have the right to request a second opinion if they have been referred to a specialist and feel that such evaluation was unsatisfactory. A Member's first request for a second opinion may not be denied.
- B. When the PCP requests a second opinion, the PCP submits a referral for the second specialist visit in the same method as all specialty referrals.
- C. When the Member requests a third opinion, which the PCP does not believe to be necessary, the PCP will refer the request to the Plan Medical Director for review and action.
- D. In response to an Authorization Request, the Plan's Medical Director/designee may require a second opinion to assist with the approval decision.

1.4.7 Other Coverage or Third Party Liability

- A. In the event the Member has other coverage designated on the Medi-Cal Card) or third-party liability is involved, the Physician will follow procedures outlined in the current Medi-Cal Provider Manual to bill the appropriate parties prior to billing Plan. Medi-Cal and Plan are secondary payors for services rendered. Claims for payment from Plan will be mailed to the Plan - NOT THE FISCAL INTERMEDIARY FOR MEDI-CAL.
- B. Claims for other Title XIX reimbursable services not covered by Plan (e.g. Dental) will be billed to the appropriate program.

1.5 Specialist Responsibilities

1.5.1 The responsibilities of the Specialist are as follows:

- A. Upon receipt of the proper treatment authorization and verification of Member eligibility, the Specialist will provide to Member those authorized medical services normally performed in his/her practice.
- B. Upon receipt of the proper treatment authorization and verification of beneficiary eligibility, the Specialist may serve as a consultant to the PCP.
- C. Upon completion of the initial examination of the Member and subsequent authorized treatment, the Specialist will:
 - (1) Advise the PCP of the patient's condition, proposed procedures, and prognosis throughout the period of treatment; and
 - (2) Provide to the PCP a written report, and other oral reports as appropriate, regarding the diagnosis, treatment, other findings and prognosis within thirty (30) days after patient contact. (The PCP office should maintain a "tickler file" on all requested referrals, to ensure a report is received by the 30-day turnaround time.)
- D. To secure a referral from the PCP prior to rendering treatment or treatment authorization from Plan.
- E. To participate in and accept continuing peer review of the medical or surgical services provided for Members.
- F. To participate in Quality Improvement and Utilization Management Programs as defined by the Plan.
- G. To permit review/audit of services provided to Members by the staff of Plan the California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) according to federal and state regulatory requirements and guidelines issued by Plan.
- H. To use as appropriate the appeal procedures for providers as established by Plan.
- I. To preserve the dignity of the Member.

1.5.2 Member Medical Record Data

- A. In addition to issuing a Referral Authorization Form (RAF), the PCP will provide to the Specialist significant physical findings, radiographic or laboratory results from the Member's general medical record which may assist the consultation process.

1.5.3 Authorization For Additional Data Needs

- A. If the Specialist requires radiographic, laboratory or other diagnostic studies in order to evaluate the patient's condition or to make a diagnosis, the Specialist may arrange for such studies which do not unnecessarily duplicate materials that were made available by the PCP or do not contradict the scope of referral granted by the PCP. Specialist is required to obtain appropriate authorization

from Plan for services that require prior authorization per Plan authorization requirements.

- B. All covered services provided at the Specialist's office will be billed by the Specialist to Plan.
- C. If any of the services are rendered by a provider other than the specialist, the provider must obtain the proper referral from the PCP.
- D. All such referrals must be made to providers who contract with Plan.

1.5.4 Additional Consultation/Treatment Authorization

- A. Additional consultation/treatment beyond that authorized by the original RAF may be required to bring the patient to a satisfactory level of health. The Specialist must obtain authorization for all services for which one is required.
- B. Such additional treatment will conform to accepted medical or surgical standards and to Plan and Medi-Cal coverage limitations. The specialist will bill Plan for payment for authorized services.
- C. The PCP may issue additional referrals for further treatment by the Specialist or arrange another course of action which is satisfactory to the Member and the PCP.

1.6 Non-Physician Medical Practitioners

- 1.6.1 When a PCP employs a physician assistant, nurse practitioner or certified nurse midwife, the non-physician medical practitioner will be directed according to Medi-Cal regulations and other written policies of Plan.
- 1.6.2 The Supervising Physician will have an appropriate certification from the California Medical Quality Board to supervise the physician assistant. The Physician Assistant will hold a current license to practice.
- 1.6.3 The nurse practitioner or nurse midwife will hold a current professional license for the position and act according to the agreed upon protocols and interface requirements cited in the Medi-Cal regulations.
- 1.6.4 Services rendered by non-physician medical practitioners are recognized by Plan as professional services to be billed as a physician service according to the contract with Plan.
- 1.6.5 If the non-physician medical practitioner provides after-hours coverage, that practitioner must be supervised by a licensed M.D. or D.O. who is immediately available by telephone to the covering non-physician practitioner.

1.7 Out Of Area Service Claims

- 1.7.1 Plan will pay for medical claims for the care of any Member who receives medically necessary emergency treatment rendered outside Ventura County.

- 1.7.2 PCP's will discuss out-of-area emergency coverage with their Members. The out-of-area emergency care does not require prior authorization.

1.8 Twenty-Four Hour Coverage

- 1.8.1 The PCP will assure access to Physician care for case-managed Members 24 hours per day, 7 days per week. After business hours the PCP or attending physician for case managed Members may designate a covering practitioner to provide after-hours care. The on-call practitioner must be available by telephone to respond to call from Members, organizational providers and other practitioners. After business hours it is expected that the answering service contact the practitioner or designee within 30 minutes for urgent questions. The practitioner on-call for the practice is expected to call the answering service within 30 minutes of contact by the answering service. The practitioner on call is required to call the Member back within 60 minutes for probable urgent problems and within 4 hours for probable non-urgent matters.
- 1.8.2 The PCP will designate a backup Physician when unavailable to render care.
- 1.8.3 The PCP will provide to Plan a list with the names and telephone numbers of backup Physicians.
- 1.8.4 Should the backup Physician render any Covered Services to the PCP's Members, the backup Physician will send the claims to Plan for processing of the encounter data only. Actual payment for any services rendered will be determined by a separate understanding between the PCP and covering backup Physician. ***Any payments owing to the backup Physician will be made by the PCP not the Plan.*** Prior to rendering care, the backup Physician will confirm Member eligibility.
- 1.8.5 Following care of any of the PCP's Plan Members, the backup Physician will update the PCP on any treatment rendered as well as any questions or concerns regarding the patient. Further follow-up of the patient is now the responsibility of the PCP.
- 1.8.6 A PCP may elect to have a mid-level clinician or registered nurse who is part of the PCP's practice take after hours calls provided they follow standardized protocols and a Physician is always available for back-up.

1.9 Delegation of Treatment Responsibility

- 1.9.1 Certain patient conditions may demand ongoing treatment by a Specialist Physician (e.g., OB-GYN).
 - A. The PCP may delegate the responsibility for continuing specialty care to a specialist for a specified time (6 months). The PCP must issue a RAF for a delegated Specialist. The PCP will remain the PCP to the Member.
 - B. Any hospitalization of the Member which may be recommended or required, however, will be prior authorized by the PCP. The Specialist will request such authorizations from the PCP. Hospitalization authorization procedures will apply to this request.

- C. As required for all consultations the Physician rendering care will provide written reports of the patient's condition, treatment, prognosis, etc. to the PCP within thirty (30) days of service.

1.10 Utilization Controls

- 1.10.1 In the interest of program integrity and the welfare of Members, Plan may introduce utilization controls as may be necessary. In the event such changes are made, the Physician will be given 30 days advance notice by Plan.

1.11 Production and Distribution of Case Management List

- 1.11.1 Case management lists are the monthly lists of Members selected or assigned to the PCP.

- 1.11.2 Case management lists are produced prior to the first day of each calendar month. Each PCP with selections receives an individual list of eligible Members for that month.

1.12 Monitoring and Evaluation

- 1.12.1 A periodic random sample of medical records may be audited for appropriateness of case management activities

ATTACHMENT B

**PRIMARY CARE PHYSICIAN
MONTHLY CAPITATION AMOUNTS**

MEDI-CAL AID CODE CATEGORY	CAP \$
Adult/Family	\$8.38
Aged Medi-Cal only	\$10.99
Disabled Medi-Cal only	\$12.06

ATTACHMENT C
Primary Care Physician - Scope of Capitated Services

The services listed in this Attachment are included in your monthly Member capitation payment. You are expected to provide these services to your Member Patients as deemed medically appropriate. In the event that a Primary Care Physician needs to provide Covered Services that fall outside this list, the PCP should submit a claim to the Plan; services will be reimbursed at the prevailing Medi-Cal fee-for-service rate schedule. If the service is included in the list of services requiring Prior Authorization as described in the Gold Coast Health Plan Provider Manual then the PCP must obtain Prior Authorization in order to provide the service.

OFFICE VISITS

CPT Code – New Patient

99201	Problem focused history and exam; straight forward; 10 minutes
99202	Expanded problem focused history and exam; straight forward; 20 minutes
99203	Detailed history and exam; low complexity; 30 min
99204	Comprehensive history and exam; moderate complexity; 45 minutes
99205	Comprehensive history and exam; high complexity; 60 minutes

Established Patient

99211	Minimal Problem; physician supervised services; 5 minutes
99212	Problem focused history and exam; straight forward; 10 minutes
99213	Expanded problem focused history and exam; straight forward; 15 minutes
99214	Detailed history and exam; moderate complexity; 25 minutes
99215	Comprehensive history and exam; high complexity; 40 minutes

PREVENTIVE MEDICINE SERVICES (*if not covered by CHDP*)

99381	Initial Evaluation and Management of Healthy Individual
99382	Early Childhood ó age 1 to 4 years
99383	Late Childhood ó age 5 to 11 years
99384	Adolescent ó age 12 to 17 years
99385	18 ó 39 years
99386	40 ó 64 years
99387	65 years and older

Established Patient

99391	Periodic Reevaluation and management of Healthy Individual
99392	Early Childhood ó age 1 to 4 years
99393	Late Childhood ó age 5 to 11 years
99394	Adolescent ó age 12 to 17 years
99395	18 ó 39 years

99396 40 ó 64 years
99397 65 years and older

MINOR SURGICAL AND OTHER MISCELLANEOUS PROCEDURES

Surgical Procedures

10060 Drainage of Boil
10080 Drainage of Pilonidal Cyst
10120 Remove Foreign
10140 Drainage of Hematoma
10160 Puncture Drainage of Lesion
11740 Drain Blood from under Nail
11900 Injection into Skin Lesions
16000 Initial Treatment of Burn(s)
20600 Arthrocentesis, Aspiration and/or Injection; Small Joint, Burns or Ganglion Cyst
26720 Treat Finger Fracture, Each
28490 Treat Big Toe Fracture
28510 Treatment of Toe Fracture

Splints

29105 Application of long arm splint (shoulder to hand)
29125 Application of short arm splint (forearm to hand); static
29126 dynamic
29130 Application of finger splint; static
29131 dynamic
29505 Application of long leg splint (thigh to ankle or toes)
29515 Application of short leg splint (calf to foot)

Strapping – Any Age

29200 Strapping; thorax
29220 low back
29240 shoulder (eg. Velpeau)
29260 elbow or wrist
29280 hand or finger
29520 Strapping; hip
29530 knee
29540 ankle
29550 toes

46600 Diagnostic Anoscopy
51701 Insertion of non-indwelling bladder catheter
51702 Insertion of temporary indwelling bladder catheter
65205 Removal of Foreign Body, Eye

69200 Clear Outer Ear Canal
69210 Remove Impacted Ear Wax

Laboratory

81000 Urinalysis with Microscopy
81002 Routine Urine Analysis
81005 Urinalysis; Chemical, qualitative
81205 Urine Pregnancy Test, by Visual Color Comparison Methods
82270 Blood; Occult, Feces
82271 Blood; Occult ó Other Sources
82948 Stick Assay Blood Glucose
82947 Glucose; Quantitative
85014 Hematocrit
85018 Hemoglobin, Colorimetric
85025 Automated Hemogram
86580 TB Intradermal Test
87081/87084 Bacteria Culture screen only, e.g., Rapid Strep test
87205 Smear, Stain & Interpretation - Routine Stain
87210 Smear, Stain & Interpretation ó Wet Mount
87220 Tissue Examination for Fungi (KOH Slide)

ECG, HEARING TEST, SUPPLIES

93005 Electrocardiogram, tracing only
93041 Rhythm ECG, Tracing
92567 Tympanometry
Z0316 Tympanometry codes
99070 Special Supplies

IMMUNIZATIONS

90471/90472 Immunization Administration*

NOTE: * Administration of vaccines only. Cost of the vaccine may be reimbursed with invoice.

ATTACHMENT D

DISCLOSURE FORM (Welfare and Institutions Code Section 14452)

Name of Primary Care Physician

The undersigned hereby certifies that the following information regarding the Primary Care Physician is true and correct as of the date set forth below:

Form of Primary Care Physician (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

If a proprietorship, Co-Owner(s). If a partnership, partners.

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

Stockholders owning more than ten percent (10%) of the stock of the Provider:

Major creditors holding more than five (5) percent of Provider debt:

If not already disclosed above, is Primary Care Physician, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

Dated: _____

Signature: _____

Name: _____

(Please type or print)

Title: _____

(Please type or print)

ATTACHMENT E

List the physician name, Ventura County location(s) and hours of operation, mid-level practitioners supervised and languages spoken that shall apply to this Agreement.

MEDICAL SERVICES AGREEMENT

**Between
VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION**

**And
SPECIALIST PHYSICIAN**

This Medical Services Agreement (this "Agreement") is made effective as of the _____ day of _____, 20__ (the "Effective Date"), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as "Plan," and _____ (please print) ("Specialist" or "Specialist Physician"), a physician licensed to practice in the State of California pursuant to California Business and Professions Code, Division II, Chapter 5, Section 200 et. seq., who is eligible to participate in and certified to provide services under the California Medi-Cal (Medicaid) program, and meets applicable requirements under Titles XVIII and XIX of the Social Security Act.

IN WITNESS WHEREOF, the subsequent Agreement between Plan and Specialist Physician is entered into by and between the undersigned parties.

Specialist Physician:

Plan:

*(List Specialist Physician
Name Above)*

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

Executed by:

Signature

Signature

Printed Name

Earl Greenia
Chief Executive Officer

Title

Date

Date

Address for Notices:

Address for Notices:

Gold Coast Health Plan
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-8294

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
SPECIALIST PHYSICIAN MEDICAL SERVICE AGREEMENT**

Table of Contents

RECITALS3

SECTION 1 – DEFINITIONS3

SECTION 2 – QUALIFICATIONS, OBLIGATIONS AND COVENANTS8

SECTION 3 – SCOPE OF SERVICES TO BE PROVIDED 12

SECTION 4 – EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES 15

SECTION 5 – PAYMENTS 17

SECTION 6 – MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES 20

SECTION 7 – INSURANCE AND INDEMNIFICATION 23

SECTION 8 – GRIEVANCES AND APPEALS 24

SECTION 9 – TERM, TERMINATION, AND AMENDMENT 25

SECTION 10 – GENERAL PROVISIONS..... 28

SECTION 11 – RELATIONSHIP OF PARTIES 30

SECTION 12 – ADDITIONAL LEGAL REQUIREMENTS 31

Attachment A – Primary Care Provider and Specialist Physician Case Management Protocol 36

Attachment B – Information Regarding Officers, Owners, and Stockholders..... 47

Attachment C – Facility Locations..... 48

Attachment D – Physician Rates..... 49

RECITALS

- A. WHEREAS, Plan is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.
- B. Whereas Plan 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 the Plan.
- C. Whereas Plan will arrange for Covered Services for its Medi-Cal Members under the case management of designated Primary Care Physicians chosen by or assigned to Medi-Cal Members, and all Specialist Physician Services will be delivered only with authorization from Plan if services being provided require prior authorization.
- D. Whereas Specialist Physician will participate in providing Covered Services to Medi-Cal Members and will receive payment from Plan for the rendering of those Covered Services.
- E. Whereas Specialist Physician desires to provide specialty medical care for such Medi-Cal Members.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the parties set forth in this Agreement agree and covenant as follows:

SECTION 1 DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

- 1.1 Administrative Member. Medi-Cal Members enrolled with Plan who have not been assigned to a Primary Care Physician for administrative reasons.
- 1.2 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.
- 1.3 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.
- 1.4 Authorization Request Form (ARF). The form approved by Plan for the provision of Outpatient Services set forth in the Provider Manual.

- 1.5 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.
- 1.6 Capitation Payment. The prepaid monthly amount that Plan pays to Primary Care Physician (PCP) as compensation for those Covered Medical Services which are set forth in Attachment C, attached to and incorporated within the PCP Medical Services Agreement with Plan.
- 1.7 Case Managed Members. Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care.
- 1.8 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.
- 1.9 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.
- 1.10 Complex Case. Members requiring comprehensive care management and coordination of services. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex psychosocial 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.
- 1.11 Contract Year. The 12-month period following the effective date of this Agreement between Specialist Physician and Plan 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 Plan operational date will apply.
- 1.12 County Organized Health System (COHS). A plan serving either a single or multiple county areas.
- 1.13 Covered Medical Services. Those Covered Services that are set forth in the Member Handbook some of which are to be provided to, or arranged for, Members by Specialist Physician, within the scope of its licensure, pursuant to this Agreement and for which Specialist Physician is to be compensated by Plan in accordance with Attachment D of this Agreement.
- 1.14 Covered Services. All Medically Necessary services to which Members are entitled from Plan as set forth in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services. Covered Services includes Covered Medical Services.
- 1.15 DHCS. The State of California Department of Health Care Services.

- 1.16 Direct Referral Authorization Form (DRAF). The Plan's form, evidencing referral by PCP or Medical Director, or designee for initial specialist consultation or return follow-up with forty-five (45) days.
- 1.17 Eligible Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the Plan 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.
- 1.18 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.
- 1.19 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.
- 1.20 Encounter Form. The CMS-1500 claim form used by Specialist Physician to report to the Plan provision of covered services to Medi-Cal Members.
- 1.21 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the Plan.
- 1.22 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.
- 1.23 Fee-For-Service Payment (FFS). (1) The maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by Plan and the Specialist Physician. All Covered Services authorized by Plan pursuant to this Agreement will be compensated by Plan as described in Attachment D.
- 1.24 Fiscal Year. The 12 month period starting July 1.
- 1.25 Governmental Agencies. Any agency that has legal jurisdiction over Plan, Medi-Cal or Medicaid, such as: the Department of Managed Health Care ("DMHC"), DHCS, United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General.
- 1.26 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.
- 1.27 Identification Card. The card that is prepared by the Plan which bears the name and symbol of Plan and contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with Plan or proof of Medi-Cal eligibility.
- 1.28 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.

- 1.29 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by Plan to monitor the quality assurance and implement Quality Improvement Program of Plan. Also called Chief Medical Officer.
- 1.30 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. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.
- 1.31 Medi-Cal Managed Care Program. The program that Plan operates under its Medi-Cal Agreement with the DHCS for the Service Area.
- 1.32 Medi-Cal Provider Manual. The Medical Services Provider Manual of the DHCS, issued by the DHCS Fiscal Intermediary.
- 1.33 Medical Transportation. "Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, specially equipped 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.
- 1.34 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the Plan.
- 1.35 Member Handbook. The Plan 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 Plan and the Medi-Cal Member.
- 1.36 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.
- 1.37 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.
- 1.38 Operations Manual. The Manual of Operational Policies and Procedures for the Plan Medi-Cal Managed Care Program. Also called Provider Manual.
- 1.39 Other Services. Other covered services not included in the Specialty Care and Inpatient Hospital Services sub-accounts, as described in this Agreement.
- 1.40 Out-of-Area. The geographic area outside Ventura County.
- 1.41 Participating Referral Provider. Any health professional or institution contracted with Plan that meets the Standards for Participation in the State Medi-Cal Program to render medical services to Medi-Cal Members.

- 1.42 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with Plan and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program and who has contracted with Plan to provide medical services to Medi-Cal members.
- 1.43 Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the Plan. Such limit may be changed by mutual agreement of the parties.
- 1.44 Plan. The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission and serving Ventura County Medi-Cal Eligible Beneficiaries. Also called Gold Coast Health Plan.
- 1.45 Primary Care Physician or PCP. A physician duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; 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, and pediatricians but may or may not include Obstetrician-Gynecologists depending on their scope of practice.
- 1.46 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.
- 1.47 Primary Hospital. Any hospital affiliated with Medical Group that has entered into an Agreement with the Plan.
- 1.48 Provider Manual. The Plan's Manual describing operational policies and procedures relevant to Providers. Also called Operations Manual.
- 1.49 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.
- 1.50 Referral Physician. Any qualified physician, duly licensed in California who meets the Standards of Participation, has been enrolled in the State Medi-Cal Program in accordance with Article 3, Title 22, CCR. Exception to this requirement must be authorized by Plan CEO and/or Medical Director. A Referral Physician must have an Agreement with Plan or authorized by a subcontracted Plan provider. Primary Care Physician may refer any Member for consultation or treatment to a Referral Physician.
- 1.51 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.
- 1.52 Service Area. The County of Ventura.

- 1.53 Treatment Authorization Request or TAR. The Plan's form for the provision of inpatient Non-Emergency Services as set forth in the Provider Manual.
- 1.54 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).
- 1.55 Utilization Management Program. The program(s) approved by Plan, which are designed to review and monitor the utilization of Covered Services. Such program(s) are set forth in the Plan's Provider Manual.
- 1.56 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

SECTION 2 QUALIFICATIONS, OBLIGATIONS AND COVENANTS

- 2.1 Specialist Physician is responsible for:
 - 2.1.1 Standards of Care. Provide Covered Services for those complaints and disorders of Plan Members that are within his/her professional competence with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.
 - 2.1.2 Licensure. Warrant that Specialist Physician has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license to practice medicine or osteopathy in the State of California to provide the Covered Services under the terms of this Agreement. Warrant that Specialist Physician has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by Plan. Warrant that the Specialist Physician has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in the Medi-Cal Program in accordance with the program Standards of Participation as contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations.
 - 2.1.3 Referrals. Except for Emergency Services and Urgent Care Services, Specialist Physician shall provide Covered Services to Medi-Cal Members only upon receipt of an appropriate referral and authorization from Medi-Cal Member's Primary Care Physician, Plan, or such other treatment authorization as described in the Plan's Provider Manual, unless such services are excluded or exempt from prior authorization in accordance with Section 4 of this Agreement.
 - a. Primary Care Physician has the right to refer Member to any Referral (Specialist) Physician. Referrals to contracting providers outside the County may be made only after authorization for such has been obtained from the Plan Medical Director or designee.
 - b. The Specialist Physician will consult with Primary Care Physician and Plan's Medical Director as soon as possible when a Medi-Cal Member who, for

conscientious or other personal reasons, refuses to follow or undergo one or more procedures or courses of treatment recommended by the Specialist Physician if the Specialist Physician determines no professionally acceptable alternatives to such recommended procedures or courses of treatment exists as a Covered Service under the Medi-Cal Managed Care Program.

2.1.4 Case Management. Cooperate with Medi-Cal Member's Primary Care Physician and Plan in the Primary Care Physician's monitoring, coordination, and case management of the Medi-Cal Member's overall health care. Specialist Physician will promptly furnish a complete report of the services rendered to a Medi-Cal Member to the Medi-Cal Member's Primary Care Physician and, upon Plan's request, to Plan, on such form as may be prescribed in the Plan's Provider Manual.

- a. Specialist Physician agrees to abide by the Case Management Protocols, which are included as Attachment A to this Agreement and are incorporated herein by this reference, which may be amended by Plan from time to time with thirty (30) days notice to Specialist Physician.
- b. Specialist Physician agrees to abide by the Plan's Provider Manual policies and procedures, which may be amended by Plan from time to time with thirty (30) days notice to Specialist Physician.
- c. Specialist or Referral Physician to whom the Primary Care Physician has delegated the authority by a referral to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.
- d. Specialist Physician acknowledges that Plan Medical Director will assist in the management of complex cases. Specialist Physician will fully cooperate with Plan Medical Director by providing information that may be required in the transfer of a Medi-Cal Member into medical facilities designated by Plan for the care of complex cases, including but not limited to, prompt notification of known or suspected complex cases.

2.1.5 Accessibility and Hours of Service. Providing Covered Services to Medi-Cal Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan's Provider Manual during normal business hours at Specialist Physician's usual place of business and will arrange for Emergency Services and Urgent Care Services as Medically Necessary.

- a. No payment shall be made by the Plan for the services rendered to referred Members unless evidence of Primary Care Physician or Plan authorization has been made or the services are excluded or exempt from prior authorization in accordance with Section 4 of this Agreement.

2.1.6 Hospital Privileges. Maintain active medical staff privileges and is a member in good standing of the medical staff with at least one (1) Hospital contracting with Plan or has been specifically excluded from this requirement by the Plan Medical Director.

- 2.1.7 Officers, Owners and Stockholders. Providing information regarding officers, owners and stockholders as set forth in Attachment B, attached hereto and incorporated herein.
- 2.1.8 Credentialing. Provide Plan with a completed credentialing form, will use best efforts to notify Plan in advance of any change in such information, and will successfully complete a facility site review, if deemed necessary by Plan in accordance with DHCS Medi-Cal Agreement.
- 2.1.9 Actions Against Specialist Physician. Specialist Physician will adhere to the requirements as set forth in the Plan Operations Manual and notify Plan by certified mail within five (5) days of Specialist Physician's learning of any action taken which results in restrictions on Specialist Physician staff privileges, membership, employment for a medical disciplinary cause or reason as defined in the California Business & Professions Code, Section 805, regardless of the duration of the restriction or exclusion from participating in the Medi-Cal Program in accordance with the Standards of Participation.
- 2.1.10 Financial and Accounting Records. Maintain, in accordance with standard and generally accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Submit reports as required by Plan or DHCS.
- 2.1.11 Compliance with Member Handbook. Specialist Physician acknowledges that Specialist Physician is not authorized to make nor will Specialist Physician make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.
- 2.1.12 Promotional Materials. Specialist Physician will consent to be identified as a Specialist Physician in written materials published by Plan, including without limitation, marketing materials prepared and distributed by Plan and display promotional materials provided by Plan within his/her office.
- 2.1.13 Specialist Physician shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Agreements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Specialist Physician shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 2.1.14 Compliance with Plan Policies and Procedures. Specialist Physician agrees to comply with all policies and procedures set forth in the Plan Provider Manual. Plan may modify Provider Manual from time to time. In the event the provisions of the Provider Manual are inconsistent with the terms of this Agreement; the terms of this Agreement shall prevail.

2.1.15 Cultural and Linguistic Services. Specialist Physician shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. Specialist Physician shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. Specialist Physician shall comply with Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with Plan by providing any information necessary to assess compliance. Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. Specialist Physician has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in Plan Provider Manual.

2.2 Plan is responsible for:

2.2.1 Member Assignment. Assigning Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician and such Members are hereafter referred to as Case Managed Members.

- a. The Medi-Cal Member can select from the Primary Care Physicians contracting with Plan.
- b. The Medi-Cal Member will seek all medical services, except those outlined in Section 4 from their assigned Primary Care Physician.
- c. If the Medi-Cal Member does not select a Primary Care Physician, Plan will assign Members to a Primary Care Physician in a systematic manner as the Plan deems appropriate and/or in accordance with established protocol.

2.2.2 Listing. Plan may enter the name of each contracted Specialist Physician onto a list or provider directory from which Medi-Cal Members may receive healthcare services. Such a list may contain the following information concerning the Specialist Physician.

- a. Name
- b. Address(es)
- c. Telephone and FAX numbers
- d. Scope of services (specialty or provider type)

2.2.3 Payment for Authorized Service Only. The Plan will reimburse Specialist Physician for covered medical services that are properly authorized by the Plan Medical Director (or his/her designee) or for Covered Services provided to an Administrative Member. Payment will be made based on required authorization and claim billing requirements as identified in the Plan Operations Manual.

2.3 Member Eligibility. Specialist Physician will verify Medi-Cal Member eligibility with Plan prior to admission for inpatient services and prior to rendering medical services. Prior Authorization from Plan is not a guarantee of Medi-Cal Member eligibility with Plan or eligibility in the State Medi-Cal Program.

2.3.1 The notification will be provided via telephone, facsimile, mail or electronic media, to Primary Care Physician listing all pertinent data regarding the eligibility of Medi-Cal Members who have chosen or have been assigned to Primary Care Provider. Such data

will be updated on or about the twenty-fifth (25th) of each month.

- 2.3.2 Plan will maintain (or arrange to have maintained) records and establish and adhere to procedures as will reasonably be required to accurately ascertain the number and identity of Medi-Cal Members. Specialist Physician may verify eligibility of Members with Plan.

SECTION 3 SCOPE OF SERVICES TO BE PROVIDED

- 3.1 Management of Care. With the exception of Excluded Services described in Section 4 of this Agreement, it is the responsibility of the Primary Care Physician with the assistance of appropriate Specialist Physicians to determine, to provide, to prescribe, and to manage Covered Services for Medi-Cal Members in accordance with professionally recognized standards and medical necessity.
- 3.1.1 Covered Services are as specified in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services.
- 3.1.2 Except as otherwise provided herein, it will be the responsibility of the Specialist Physician to render or provide referral for Covered Services, for each Medi-Cal Member, which has been determined to be Medically Necessary and appropriate for the control of disease, illness, or disability.
- 3.1.3 Specialist Physician will abide by Case Management Protocols, incorporated in Attachment A of this Agreement and in conformance with Plan policies and procedures as set forth in the Plan Operations Manual. Specialist will obtain referral and prior authorization when required before rendering medical services to Plan Members.
- 3.2 Consultation with Medical Director. Specialist Physician or any other provider may at any time seek consultation with Medical Director on any matter concerning the treatment of the Member.
- 3.3 Covered Services. Covered Services are services covered under the California State Medi-Cal program and the Medi-Cal Agreement when they are necessary and appropriate for the care of that Member. Covered services include but are not limited to:
- 3.3.1 Accessibility and Hours of Service. Provide Covered Services to Case Managed Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan Operations Manual during normal business hours at Specialist Physician's usual place of business and will arrange for Emergency Services and Urgent Care Services at all other times. Any Emergency Services shall be subject to the terms set forth in the Provider Manual regarding Contracting and Non-Contracting Emergency Service Providers and Post-Stabilization. Specialist Physician will make suitable arrangements for personal contact with the Member, or for services by appropriate personnel in accordance with customary medical practice and with the law including referrals for a second professional opinion
- 3.3.2 Referrals. All referrals to Specialists for a second opinion are to be to Referral Physicians and to other professional or institutional providers who are Participating Providers unless otherwise authorized in writing by Plan. Nothing herein will be construed to impose

liability on Specialist Physician for the clinical performance of any other Physician, any hospital, or any other health care provider rendering health care services to the Medi-Cal Members without the knowledge of the Specialist Physician for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member.

a. Specialist Physician agrees to accept referrals from Plan contracted providers.

- 3.3.3 Facilities, Equipment and Personnel. Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement.
- 3.3.4 Specialist Physician agrees to provide at least 60 days notice to Plan prior to the opening of any new location and 90 days prior to the closing of any location.
- 3.3.5 Medical Transportation Ambulance (Medical Transportation) Services when medically necessary and in accordance with Title 22, CCR, Section 51323 and Plan Operations Manual policies and procedures. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.
- 3.3.6 Other Medically Necessary Services. Other necessary durable medical equipment rental, and medical supplies determined by Specialist Physician to be Medically Necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member. All services and goods required or provided hereunder will be consistent with sound professional principles, community standards of care, and Medical Necessity.
- 3.3.7 Interpreter Services. Arrange interpreter services as necessary for Members at all facilities.
- 3.3.8 Nothing expressed or implied herein shall require the Specialist Physician to provide to or order on behalf of the Medi-Cal Member, Covered Services which, in the professional opinion of the Primary Care Physician or Specialist Physician, are not Medically Necessary for the treatment of the Medi-Cal Member's disease or disability.
- 3.4 Prescription Drugs. Specialist Physician shall comply with the Plan drug formulary as approved by Plan policies and subject to the restrictions on the Plan Drug Formulary regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals, in conformance with generally accepted medical and surgical practices and standards prevailing in the professional community.
- 3.4.1 If for medical reasons, the Specialist Physician believes a generic equivalent should not be dispensed, the Specialist Physician agrees to obtain prior authorization from the Plan Pharmacy Director.
- 3.4.2 Specialist Physician acknowledges the authority of Plan's participating pharmacists to substitute generics for trade name drugs, as specified in Section 4073 of the California Business & Professions Code, and Title 22 CCR Section 51313 unless otherwise indicated.

3.5 Non-Discrimination

- 3.5.1 Medi-Cal Members. Specialist Physician will provide services to Medi-Cal Members in the same manner as such services are provided to other patients of Specialist Physician, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Managed Care Program. Subject to the foregoing, Specialist Physician will not subject Case Managed Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan or filing a complaint as a Member of Plan in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination will include but is not limited to: denying any Case Managed Member any Covered Service or availability of a Facility; providing to a Case Managed Member any Covered Service which is different, or is provided in a different manner or as a different time from that provided to other Members under this Contract except where medically indicated; subjecting a Case Managed Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Case Managed Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered Services, treating a Case Managed Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.
- 3.5.2 For the purpose 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 affects on the carrier. Such genes include, but are not limited to, Tay-Sach trait, sickle-cell trait, Thalassemia trait, and X-linked hemophilia.
- 3.5.3 General Compliance. Pursuant to the requirements of this Section of the Medi-Cal Agreement, the Specialist Physician will not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan, or filing a complaint as a Member of Plan and denial of family care leave. Specialist Physician will ensure the evaluation and treatment of Specialist Physician's employees and applicants for employment are free from discrimination and harassment. Specialist Physician will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et.seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4, Chapter 5 are incorporated into

this Agreement by reference and made a part hereof as set forth in full. Specialist Physician will give notice of his obligations under this Section to labor organizations with which he has a collective bargaining or other agreement. Specialist Physician shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.

3.6 Quality Improvement and Utilization Management Programs

3.6.1 Specialist Physician will participate in Plan's Quality Improvement and Utilization Management Programs, including credentialing and recredentialing, peer review and any other activities required by Plan, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. This includes participation in office reviews, chart and access audits and focused reviews. In addition, the Specialist Physician will participate in the development of, and implement, corrective action plans for any areas that fall below Plan standards and ensuring medical records are readily available to the Plan's staff as requested.

- a. Recognizing the possibility that Plan, through the utilization management and quality assurance process there may be a requirement to consult with the Medical Director or with other Physicians prior to authorization of services or supplies or to terminate this Agreement.
- b. In the interest of program integrity or the welfare of Members, Plan may from time to time introduce additional utilization controls as may be necessary as determined by Plan.
- c. In the event of such change, a thirty (30) day notice will be given to the Specialist Physician and Specialist Physician will be entitled to appeal such action to the appropriate Reviewing Committee.

SECTION 4 EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

4.1 Exclusions. Members in need of services, which are not Covered Services, as described in the Member Handbook, will not be reimbursed by the Plan. The Specialist Physician will not bill and expect reimbursement by the Plan for the excluded services provided to Medi-Cal Members as described in this Section 4.

4.2 Services Neither Covered nor Compensated. Subject to any additional exclusions from Covered Services as set forth in the Medi-Cal Agreement, Specialist understands that Specialist will not be obligated to provide Medi-Cal Members with, and the Plan will not be obligated to reimburse Specialist for, the following Excluded Services pursuant to this Agreement (services for which Plan does not receive capitation payment from the DHCS.)

- (a) Dental Services, as defined in Title 22 CCR Section 51307 and Early and Periodic Screening Diagnosis and Treatment supplement dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;
- (b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior

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Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.

- (c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted: (i) outpatient mental health services within the Specialist Physician's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.
- (d) California Children's Services ("CCS") are not covered in Ventura County.
- (e) Services rendered in a State or Federal governmental hospital;
- (f) Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;
- (g) Fabrication of optical lenses;
- (h) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;
- (i) Direct Observed Therapy for tuberculosis;
- (j) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;
- (k) Childhood lead poisoning case management services provided by the Local Health Department;
- (l) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the State Medi-Cal Contract; and
- (m) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 United States Code ("USC") Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.
- (n) Other services as may be determined by the DHCS and the Plan, and as noticed to participating Specialist Physicians. In the event of such a change, a thirty (30) day notice will be given to the Specialist Physicians.

4.3 Restricted Services / Special Reimbursement

- 4.3.1 Specialist Physician will ensure that services provided to Medi-Cal Members will be in conformance with the limitations and procedures listed in the Medi-Cal Provider Manual and the

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Plan's Operations Manual unless notified of modification to that policy by DHCS or Plan.

- a. The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization. These services shall be subject to the limitations specified therein.
- 4.3.2 Primary Care Physician referral and/or Plan authorization are not required for reimbursement by Plan to providers of the following services.
- a. The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.
 - b. Family Planning Services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 Code of Federal Regulations Section 441.20. Family Planning services are defined in the Plan's Provider Manual and services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.
- 4.3.3. Primary Care Physician referral is not required for beneficiaries designated as Administrative Members.
- 4.3.4 California Children's Services (CCS) must be authorized by the Ventura County CCS Program.
- 4.3.5 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program.

SECTION 5

REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES

- 5.1 Payments. Specialist Physician will be reimbursed for medical services provided to Medi-Cal Members for those services which have been referred by the Member's Primary Care Physician, in accordance with the fee schedule set forth on Attachment D hereto, and upon submission of a complete CMS-1500 claim form along with evidence of prior authorization (if required in accordance with Plan policies and procedures) or submission of complete data through electronic transfer, as described in Section 5.3 of this Agreement. Reimbursement will be made within thirty (30) days of receipt by Plan of a "Clean Claim".
- 5.1.1 All CMS-1500 claim forms and/or encounter data should be submitted to the Plan within six (6) months of the date the service was provided.
 - 5.1.2 A summary report will accompany each check identifying those Medi-Cal Members who received Covered Services from Specialist Physician and the appropriate amount of reimbursement.
 - 5.1.3 The Medi-Cal Member is eligible for Covered Services on the first day of the month for which Plan receives capitation based on the most current enrollment information from the DHCS.

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5.2 Entire Payment. The Specialist Physician will accept from Plan compensation as payment in full and discharge of Plan’s financial liability. Covered Services provided to Medi-Cal Members by Specialist Physician will be reimbursed as set forth in this Agreement and in accordance with Plan’s Operations Manual policies and procedures. Specialist Physician will look only to Plan for such compensation. Plan has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to Plan are reduced by DHCS.

5.2.1 Fee-For-Service Payment (FFS) - The Plan will reimburse the Specialist Physician for the professional component of services provided at the prevailing Medi-Cal fee for service rates for all properly documented Medi-Cal Covered Services provided to:

- a. Medi-Cal Members for Covered Services, which have been properly authorized in accordance with Plan Operations Manual if services being provided require prior authorization.

5.3 Claim Submission. The Specialist Physician will obtain, complete, and submit CMS-1500 claim forms, or submit through electronic transfer, claims for all services rendered to Medi-Cal Members

5.3.1 All claims for reimbursement of Covered Services and encounter data related thereto, if applicable, should be submitted to the Plan within six (6) months from the end of the month that service was provided as described in the Plan Operations Manual.

5.3.2 Upon submission of a complete and uncontested clean claim, payment will be processed within thirty (30) days after receipt by Plan. A “complete and uncontested clean claim” will include all information needed to process the claim.

5.4 Medi-Cal Member Billing. Specialist Physician will not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal Member unless authorized share of cost, or from other persons on behalf of the Medi-Cal Member, for any service included in the Medi-Cal program’s Covered Services in addition to a claim submitted to the Plan for that service.

5.5 Coordination of Benefits. Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. Specialist Physician must bill the Other Health Coverage (primary) carrier before billing Plan for reimbursement of Covered Services and, with the exception of authorized Medi-Cal share of cost payments, will at no time seek compensation from Medi-Cal Members or from DHCS. The Specialist Physician may bill the Member for non-covered services.

Specialist Physician has the right to collect all sums as a result of Coordination of Benefits efforts for Covered Services provided to Medi-Cal Members with Other Health Coverage.

5.5.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the Plan Operations Manual.

5.5.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the Medi-Cal Agreement with Plan.

- 5.5.3 Specialist Physician will report to Plan the discovery of third party insurance coverage for a Medi-Cal Member within ten (10) days of discovery.
- 5.5.4 Specialist Physician will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the Specialist Physician, but will be reported to the Plan on the encounter form or encounter tape.
- 5.6 Third Party Liability. In the event that Specialist Physician provides services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by Specialist Physician pursuant to the terms of this Agreement.
- 5.6.1 Specialist Physician will cooperate with the DHCS and Plan in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.
- 5.6.2 Specialist Physician will report to Plan the discovery of third party tort action or potential tort action for a Medi-Cal Member within ten (10) days of discovery.
- 5.7 Subcontracts
- 5.7.1 All subcontracts between Specialist Physician and Specialist Physician's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Agreement, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.
- 5.7.2 All subcontracts and their amendments will become effective only upon written approval by Plan and DHCS, if required, and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the Specialist Physician. Specialist Physician will notify DHCS and Plan when any subcontract is amended or terminates. Specialist Physician will make available to Plan and Governmental Agencies, upon request, copies of all agreements between Specialist Physician and Subcontractor(s) for the purpose of providing Covered Services.
- 5.7.3 All agreements between Specialist Physician and any Subcontractor will require Subcontractor to comply with the following:
- a. Records and Records Inspection. Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least seven (7) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to Specialist Physician and Plan all reports required by Specialist Physician, Plan or DHCS, and timely gather, preserve and provide to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recovery for Litigation.
 - b. Surcharges. Subcontractor will not collect a Surcharge for Covered Services for any Medi-Cal Members or other persons acting on their behalf. If a Surcharge

erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Medi-Cal Member within fifteen (15) days of the occurrence and will notify Plan of the action taken. Upon notice of any Surcharge, Plan will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge.

- c. Notification. Notify DHCS and Plan in the event the agreement with Subcontractor is amended or terminated. Notice will be given in the manner specified in Section 10.4 Notices.
- d. Assignment. Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS and Plan.
- e. Additional Requirements. Be bound by the provisions of Section 9.7, Survival of Obligations after Termination, and Sections 7.5 and 7.6, Indemnification and Hold Harmless.

SECTION 6 MEDICAL RECORDS

6.1 Medical Record. Specialist Physician shall ensure that a medical record will be established and maintained for each Medi-Cal Member who has received Covered Services. Each Medi-Cal Member's medical record will be established upon the first visit to Specialist Physician. The record will contain information normally included in accordance with generally accepted practices and standards prevailing in the professional community.

6.1.1 Specialist Physician will facilitate the sharing of medical information with other providers in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.

6.1.2 Specialist Physician will ensure records are available to authorized Plan personnel in order for Plan to conduct its Quality Improvement and Utilization Management Programs to the extent permitted by law.

6.1.3 Specialist Physician will ensure that medical records are legible.

6.1.4 Specialist Physician will maintain such records for at least seven (7) years from the close of the State's fiscal year in which this Agreement was in effect.

6.2 Records and Records Inspection Rights

6.2.1 Access to Records – Specialist Physician will permit Plan Medical Director, or officers or their designees, any agency having jurisdiction over Plan including and without limitation the Governmental Agencies, to inspect the premises, records and equipment of Specialist Physician and review all operational phases of the medical services provided to Medi-Cal Members.

- a. Specialist Physician will make all of Specialist Physician's books and records, and papers ("Records") relating to the provision of goods and services to Medi-Cal Members, to the cost of such goods and services, and to payments received

by Specialist Physician from Medi-Cal Members or from others on their behalf available for inspection, examination and copying by Plan and all other state and federal agencies with jurisdiction over Plan or this Agreement, including without limitation, Governmental Agencies, at all reasonable times at Specialist Physician's place of business or at such other mutually agreeable location in California.

- b. Plan will pay for the cost of copying Records, not to exceed \$0.10 per page. The ownership of Records will be controlled by applicable law and this Agreement.
- c. Specialist Physician shall permit Plan, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review Specialist Physician's work performed or being performed hereunder, Specialist Physician's locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy Records and any other books, accounts and materials relevant to the provisions of services under this Agreement. Specialist Physician will provide all reasonable facilities, cooperation and assistance during such inspection and reviews, including for the safety and convenience of the authorized representatives in the performance of their duties. Specialist Physician shall allow such inspections and reviews for the Records retention time of seven years. The State reserves the right to conduct unannounced validation reviews to verify compliance with State and federal regulations and contract requirements.

6.2.2 Maintenance of Records. Specialist Physician will maintain records in accordance with the general standards applicable to such book and record keeping and in accordance with applicable law, and Plan directives.

- a. Records will include all encounter data, working papers, reports submitted to Plan, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Medi-Cal Members for a period of at least seven (7) years.
- b. Specialist Physician will retain all Records for a period of at least seven (7) years from the close of the State Department of Health Care Services' fiscal year in which this Agreement was in effect.
- c. Specialist Physician's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.
- d. The Specialist Physician will not charge the Medi-Cal Member for the copying and forwarding of their medical records to another provider.

6.3 Disclosure to Government Officials. Specialist Physician shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, Specialist Physician shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department

of General Services, the California Department of Industrial Relations, certified Healthcare Effectiveness Data Information Set (“HEDIS”) auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the County of Ventura Human Services Agency, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Quality Improvement Organizations (“QIOs”), their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, “Government Officials”) as may be necessary for compliance by Plan with the provisions of all state and federal laws and contractual requirements governing Plan, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at Specialist Physician’s place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. Specialist Physician shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Specialist Physician related to this Agreement.

6.4 Patient Confidentiality

- a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et. seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted thereunder.
- b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Beneficiaries will be protected by the Specialist Physician and his/her staff from unauthorized disclosure.
- c. Specialist Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information.
- d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the Specialist Physician, the Specialist Physician (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the Plan all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than Plan the federal government including the Department of Health and Human Services and Comptroller General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities over the COHS program and contracts, without 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 thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the Plan or maintain such information according to written procedures sent the Plan by the Department of Health Care Services for this purpose.

**SECTION 7
INSURANCE AND INDEMNIFICATION**

- 7.1 Insurance. Throughout the term of this Agreement and any extension thereto, Specialist Physician will maintain appropriate insurance programs or policies as follows:
- 7.1.1 Each participating Specialist Physician covered by this Agreement will secure and maintain, at its sole expense, liability insurance of at least One Million Dollars (\$1,000,000) per person per occurrence, and Three Million Dollars (\$3,000,000) in aggregate, including "tail coverage" in the same amount whenever claims made malpractice coverage is involved. Notification of Plan by Specialist Physician of cancellation or material modification of the insurance coverage or the risk protection program will be made to Plan at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to Plan upon execution of this Agreement.
- 7.2 General Liability Insurance. In addition to Subsection 7.1 above, Specialist Physician will also maintain, at its sole expense, a policy or program of comprehensive liability insurance with minimum coverage including and no less than Three Hundred Thousand Dollars (\$300,000) per person for Specialist Physician's property, together with a combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars (\$300,000). Documents evidencing such coverage will be provided to Plan upon request. The Specialist Physician will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.
- 7.3 Workers' Compensation. Specialist Physician's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing the foregoing coverage will be provided to Plan upon request. Specialist Physician will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.
- 7.4 Insurance. Plan, at its sole cost and expense, will procure and maintain a professional liability policy to insure Plan and its agents and employees, acting within the scope of their duties, in connection with the performance of Plan responsibilities under this Agreement.
- 7.5 Specialist Physician Indemnification. Specialist Physician shall indemnify, defend and hold harmless Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Specialist Physician and its officers, directors, shareholders agents, employees and Subcontractors acting alone or in collusion with others. Specialist Physician also agrees to hold harmless both the State and Members in the event that Plan cannot or will not pay for services performed by Specialist Physician pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.
- 7.6 Plan Indemnification – Plan shall indemnify, defend and hold harmless Specialist Physician its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Plan and its officers, directors, shareholders agents, employees and subcontractors (other than Specialist Physician). The terms of this section shall survive the

termination of this Agreement.

SECTION 8 GRIEVANCES AND APPEALS

8.1 Appeals and Grievances

8.1.1 Specialist Physician may have complaints, concerns, or differences, which may arise as a health care provider under contract with Plan which will be resolved as outlined in the Plan Appeals and Grievance policies as set forth in the Plan Operations Manual. Specialist Physician and Plan agree to and will be bound by the decisions of Plan grievance and appeal mechanisms.

8.1.2 Specialist Physician will cooperate with Plan in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the Plan grievance procedure set forth in this Section 8 and the Plan Provider Manual.

8.2 Responsibility

8.2.1 It is the responsibility of the Plan's Chief Executive Officer for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system. The Chief Executive Officer will be assisted in this process by the staff of Plan's Health Services and Provider Relations Departments.

8.3 Dispute Resolution.

8.3.1 For disputes unresolved by the Plan provider appeals process, Plan and Specialist Physician agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, Specialist Physician shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

8.3.2 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the

only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

8.3.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

8.3.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Ventura, State of California.

8.4 Peer Review and Fair Hearing Process. Specialist Physicians determined hereto to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to the Plan Peer Review Committee. The Specialist Physician will be afforded an opportunity to address the committee. The Specialist Physician will be notified in writing of the Peer Review Committee Recommendations and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict, or terminate the Specialist Physician's affiliation, to institute a monitoring procedure, or to implement continuing educational requirements.

8.5 Credentialing – A Credentialing Committee will review all provider files to determine whether a provider meets the Plan credentialing or recredentialing requirements. The Specialist Physician will be afforded an opportunity to address this Committee if there is an adverse recommendation by the Committee regarding the provider's credentials. The Specialist Physician will be advised in writing of the Credentialing Committee's recommendation and notified of their rights to the Fair Hearing process. The Credentialing Committee can recommend denial of a provider's initial application or can deny the recredentialing of a current provider.

SECTION 9 TERM, TERMINATION, AND AMENDMENT

9.1 Initial Term and Renewal. This Agreement will be effective as of the Effective Date and will automatically renew at the end of one year and annually thereafter unless terminated sooner as set forth below.

9.2 Termination Without Cause. Either party upon sixty (60) days prior written notice to the other party may terminate this Agreement without cause.

9.3 Immediate Termination for Cause by Plan. The Plan may terminate this Agreement immediately by written notice to the Specialist Physician upon the occurrence of any of the following events:

9.3.1 The suspension or revocation of Specialist Physician's license to practice medicine in the State of California; the suspension or termination of Specialist Physician's membership

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on the active medical staff of any hospital; or the suspension, revocation or reduction in Specialist Physician's clinical privileges at any hospital; or suspension from the State Medi-Cal Program; or loss of malpractice insurance; or failure to meet Plan recredentialing criteria; or

- 9.3.2 Specialist Physician's death or disability. As used in this Subsection, the term "disability" means any condition which renders Specialist Physician unable to carry out his/her responsibilities under this Agreement for more than forty-five (45) working days (whether or not consecutive) within any 12-month period; or
- 9.3.3 If Plan determines, pursuant to procedures and standards adopted in its Utilization Management or Quality Improvement Programs, that Specialist Physician has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of the Plan Operations Manual; or
- 9.3.4 Plan determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member; or
- 9.3.5 If Plan determines that Specialist Physician has filed a petition for bankruptcy or reorganization, insolvency, as defined by law, or Plan determines that Specialist Physician is unable to meet financial obligations as described in this Agreement; or the Specialist Physician closes his/her office and no longer provides Medically Necessary services; or
- 9.3.6 If Specialist Physician breaches Article 10.10, Marketing Activity and Patient Solicitation.

An immediate termination for cause made by Plan pursuant to this Section 9.3 will not be subject to the cure provisions specified in Section 9.4 Termination for Cause with Cure Period.

- 9.4 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3, Immediate Termination for Cause by Plan above of this Agreement, the non-breaching party may terminate this Agreement upon twenty (20) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach during the twenty (20) day period, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.
- 9.5 Continuation of Services Following Termination. Should this Agreement be terminated, Specialist Physician will, at Plan's option, continue to provide Specialist and Covered Services to Medi-Cal Members who are under the care of Specialist Physician at the time of termination in accordance with this Section and Specialist agrees to adhere to Plan policies and procedures. Medi-Cal Members are allowed to receive ongoing care for a chronic or acute medical condition for up to 90 days after the Specialist agreement has terminated. Members in their second or third trimester of pregnancy have access to Specialty care through the post partum period. Specialist Physician will ensure an orderly transition of care for Medi-Cal Members, including but not limited to the transfer of Member medical records. Payment by Plan for the continuation of services by Specialist Physician after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation

provisions herein. The costs to the physician of photocopying such records will be reimbursed by the Plan at a cost not to exceed \$.10 per page.

- 9.6 Medi-Cal Member Notification Upon Termination. Notwithstanding Section 9.3, Immediate Termination for Cause by Plan, upon the receipt of notice of termination by either Plan or Specialist Physician, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, Specialist Physician will notify Members who have had at least two visits in the previous 6 months, 30 days prior to the effective date of termination. Plan at its option, may immediately inform Medi-Cal Members of such termination notice. Such Medi-Cal Members will be required to select another Specialist Physician prior to the effective date of termination of this Agreement. Medi-Cal Members are allowed to receive ongoing care with the Specialist Physician after termination of this Agreement for up to 90 days to treat an illness.
- 9.7 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of Specialist Physician will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 9.5, Continuation of Services Following Termination; 2) Section 6.2, Records and Records Inspection; and, 3) Sections 7.5 and 7.6, Specialist Physician and Plan Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between Specialist Physician and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. Specialist Physician will assist Plan in the orderly transfer of Medi-Cal Members to the Specialist Physician they choose or to whom they are referred. Furthermore, Specialist Physician shall assist Plan in the transfer of care as set forth in the Provider Manual, in accordance with the Phaseout Requirements set forth in the Medi-Cal Contract.
- 9.8 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by Plan, Specialist Physician will allow the copying and transfer of medical records of each Medi-Cal Member to the Physician assuming the Medi-Cal Member's care at termination. Such copying of records will be at Plan's expense if termination was not for cause. Plan will continue to have access to records in accordance with the terms hereof.
- 9.9 Termination or Expiration of Plan's Medi-Cal Agreement. In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, Specialist Physician will allow DHCS and Plan to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, Specialist Physician will assist DHCS in the orderly transfer of Medi-Cal Members' medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the Specialist Physician's Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. In no circumstances will a Medi-Cal Member be billed for this service.

**SECTION 10
GENERAL PROVISIONS**

- 10.1 Assignment. This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged or hypothecated in any way by the Specialist Physician and will not be subject to execution, attachment or similar process, nor will the duties imposed on Specialist Physician be set, contracted or delegated without the prior written approval of Plan and DHCS. Subcontractor's agreements that provide for any assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
- 10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS, if required. This Agreement may also be amended by the Plan upon thirty (30) days written notice to the Specialist Physician.
- 10.2.1 If the Specialist Physician does not give written notice of termination within sixty (60) days, as authorized by Section 9.2, Specialist Physician agrees that any such amendment by Plan will be a part of the Agreement.
- 10.2.2 Unless Specialist Physician, or DHCS notifies Plan that it does not accept such amendment, the amendment will become effective sixty (60) days after the date of Plan's notice of proposed amendment.
- 10.2.3 Amendments to the compensation, services or term provisions of this Agreement, will be forwarded to DHCS.
- 10.2.4 Notwithstanding the foregoing, Plan may amend this Agreement with prior written notice to Specialist Physician in order to maintain compliance with State and Federal Law and the Medi-Cal Agreement. Such amendment shall be binding upon Specialist Physician and shall not require the consent of Specialist Physician.
- 10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.
- 10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.
- 10.4.1 Plan will notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal

Service as first class registered mail, postage attached. Such written notice will be mailed to:

California Department of Health Care Services,
Medi-Cal Managed Care Division
1501 Capitol Avenue, Suite 71.4001
MS 4407, P.O. Box 997413
Sacramento, CA 95899-7413

- 10.5 Entire Agreement. This Agreement, together with the Exhibits and the Plan Operations Manual contains the entire agreement between Plan and Specialist Physician relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.
- 10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 10.7 Governing Law. The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of Plan. Any provision required to be in this Agreement by law, regulation, or the Medi-Cal Agreement will bind Plan and Specialist Physician whether or not provided in this Agreement.
- 10.8 Affirmative Statement, Treatment Alternatives. Practitioners may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- 10.9 Reporting Fraud and Abuse. Specialist Physician is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by Plan contracted Physicians within ten (10) days to Plan for investigation.
- 10.10 Marketing Activity and Patient Solicitation. Specialist Physician will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of Plan and DHCS.
- 10.10.1 Specialist Physician will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.
- 10.10.2 During the period of this Agreement and for a one year period after termination of this Agreement, Specialist Physician and Specialist Physician's employees, agents or Subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which Specialist Physicians render contracted services to Plan Members.
- 10.10.3 In the event of breach of this Section 10.10, in addition to any other legal rights to which it may be entitled, Plan may at its sole discretion, immediately terminate this Agreement. This termination will not be subject to Section 9.4, Termination for Cause

with Cure Period.

- 10.11 Nondisclosure and Confidentiality. Specialist Physician will not disclose the payment provisions of this Agreement except as may be required by law.
- 10.12 Proprietary Information. With respect to any identifiable information concerning a Case Managed Member that is obtained by Specialist Physician or its Subcontractors, Specialist Physician and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to Plan all requests for disclosure of such information, except requests for medical records in accordance with applicable law; will not disclose any such information to any party other than DHCS without Plan's prior written authorization, except as specifically permitted by this Agreement or the Plan Medi-Cal Agreement with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Agreement; and, will, at expiration or termination of this Agreement, return all such information to Plan or maintain such information according to written procedures provided by Plan for this purpose.
- 10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Medi-Cal Members for which Specialist Physician accepts responsibility hereunder, Specialist Physician reserves the right to provide professional services to persons who are not Case Managed Members including Eligible Beneficiaries. Nothing contained herein will prevent Specialist Physician from participating in any other prepaid health care program.
- 10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.
- 10.15 HIPAA. Specialist Physician and Plan each acknowledge that it is a "Covered Entity" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the "HIPAA Privacy Rule"). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members' individually identifiable health information. If the Specialist Physician identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to Plan or Members, the Specialist Physician must notify Plan's Privacy Officer immediately.

SECTION 11 RELATIONSHIP OF PARTIES

- 11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent Specialist Physician from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, Specialist Physician will provide written assurance to Plan that any contract providing commitments to any other prepaid program will not prevent

Specialist Physician from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.

- 11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of Plan to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.
- 11.3 Physician-Patient Relationship. This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her Specialist Physician. Specialist Physicians will be responsible for maintaining the professional relationship with Medi-Cal Members and are solely responsible to such Medi-Cal Members for all medical services provided. Plan will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of Specialist Physician.

SECTION 12 ADDITIONAL LEGAL REQUIREMENTS

12.1 Compliance With Laws.

12.1.1 Specialist Physician represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives 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, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used for the acquisition, operation or maintenance of computer software in violation of copyright laws.

12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are \$100,000 or more, Specialist Physician certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Specialist Physician, 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 the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are \$100,000 or more, Specialist Physician shall submit to Plan the “Certification Regarding Lobbying” set forth in the Provider Manual. If any funds other than Federally 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 Agreement, Specialist Physician shall complete and submit to Plan standard form LLL, “Disclosure of Lobbying Activities” in accordance with its instructions. Specialist Physician shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Specialist Physician. Specialist Physician shall require that the language of this certification be included in all subcontracts at all tiers which exceed \$100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.

- 12.1.3 Specialist Physician 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 Medicaid programs, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.
- 12.1.4 If Specialist Physician 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, Specialist Physician, upon request, shall make available to Plan its policies and procedures related to economic profiling used by Specialist Physician. The term “economic profiling” as used in this Section 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 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.
- 12.1.5 Specialist Physician shall immediately notify Plan of (i) investigations of Specialist Physician in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. Specialist Physician shall comply with Plan’s antifraud plan, including its policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. Specialist Physician 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).

- 12.1.6 If required by Health and Safety Code Section 1375.4, (1) Specialist Physician shall meet the financial requirements that assist Plan in maintaining the financial viability of arrangements for the provision of Covered Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) Specialist Physician shall abide by Plan's process for corrective action plans if there is a deficiency, and (3) Plan shall disclose information to Specialist Physician that enables Specialist Physician to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), Plan and Specialist Physician shall meet the requirements set forth in such Regulations. Members may request general information from Plan or Specialist Physician about any bonuses or incentives paid by Plan, if applicable.
- 12.1.7 Specialist Physician shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, Specialist Physician shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If Specialist Physician is required to file monthly financial statements with DMHC, then Specialist Physician shall simultaneously file monthly financial statements with DHCS. In addition, Specialist Physician shall file monthly financial statements with DHCS upon request.
- 12.1.8 If payments under this Agreement are in excess of \$100,000, Specialist Physician shall comply with the following provisions unless this Agreement is exempt under 40 CFR Part 30. (i) Specialist Physician shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) Specialist Physician shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

12.2 Federal Equal Opportunity Requirements.

- (a) Specialist Physician 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. Specialist Physician will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship.
- (b) Specialist Physician shall post in conspicuous places, available to employees and

applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor. Such notices shall state Specialist Physician'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.

- (c) Specialist Physician 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 Specialist Physician's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- (d) Specialist Physician will comply with and furnish all information and reports required by items described above in items (a) through (c) above 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.
- (e) In the event of Specialist Physician's noncompliance with the requirements of this Section 12.2, which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement 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 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.
- (f) Specialist Physician will include the provisions of subparagraphs (a) through (e) in every subcontract 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 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 USC 4212) of the Vietnam Era

Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. Specialist Physician will take such action with respect to any subcontract 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 Specialist Physician becomes involved in, or is threatened with litigation by a subcontractor as a result of such direction by DHCS, Specialist Physician 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.

**ATTACHMENT A
PRIMARY CARE AND SPECIALIST PHYSICIANS
CASE MANAGEMENT PROTOCOL
Table of Contents**

1.0	Primary Care and Specialist Physician Case Management Protocol	36
1.1	Definition of Case Management	37
1.2	Objectives	37
1.3	PCP Responsibilities.....	38
	1.3.1 Responsibilities	
	1.3.2 Request For Change of Primary Care Physician	
	A. Physician Initiated	
	B. Member Initiated	
	C. Transfer Request During Active Treatment	
1.4	Authorization of Services	40
	1.4.1 General Procedure	
	1.4.2 Emergency Service Authorization	
	1.4.3. Non-Emergency Care Services	
	1.4.4 Eligibility Verification	
	1.4.5 Payment for Authorized Services	
	1.4.6 Second Medical Opinions	
	1.4.7 Other Coverage or Third Party Liability	
1.5	Specialist Physician Responsibilities.....	42
	1.5.1 Responsibilities	
	1.5.2 Patient Medical Record Data	
	1.5.3 Authorization for Additional Data Needs	
	1.5.4 Additional Consultation Treatment Authorization	
1.6	Non Physician Medical Practitioners.....	44
1.7	Out-of-Area Service Claims	45
1.8	Twenty-Four Hour Case Management Coverage	45
1.9	Delegation of Treatment Responsibility	45
1.10	Utilization Controls.....	46
1.11	Production and Distribution of Case Management List.....	46
1.12	Monitoring and Evaluation	46

CASE MANAGEMENT PROTOCOL

1.0 Primary Care and Specialist Physician Case Management Protocol

1.1 Definition of Case Management

The California Department of Health Care Services defines case management as "Guiding the course of resolution of a personal medical problem (including the "problem" of the need for health education, screening or preventive services) so that the recipient is brought together with the most appropriate provider at the most appropriate times, in the most appropriate setting."

The following requirements are necessary for the case management system to function:

- 1.1.1 Medi-Cal beneficiaries (also referred to herein as "Members") are required to select a Primary Care Physician, or to be assigned to Primary Care Physician.
- 1.1.2 Participating Primary Care and Specialist Physicians are required to contract with the Plan for provision of the services at rates established by the Plan and by the Department of Health Care Services Medi-Cal fee-for-service program.
- 1.1.3 Through the referral process, Primary Care Physicians will control Member referral to all services except Emergency and Limited Services as defined in the Medical Service Agreement. Services for retroactive eligible Members and share of cost Members may be exempted from case management.
- 1.1.4 To facilitate accessibility of care to Members of the Plan, individual and group practice Primary Care Physicians, in private and public settings, will be geographically located throughout the county.
- 1.1.5 Providers must meet the Medi-Cal Program Standards of Participation and be credentialed by Plan or an entity that it has delegated the activity to in the formal process of a delegation agreement.

1.2 Objectives

The objectives of physician case management of Member's medical care are as follows:

- 1.2.1 To foster continuity of care and longitudinal provider/patient relationships for Medi-Cal beneficiaries (also referred to subsequently as "Members") in Ventura County.
- 1.2.2 To coordinate the care of Members in order to achieve satisfactory care results.
- 1.2.3 To contribute to the reduction in the use of hospital emergency rooms as a source of non-emergency, first-contact and urgent medicine by Members.
- 1.2.4 To reduce unnecessary referral of Members to specialty providers.
- 1.2.5 To discourage inappropriate use of pharmacy and drug benefits by Members.

- 1.2.6 To facilitate the Member's understanding and use of health promotion, disease prevention practices, and early diagnostic services.
- 1.2.7 To provide a structure for Physicians to manage services to the Medi-Cal population by means of the following:
 - A. Selection of medical specialists based upon quality of care and adherence to the case management system to promote the cost effective delivery of services.
 - B. Reimbursement to Physicians through a payment structure based upon measurement of individual and group Physician utilization and quality of care performance.
- 1.2.8 To facilitate the smooth transition of Members from one PCP to another when necessary.

1.3 PCP Responsibilities

- 1.3.1 The responsibilities of the PCP are the following:
 - A. As specified in the Medical Service Agreement, to provide the scope of primary care services to health plan Members who have designated the Physician as his or her PCP.
 - B. To refer all Medically Necessary non-emergency hospital and/or specialty services for each case managed Member, and to arrange for those services to be delivered by hospitals and Specialists who contract with the Plan. To refer Medically Necessary care to Specialists for purposes of continuity of care.
 - C. To coordinate and direct appropriate care for Members by means of initial diagnosis and treatment, consultation with specialists, and follow-up of care to assess the results of the primary care, medication regimen and special treatment within the framework of integrated, continuous care.
 - D. To record legibly and completely any information about patient visits, efforts to contact patients, treatment, referral and consultation reports in the medical record.
 - E. To maintain a follow-up system of referrals to determine whether or not the Member obtained the referral and the results of such referral.
 - F. To facilitate and ensure patient quality of care by establishing procedures to contact Members when they miss appointments, requiring rescheduling for additional visits, or confirming referrals to a specialist for care.
 - G. To maintain patient medical records for the Members consistent with standard medical practice and to make the individual patient medical records available upon request for audit/review by the staff of the Plan, the California Department of Health Care Services and the U.S. Department of Health and Human Services.

- H. To participate in and accept the Plan's continuing peer review of case managed and referred medical services.
- I. To participate in Plan Quality Assurance and Utilization Management Programs.
- J. To use as appropriate the appeal procedures for providers as established by Plan.
- K. To preserve the dignity of the Member.
- L. To maintain confidentiality of medical information about the Member.
- M. To coordinate Member discharge planning and referral to long term care with Plan staff.

1.3.2 Request for Change of PCP

- A. A Physician's request to transfer the Member to another PCP requires the approval of Plan
- B. Such requests will be granted for the following reasons:
 - (1) Significant lack of cooperation, understanding and/or communication between doctor and patient. In such cases, the PCP and Plan will use their best efforts to provide the Member with the opportunity to be served by a PCP with whom a satisfactory physician-patient relationship can be developed. If the Plan is unable to make such arrangements and the Member is in active care, the PCP will continue to serve the Member according to the PCP's best professional judgment until the Plan is able to change the Member's PCP, a period not to exceed two months.
 - (2) Requests to transfer a Member to another PCP due to high cost or frequent visits will not be granted.
 - (3) The PCP must notify Provider Relations in writing regarding the PCP's desire to disenroll a Member in their practice. Complete documentation regarding the nature of the problem must be included with the request. Requests to disenroll a Member will be considered based on criteria outlined in Plan Provider Manual.
 - (4) Requests will be reviewed and the Member's PCP will be notified of the decision. Once the PCP has been notified of the disenrollment, it is expected that the PCP will notify the Member in writing regarding the PCP's decision to terminate the Member from their practice and that the PCP will no longer be responsible for the Member's medical care effective the date of the disenrollment. Plan will contact the patient to facilitate enrollment with a new PCP.
 - (5) Exceptions to this policy will be considered on a case by case basis.
 - (6) A Physician can cease providing care for a non-assigned Member when

the Physician/patient relationship becomes unsatisfactory. In these cases, the Physician must notify the Member in writing that they will no longer provide care for the Member. The Physician should assist the Member in choosing another Physician and transfer appropriate office medical records to that Physician.

- (7) A Specialist physician can cease providing care for any Member when the physician/patient relationship becomes unsatisfactory. In these cases, the Specialist Physician must notify both the PCP and the patient that they will no longer provide care to the patient. The PCP will refer the Member to another specialist for treatment if specialist care still is necessary.

1.3.3 Member Requests for change of PCP will be reviewed by Member Services Department.

1.3.4 Change of PCP requests from Members during active treatment requires special review by the Plan's Medical Director. Normally, such requests will not be granted until the treatment plan is completed. However, if the new PCP is willing to accept the transfer of the Member in active care, the request will be granted.

1.4 Authorization of Services

1.4.1 General Procedure

- A. Plan will pay for properly prior authorized claims only according to the specific contract terms with each Physician, hospital, and other provider. Providers should obtain the identification information from the Member. The Member should have a Plan ID Card with the name and telephone number of the PCP and a Medi-Cal card.
- B. All PCPs will use Plan's Direct Referral Authorization Form (DRAF) procedures whenever referring a Member to a Specialist.
- C. Specialists must obtain a Direct Referral Authorization Form (DRAF) from the PCP in order to be paid for the care given. Exceptions are as follows:
 - (1) Emergency care, DME, medical supplies, routine radiology including ultrasound, and laboratory services do not require a Direct Referral Authorization Form (DRAF) except as noted in Plan's Provider Manual.
 - (2) The following services do not require a formal referral or completion of a DRAF by the PCP.
 - a. Family planning services involving delaying and preventing pregnancy, vasectomy, tubal ligation, STD diagnosis and treatment, abortions, pregnancy testing and HIV testing, when provided by a family planning provider;
 - (3) Obstetrical Services do not require a formal referral or completion of a DRAF by the PCP unless services are accessed outside the county.

- D. The referring Physician must complete the original and attached copies of the DRAF. The eligibility of the Member and number of visits, services and/or period of service to be rendered must appear in the proper location on the DRAF.
- E. The PCP files his/her copy and the respective reports in the patient's medical record.
- F. Specialist or other provider retains the specified copy for his/her file.
- G. When submitting claims, the DRAF or TAR authorization number should be indicated on the claim form.

1.4.2 Emergency Services Notification

- A. Emergency services are defined in the Physician Agreement as those health services required for an Emergency Medical Condition, which is defined as 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.
- B. Emergency services rendered at hospitals do not require prior authorization.
- C. When a Member presents with an emergency condition to the Emergency Department, the attending physician/hospital must do the following:
 - (1) Verify Member eligibility, as well as PCP or Member status.
 - (2) Notify the PCP or alternate provider as soon as possible, but not later than 24 hours following service.
- D. When a Member with an emergency condition is admitted for in-patient services, the attending Physician/hospital will notify the PCP and Plan within 24 hours of the admission.

1.4.3 Non-Emergency Services Authorization

- A. When a Member reports to a hospital emergency room or urgent care facility for a non-emergency medical condition, the ER or urgent care report or face sheet shall be forwarded to the PCP within twenty-four (24) hours, or next business day, subsequent to rendering services.

1.4.4 Eligibility Verification

- A. PCPs, Specialists, and ancillary providers must verify both Medi-Cal eligibility of the Member and the assignment of PCP for the month of service. This

verification is necessary for all service authorizations.

The PCP should consult the monthly list of Members furnished by Plan at the beginning of each month that designates Members for whom the Physician has assumed case management responsibility.

1.4.5 Payment For Authorized Services

- A. Payment for services rendered by a Specialist, Physician, Hospital or other provider may not be claimed without the following:
 - (1) Eligibility verification of the Member for the month during which the service was or is to be rendered.
 - (2) A referral from the PCP or authorization from the Plan. If the claim is submitted without the Prior Authorization when required, the claim will be denied for no Prior Authorization.
- B. When submitting claims for authorized services, the referral number and/or authorization number must be indicated on the Medi-Cal claim form.

1.4.6 Second Medical Opinions

- A. Members have the right to request a second opinion if they have been referred to a Specialist and feel that such evaluation was unsatisfactory. A Member's first request for a second opinion may not be denied.
- B. When the PCP requests a second opinion, the PCP submits a referral for the second Specialist visit in the same method as all specialty referrals.
- C. When the Member requests a third opinion, which the PCP does not believe to be necessary, the PCP will refer the request to the Plan Medical Director for review and action.
- D. In response to an Authorization Request, the Plan's Medical Director/designee may require a second opinion to assist with the approval decision.

1.4.7 Other Coverage or Third Party Liability

- A. In the event the Member has other coverage (designated on the Medi-Cal Card) or third-party liability is involved, the Physician will follow procedures outlined in the current Medi-Cal Provider Manual to bill the appropriate parties prior to billing Plan. Medi-Cal and Plan are secondary payors for services rendered. Claims for payment from Plan will be mailed to the Plan - NOT THE FISCAL INTERMEDIARY FOR MEDI-CAL.
- B. Claims for other Title XIX reimbursable services not covered by Plan (e.g. Dental) will be billed to the appropriate program.

1.5 Specialist Responsibilities

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1.5.1 The responsibilities of the Specialist are as follows:

- A. Upon receipt of the proper treatment authorization and verification of Member eligibility, the Specialist will provide to Member those authorized medical services normally performed in his/her practice.
- B. Upon receipt of the proper treatment authorization and verification of beneficiary eligibility, the Specialist may serve as a consultant to the PCP.
- C. Upon completion of the initial examination of the Member and subsequent authorized treatment, the Specialist will:
 - (1) Advise the PCP of the patient's condition, proposed procedures, and prognosis throughout the period of treatment; and
 - (2) Provide to the PCP a written report, and other oral reports as appropriate, regarding the diagnosis, treatment, other findings and prognosis within thirty (30) days after patient contact. (The PCP office should maintain a "tickler file" on all requested referrals, to ensure a report is received by the 30-day turnaround time.)
- D. To secure a referral from the PCP prior to rendering treatment or treatment authorization from Plan.
- E. To participate in and accept continuing peer review of the medical or surgical services provided for Members.
- F. To participate in Quality Improvement and Utilization Management Programs as defined by the Plan.
- G. To permit review/audit of services provided to Members by the staff of Plan, the California Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC) according to federal and state regulatory requirements and guidelines issued by Plan.
- H. To use as appropriate the appeal procedures for providers as established by Plan.
- I. To preserve the dignity of the Member.

1.5.2 Member Medical Record Data

- A. In addition to issuing a Direct Referral Authorization Form (DRAF), the PCP will provide to the Specialist significant physical findings, radiographic or laboratory results from the Member's general medical record which may assist the consultation process.

1.5.3 Authorization For Additional Data Needs

- A. If the Specialist requires radiographic, laboratory or other diagnostic studies in order to evaluate the patient's condition or to make a diagnosis, the Specialist may arrange for such studies which do not unnecessarily duplicate materials that were made available by the PCP or do not contradict the scope of referral granted by the PCP. Specialist is required to obtain appropriate authorization from Plan for services that require Prior Authorization per Plan authorization requirements.
- B. All Covered Services provided at the Specialist's office will be billed by the Specialist to Plan.
- C. If any of the services are rendered by a provider other than the Specialist, the provider must obtain the proper referral from the PCP.
- D. All such referrals must be made to providers who contract with Plan.

1.5.4 Additional Consultation/Treatment Authorization

- A. Additional consultation/treatment beyond that authorized by the original DRAF may be required to bring the patient to a satisfactory level of health. The Specialist must obtain authorization for all services for which one is required.
- B. Such additional treatment will conform to accepted medical or surgical standards and to Plan and Medi-Cal coverage limitations. The Specialist will bill Plan for payment of authorized services.
- C. The PCP may issue additional referrals for further treatment by the Specialist or arrange another course of action which is satisfactory to the Member and the PCP.

1.6 Non-Physician Medical Practitioners

- 1.6.1 When a PCP employs a physician assistant, nurse practitioner or certified nurse midwife, the non-physician medical practitioner will be directed according to Medi-Cal regulations and other written policies of Plan.
- 1.6.2 The Supervising Physician will have an appropriate certification from the California Medical Quality Board to supervise the physician assistant. The Physician Assistant will hold a current license to practice.
- 1.6.3 The nurse practitioner or nurse midwife will hold a current professional license for the position and act according to the agreed upon protocols and interface requirements cited in the Medi-Cal regulations.
- 1.6.4 Services rendered by non-physician medical practitioners are recognized by Plan as professional services to be billed as a physician service according to the contract with Plan.
- 1.6.5 If the non-physician medical practitioner provides after-hours coverage, that practitioner must be supervised by a licensed M.D. or D.O. who is immediately available by

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telephone to the covering non-physician practitioner.

1.7 Out Of Area Service Claims

1.7.1 Plan will pay for medical claims for the care of any Member who receives Medically Necessary emergency treatment rendered outside Ventura County.

1.7.2 PCPs will discuss out-of-area emergency coverage with their Members. The out-of-area emergency care does not require Prior Authorization.

1.8 Twenty-Four Hour Coverage

1.8.1 The PCP will assure access to Physician care for case-managed Members 24 hours per day, 7 days per week. After business hours the PCP or attending physician for case managed Members may designate a covering practitioner to provide after-hours care. The on-call practitioner must be available by telephone to respond to calls from Members, organizational providers and other practitioners. After business hours it is expected that the answering service contact the practitioner or designee within 30 minutes for urgent questions. The practitioner on-call for the practice is expected to call the answering service within 30 minutes of contact by the answering service. The practitioner on call is required to call the Member back within 60 minutes for probable urgent problems and within 4 hours for probable non-urgent matters.

1.8.2 The PCP will designate a backup Physician when unavailable to render care.

1.8.3 The PCP will provide to Plan a list with the names and telephone numbers of backup Physicians.

1.8.4 Should the backup Physician render any Covered Services to the PCP's Members, the backup Physician will send the claims to Plan for processing of the encounter data only. Actual payment for any services rendered will be determined by a separate understanding between the PCP and covering backup Physician. ***Any payments owing to the backup Physician will be made by the PCP not the Plan.*** Prior to rendering care, the backup Physician will confirm Member eligibility.

1.8.5 Following care of any of the PCP's Plan Members, the backup Physician will update the PCP on any treatment rendered as well as any questions or concerns regarding the patient. Further follow-up of the patient is now the responsibility of the PCP.

1.8.6 A PCP may elect to have a mid-level clinician or registered nurse who is part of the PCP's practice take after hours calls provided they follow standardized protocols and a Physician is always available for back-up.

1.9 Delegation of Treatment Responsibility

1.9.1 Certain patient conditions may demand ongoing treatment by a Specialist Physician (e.g., OB-GYN).

A. The PCP may delegate the responsibility for continuing specialty care to a specialist for a specified time (6 months). The PCP must issue a DRAF for a

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delegated Specialist. The PCP will remain the PCP to the Member.

- B. Any hospitalization of the Member which may be recommended or required, however, will be prior authorized by the PCP. The Specialist will request such authorizations from the PCP. Hospitalization authorization procedures will apply to this request.
- C. As required for all consultations the Physician rendering care will provide written reports of the patient's condition, treatment, prognosis, etc. to the PCP within thirty (30) days of service.

1.10 Utilization Controls

1.10.1 In the interest of program integrity and the welfare of Members, Plan may introduce utilization controls as may be necessary. In the event such changes are made, the Physician will be given 30 days advance notice by Plan.

1.11 Production and Distribution of Case Management List

1.11.1 Case management lists are the monthly lists of Members selected or assigned to the PCP.

1.11.2 Case management lists are produced prior to the first day of each calendar month. Each PCP with selections receives an individual list of eligible Members for that month.

1.12 Monitoring and Evaluation

1.12.1 A periodic random sample of medical records may be audited for appropriateness of case management activities

ATTACHMENT B

DISCLOSURE FORM (Welfare and Institutions Code Section 14452)

TAX I.D. # _____

Name of Specialist Physician

The undersigned hereby certifies that the following information regarding the Specialist Physician is true and correct as of the date set forth below:

Form of Specialist Physician (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

If a proprietorship, Co-Owner(s). If a partnership, partners.

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

Stockholders owning more than ten percent (10%) of the stock of the Provider:

Major creditors holding more than five (5) percent of Provider debt:

If not already disclosed above, is Specialist Physician, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

Dated: _____

Signature: _____

Name: _____

(Please type or print)

Title: _____

(Please type or print)

**ATTACHMENT C
FACILITY LOCATIONS**

List each Specialist Physician name, Ventura County location(s) and hours of operation, mid-level practitioners supervised and languages spoken that shall apply to this Agreement.

ATTACHMENT D
SPECIALIST PHYSICIAN RATES

The following rates shall apply to professional services rendered for Covered Services to eligible Plan Members:

Specialty Type:

Rate: Prevailing Medi-Cal fee-for-service rates as determined by the California Department of Health Care Services.

MEDICAL SERVICES AGREEMENT

Between
VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

And
SPECIALIST PHYSICIAN

This Medical Services Agreement (this "Agreement") is made effective as of the _____ day of _____, 2011 (the "Effective Date"), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as "Plan" and _____ ("Specialist" or "Specialist Physician"), a group of physicians each of whom is licensed to practice in the State of California pursuant to California Business and Professions Code, Division II, Chapter 5, Section 200 et. seq., each of whom is eligible to participate in and certified to provide services under the California Medi-Cal (Medicaid) program, and each of whom meets applicable requirements under Titles XVIII and XIX of the Social Security Act.

IN WITNESS WHEREOF, the subsequent Agreement between Plan and Specialist Physician is entered into by and between the undersigned parties.

Specialist Physician:

Plan:

(Name of Anesthesiology Group)
Executed by:

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

Executed by:

Signature

Signature

Printed Name

Earl Greenia
Chief Executive Officer

Title

Date

Date

Address for Notices:

Address for Notices:

Gold Coast Health Plan
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-8294

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
SPECIALIST PHYSICIAN MEDICAL SERVICE AGREEMENT**

Table of Contents

RECITALS3

SECTION 1 – DEFINITIONS3

SECTION 2 – QUALIFICATIONS, OBLIGATIONS AND COVENANTS8

SECTION 3 – SCOPE OF SERVICES TO BE PROVIDED 11

SECTION 4 – EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES 14

SECTION 5 – PAYMENTS 15

SECTION 6 – MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES 16

SECTION 7 – INSURANCE AND INDEMNIFICATION 19

SECTION 8 – GRIEVANCES AND APPEALS 20

SECTION 9 – TERM, TERMINATION, AND AMENDMENT 22

SECTION 10 – GENERAL PROVISIONS..... 24

SECTION 11 – RELATIONSHIP OF PARTIES 26

SECTION 12 – ADDITIONAL LEGAL REQUIREMENTS 27

Attachment A – Information Regarding Officers, Owners, and Stockholders..... 30

Attachment B – Facility Locations..... 31

Attachment C – Physician Rates..... 32

RECITALS

- A. WHEREAS, Plan is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.
- B. Whereas Plan 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 the Plan.
- C. Whereas Plan will arrange for Covered Services for its Medi-Cal Members under the case management of designated Primary Care Physicians chosen by or assigned to Medi-Cal Members, and all Specialist Physician Services will be delivered only with authorization from Plan if services being provided require prior authorization.
- D. Whereas Specialist Physician will participate in providing Covered Services to Medi-Cal Members and will receive payment from Plan for the rendering of those Covered Services.
- E. Whereas Specialist Physician desires to provide specialty medical care for such Medi-Cal Members.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the parties set forth in this Agreement agree and covenant as follows:

SECTION 1 DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

- 1.1 Administrative Member. Medi-Cal Members enrolled with Plan who have not been assigned to a Primary Care Physician for administrative reasons.
- 1.2 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.
- 1.3 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.
- 1.4 Authorization Request Form (ARF). The form approved by Plan for the provision of Outpatient Services set forth in the Provider Manual.

- 1.5 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.
- 1.6 Capitation Payment. The prepaid monthly amount that Plan pays to Primary Care Physician (PCP) as compensation for those Covered Medical Services which are set forth in Attachment C, attached to and incorporated within the PCP Medical Services Agreement with Plan.
- 1.7 Case Managed Members. Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care.
- 1.8 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.
- 1.9 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.
- 1.10 Complex Case. Members requiring comprehensive care management and coordination of services. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex psychosocial 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.
- 1.11 Contract Year. The 12-month period following the effective date of this Agreement between Specialist Physician and Plan 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 Plan operational date will apply.
- 1.12 County Organized Health System (COHS). A plan serving either a single or multiple county areas.
- 1.13 Covered Medical Services. Those Covered Services that are set forth in the Member Handbook some of which are to be provided to, or arranged for, Members by Specialist Physician, within the scope of its licensure, pursuant to this Agreement and for which Specialist Physician is to be compensated by Plan in accordance with Attachment D of this Agreement.
- 1.14 Covered Services. All Medically Necessary services to which Members are entitled from Plan as set forth in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services. Covered Services includes Covered Medical Services.
- 1.15 DHCS. The State of California Department of Health Care Services.

- 1.16 Direct Referral Authorization Form (DRAF). The Plan's form, evidencing referral by PCP or Medical Director, or designee for initial specialist consultation or return follow-up with forty-five (45) days.
- 1.17 Eligible Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the Plan 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.
- 1.18 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.
- 1.19 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.
- 1.20 Encounter Form. The CMS-1500 claim form used by Specialist Physician to report to the Plan provision of covered services to Medi-Cal Members.
- 1.21 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the Plan.
- 1.22 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.
- 1.23 Fee-For-Service Payment (FFS). (1) The maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by Plan and the Specialist Physician. All Covered Services authorized by Plan pursuant to this Agreement will be compensated by Plan as described in Attachment D.
- 1.24 Fiscal Year. The 12 month period starting July 1.
- 1.25 Governmental Agencies. Any agency that has legal jurisdiction over Plan, Medi-Cal or Medicaid, such as: the Department of Managed Health Care ("DMHC"), DHCS, United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General.
- 1.26 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.
- 1.27 Identification Card. The card that is prepared by the Plan which bears the name and symbol of Plan and contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with Plan or proof of Medi-Cal eligibility.
- 1.28 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.

- 1.29 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by Plan to monitor the quality assurance and implement Quality Improvement Program of Plan. Also called Chief Medical Officer.
- 1.30 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. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.
- 1.31 Medi-Cal Managed Care Program. The program that Plan operates under its Medi-Cal Agreement with the DHCS for the Service Area.
- 1.32 Medi-Cal Provider Manual. The Medical Services Provider Manual of the DHCS, issued by the DHCS Fiscal Intermediary.
- 1.33 Medical Transportation. "Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, specially equipped 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.
- 1.34 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the Plan.
- 1.35 Member Handbook. The Plan 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 Plan and the Medi-Cal Member.
- 1.36 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.
- 1.37 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.
- 1.38 Operations Manual. The Manual of Operational Policies and Procedures for the Plan Medi-Cal Managed Care Program. Also called Provider Manual.
- 1.39 Other Services. Other covered services not included in the Specialty Care and Inpatient Hospital Services sub-accounts, as described in this Agreement.
- 1.40 Out-of-Area. The geographic area outside Ventura County.
- 1.41 Participating Referral Provider. Any health professional or institution contracted with Plan that meets the Standards for Participation in the State Medi-Cal Program to render medical services to Medi-Cal Members.

- 1.42 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with Plan and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program and who has contracted with Plan to provide medical services to Medi-Cal members.
- 1.43 Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the Plan. Such limit may be changed by mutual agreement of the parties.
- 1.44 Plan. The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission and serving Ventura County Medi-Cal Eligible Beneficiaries. Also called Gold Coast Health Plan.
- 1.45 Primary Care Physician or PCP. A physician duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; 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, and pediatricians but may or may not include Obstetrician-Gynecologists depending on their scope of practice.
- 1.46 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.
- 1.47 Primary Hospital. Any hospital affiliated with Medical Group that has entered into an Agreement with the Plan.
- 1.48 Provider Manual. The Plan's Manual describing operational policies and procedures relevant to Providers. Also called Operations Manual.
- 1.49 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.
- 1.50 Referral Physician. Any qualified physician, duly licensed in California who meets the Standards of Participation, has been enrolled in the State Medi-Cal Program in accordance with Article 3, Title 22, CCR. Exception to this requirement must be authorized by Plan CEO and/or Medical Director. A Referral Physician must have an Agreement with Plan or authorized by a subcontracted Plan provider. Primary Care Physician may refer any Member for consultation or treatment to a Referral Physician.
- 1.51 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.
- 1.52 Service Area. The County of Ventura.

- 1.53 Treatment Authorization Request or TAR. The Plan's form for the provision of inpatient Non-Emergency Services as set forth in the Provider Manual.
- 1.54 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).
- 1.55 Utilization Management Program. The program(s) approved by Plan, which are designed to review and monitor the utilization of Covered Services. Such program(s) are set forth in the Plan's Provider Manual.
- 1.56 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

SECTION 2 QUALIFICATIONS, OBLIGATIONS AND COVENANTS

- 2.1 Specialist Physician is responsible for:
 - 2.1.1 Standards of Care. Provide Covered Services for those complaints and disorders of Plan Members that are within his/her professional competence with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.
 - 2.1.2 Licensure. Warrant that Specialist Physician has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license to practice medicine or osteopathy in the State of California to provide the Covered Services under the terms of this Agreement. Warrant that Specialist Physician has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by Plan.
 - 2.1.3 Referrals. Except for Emergency Services and Urgent Care Services, Specialist Physician shall provide Covered Services to Medi-Cal Members only upon receipt of an appropriate authorization from Medi-Cal Member's Primary Care Physician or Plan.
 - a. Primary Care Physician has the right to refer Member to any Referral (Specialist) Physician.
 - b. The Specialist Physician will consult with Primary Care Physician and Plan's Medical Director as soon as possible when a Medi-Cal Member who, for conscientious or other personal reasons, refuses to follow or undergo one or more procedures or courses of treatment recommended by the Specialist Physician if the Specialist Physician determines no professionally acceptable alternatives to such recommended procedures or courses of treatment exists as a Covered Service under the Medi-Cal Managed Care Program.
 - 2.1.4 Case Management. Cooperate with Medi-Cal Member's Primary Care Physician and Plan in the Primary Care Physician's monitoring, coordination, and case management of the

Medi-Cal Member's overall health care. Specialist Physician will promptly furnish a complete report of the services rendered to a Medi-Cal Member to the Medi-Cal Member's Primary Care Physician and, upon Plan's request, to Plan, on such form as may be prescribed in the Plan's Provider Manual.

- a. Specialist or Referral Physician to whom the Primary Care Physician has delegated the authority by a referral to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.
- b. Specialist Physician acknowledges that Plan Medical Director will assist in the management of complex cases. Specialist Physician will fully cooperate with Plan Medical Director by providing information that may be required in the transfer of a Medi-Cal Member into medical facilities designated by Plan for the care of complex cases, including but not limited to, prompt notification of known or suspected complex cases.

2.1.5 Accessibility and Hours of Service. Providing Covered Services to Medi-Cal Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan's Provider Manual during normal business hours at Specialist Physician's usual place of business and will arrange for Emergency Services and Urgent Care Services as Medically Necessary.

- a. No payment shall be made by the Plan for the services rendered to referred Members unless evidence of Primary Care Physician or Plan authorization has been made or the services are excluded or exempt from prior authorization in accordance with Section 4 of this Agreement.

2.1.6 Hospital Privileges. Maintain active medical staff privileges and is a member in good standing of the medical staff with at least one (1) Hospital contracting with Plan or has been specifically excluded from this requirement by the Plan Medical Director.

2.1.7 Officers, Owners and Stockholders. Providing information regarding officers, owners and stockholders as set forth in Attachment B, attached hereto and incorporated herein.

2.1.8 Credentialing. Provide Plan with a completed credentialing form, will use best efforts to notify Plan in advance of any change in such information, and will successfully complete a facility site review, if deemed necessary by Plan in accordance with DHCS Medi-Cal Agreement.

2.1.9 Actions Against Specialist Physician. Specialist Physician will adhere to the requirements as set forth in the Plan Operations Manual and notify Plan by certified mail within five (5) days of Specialist Physician's learning of any action taken which results in restrictions on Specialist Physician staff privileges, membership, employment for a medical disciplinary cause or reason as defined in the California Business & Professions Code, Section 805, regardless of the duration of the restriction or exclusion from participating in the Medi-Cal Program in accordance with the Standards of Participation.

2.1.10 Financial and Accounting Records. Maintain, in accordance with standard and generally accepted accounting practices, financial and accounting records relating to services

provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Submit reports as required by Plan or DHCS.

- 2.1.11 Compliance with Member Handbook. Specialist Physician acknowledges that Specialist Physician is not authorized to make nor will Specialist Physician make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.
- 2.1.12 Promotional Materials. Specialist Physician will consent to be identified as a Specialist Physician in written materials published by Plan, including without limitation, marketing materials prepared and distributed by Plan and display promotional materials provided by Plan within his/her office.
- 2.1.13 Specialist Physician shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Agreements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. Specialist Physician shall also provide, as applicable, the “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions” and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 2.1.14 Compliance with Plan Policies and Procedures. Specialist Physician agrees to comply with all policies and procedures set forth in the Plan Provider Manual. Plan may modify Provider Manual from time to time. In the event the provisions of the Provider Manual are inconsistent with the terms of this Agreement; the terms of this Agreement shall prevail.
- 2.1.15 Cultural and Linguistic Services. Specialist Physician shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. Specialist Physician shall recognize and integrate Members’ practices and beliefs about disease causation and prevention into the provision of Covered Services. Specialist Physician shall comply with Plan’s language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with Plan by providing any information necessary to assess compliance. Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. Specialist Physician has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in Plan Provider Manual.

2.2 Plan is responsible for:

- 2.2.1 Member Assignment. Assigning Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician and such Members are hereafter referred to as Case Managed Members.

- a. The Medi-Cal Member can select from the Primary Care Physicians contracting with Plan.
 - b. The Medi-Cal Member will seek all medical services, except those outlined in Section 4 from their assigned Primary Care Physician.
 - c. If the Medi-Cal Member does not select a Primary Care Physician, Plan will assign Members to a Primary Care Physician in a systematic manner as the Plan deems appropriate and/or in accordance with established protocol.
- 2.2.2 Listing. Plan may enter the name of each contracted Specialist Physician onto a list or provider directory from which Medi-Cal Members may receive healthcare services. Such a list may contain the following information concerning the Specialist Physician.
- a. Name
 - b. Address(es)
 - c. Telephone and FAX numbers
 - d. Scope of services (specialty or provider type)
- 2.2.3 Payment for Authorized Service Only. The Plan will reimburse Specialist Physician for covered medical services that are properly authorized by the Plan Medical Director (or his/her designee) or for Covered Services provided to an Administrative Member. Payment will be made based on required authorization and claim billing requirements as identified in the Plan Operations Manual.

SECTION 3 SCOPE OF SERVICES TO BE PROVIDED

- 3.1 Management of Care. With the exception of Excluded Services described in Section 4 of this Agreement, it is the responsibility of the Primary Care Physician with the assistance of appropriate Specialist Physicians to determine, to provide, to prescribe, and to manage Covered Services for Medi-Cal Members in accordance with professionally recognized standards and medical necessity.
- 3.1.1 Covered Services are as specified in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services.
 - 3.1.2 Except as otherwise provided herein, it will be the responsibility of the Specialist Physician to render or provide referral for Covered Services, for each Medi-Cal Member, which has been determined to be Medically Necessary and appropriate for the control of disease, illness, or disability.
- 3.2 Consultation with Medical Director. Specialist Physician or any other provider may at any time seek consultation with Medical Director on any matter concerning the treatment of the Member.
- 3.3 Covered Services. Covered Services are services covered under the California State Medi-Cal program and the Medi-Cal Agreement when they are necessary and appropriate for the care of that Member. Covered services include but are not limited to:
- 3.3.1 Accessibility and Hours of Service. Provide Covered Services to Case Managed

Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan Operations Manual during normal business hours at Specialist Physician's usual place of business and will arrange for Emergency Services and Urgent Care Services at all other times. Any Emergency Services shall be subject to the terms set forth in the Provider Manual regarding Contracting and Non-Contracting Emergency Service Providers and Post-Stabilization. Specialist Physician will make suitable arrangements for personal contact with the Member, or for services by appropriate personnel in accordance with customary medical practice and with the law including referrals for a second professional opinion.

- 3.3.2 Facilities, Equipment and Personnel. Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement.
 - 3.3.3 Other Medically Necessary Services. Other necessary durable medical equipment rental, and medical supplies determined by Specialist Physician to be Medically Necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member. All services and goods required or provided hereunder will be consistent with sound professional principles, community standards of care, and Medical Necessity.
 - 3.3.4 Nothing expressed or implied herein shall require the Specialist Physician to provide to or order on behalf of the Medi-Cal Member, Covered Services which, in the professional opinion of the Primary Care Physician or Specialist Physician, are not Medically Necessary for the treatment of the Medi-Cal Member's disease or disability.
- 3.4 Prescription Drugs. Specialist Physician shall comply with the Plan drug formulary as approved by Plan policies and subject to the restrictions on the Plan Drug Formulary regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals, in conformance with generally accepted medical and surgical practices and standards prevailing in the professional community.
- 3.4.1 If for medical reasons, the Specialist Physician believes a generic equivalent should not be dispensed, the Specialist Physician agrees to obtain prior authorization from the Plan Pharmacy Director.
 - 3.4.2 Specialist Physician acknowledges the authority of Plan's participating pharmacists to substitute generics for trade name drugs, as specified in Section 4073 of the California Business & Professions Code, and Title 22 CCR Section 51313 unless otherwise indicated.
- 3.5 Non-Discrimination
- 3.5.1 Medi-Cal Members. Specialist Physician will provide services to Medi-Cal Members in the same manner as such services are provided to other patients of Specialist Physician, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Managed Care Program. Subject to the foregoing, Specialist Physician will not subject Case Managed Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex,

gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan or filing a complaint as a Member of Plan in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination will include but is not limited to: denying any Case Managed Member any Covered Service or availability of a Facility; providing to a Case Managed Member any Covered Service which is different, or is provided in a different manner or as a different time from that provided to other Members under this Contract except where medically indicated; subjecting a Case Managed Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Case Managed Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered Services, treating a Case Managed Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.

- 3.5.2 For the purpose 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 affects on the carrier. Such genes include, but are not limited to, Tay-Sach trait, sickle-cell trait, Thallassemia trait, and X-linked hemophilia.

3.6 Quality Improvement and Utilization Management Programs

- 3.6.1 Specialist Physician will participate in Plan's Quality Improvement and Utilization Management Programs, including credentialing and recredentialing, peer review and any other activities required by Plan, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. This includes participation in office reviews, chart and access audits and focused reviews. In addition, the Specialist Physician will participate in the development of, and implement, corrective action plans for any areas that fall below Plan standards and ensuring medical records are readily available to the Plan's staff as requested.
- a. Recognizing the possibility that Plan, through the utilization management and quality assurance process there may be a requirement to consult with the Medical Director or with other Physicians prior to authorization of services or supplies or to terminate this Agreement.
 - b. In the interest of program integrity or the welfare of Members, Plan may from time to time introduce additional utilization controls as may be necessary as determined by Plan.
 - c. In the event of such change, a thirty (30) day notice will be given to the Specialist Physician and Specialist Physician will be entitled to appeal such action to the appropriate Reviewing Committee.

SECTION 4
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

- 4.1 Exclusions. Members in need of services, which are not Covered Services, as described in the Member Handbook, will not be reimbursed by the Plan. The Specialist Physician will not bill and expect reimbursement by the Plan for the excluded services provided to Medi-Cal Members as described in this Section 4.
- 4.2 Services Neither Covered nor Compensated. Subject to any additional exclusions from Covered Services as set forth in the Medi-Cal Agreement, Specialist understands that Specialist will not be obligated to provide Medi-Cal Members with, and the Plan will not be obligated to reimburse Specialist for Excluded Services pursuant to this Agreement (services for which Plan does not receive capitation payment from the DHCS.)
- 4.3 Restricted Services / Special Reimbursement
- 4.3.1 Specialist Physician will ensure that services provided to Medi-Cal Members will be in conformance with the limitations and procedures listed in the Medi-Cal Provider Manual and the Plan's Operations Manual unless notified of modification to that policy by DHCS or Plan.
- a. The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization. These services shall be subject to the limitations specified therein.
- 4.3.2 Primary Care Physician referral and/or Plan authorization are not required for reimbursement by Plan to providers of the following services.
- a. The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.
- b. Family Planning Services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 Code of Federal Regulations Section 441.20. Family Planning services are defined in the Plan's Provider Manual and services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.
- 4.3.3. Primary Care Physician referral is not required for beneficiaries designated as Administrative Members.
- 4.3.4 California Children's Services (CCS) must be authorized by the Ventura County CCS Program.
- 4.3.5 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program.

SECTION 5
REIMBURSEMENT, ACCOUNTS, REPORTING AND RECOVERIES FOR SERVICES

- 5.1 Payments. Specialist Physician will be reimbursed for medical services provided to Medi-Cal Members for those services which have been referred by the Member's Primary Care Physician, in accordance with the fee schedule set forth on Attachment D hereto, and upon submission of a complete CMS-1500 claim form along with evidence of prior authorization (if required in accordance with Plan policies and procedures) or submission of complete data through electronic transfer, as described in Section 5.3 of this Agreement. Reimbursement will be made within thirty (30) days of receipt by Plan of a "Clean Claim".
- 5.1.1 All CMS-1500 claim forms and/or encounter data should be submitted to the Plan within six (6) months of the date the service was provided.
- 5.1.2 A summary report will accompany each check identifying those Medi-Cal Members who received Covered Services from Specialist Physician and the appropriate amount of reimbursement.
- 5.1.3 The Medi-Cal Member is eligible for Covered Services on the first day of the month for which Plan receives capitation based on the most current enrollment information from the DHCS.
- 5.2 Entire Payment. The Specialist Physician will accept from Plan compensation as payment in full and discharge of Plan's financial liability. Covered Services provided to Medi-Cal Members by Specialist Physician will be reimbursed as set forth in this Agreement and in accordance with Plan's Operations Manual policies and procedures. Specialist Physician will look only to Plan for such compensation. Plan has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to Plan are reduced by DHCS.
- 5.2.1 Fee-For-Service Payment (FFS) - The Plan will reimburse the Specialist Physician for the professional component of services provided at the prevailing Medi-Cal fee for service rates for all properly documented Medi-Cal Covered Services provided to:
- a. Medi-Cal Members for Covered Services, which have been properly authorized in accordance with Plan Operations Manual if services being provided require prior authorization.
- 5.3 Claim Submission. The Specialist Physician will obtain, complete, and submit CMS-1500 claim forms, or submit through electronic transfer, claims for all services rendered to Medi-Cal Members
- 5.3.1 All claims for reimbursement of Covered Services and encounter data related thereto, if applicable, should be submitted to the Plan within six (6) months from the end of the month that service was provided as described in the Plan Operations Manual.
- 5.3.2 Upon submission of a complete and uncontested clean claim, payment will be processed within thirty (30) days after receipt by Plan. A "complete and uncontested clean claim" will include all information needed to process the claim.

5.4 Medi-Cal Member Billing. Specialist Physician will not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal Member unless authorized share of cost, or from other persons on behalf of the Medi-Cal Member, for any service included in the Medi-Cal program's Covered Services in addition to a claim submitted to the Plan for that service.

5.5 Coordination of Benefits. Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. Specialist Physician must bill the Other Health Coverage (primary) carrier before billing Plan for reimbursement of Covered Services and, with the exception of authorized Medi-Cal share of cost payments, will at no time seek compensation from Medi-Cal Members or from DHCS. The Specialist Physician may bill the Member for non-covered services.

Specialist Physician has the right to collect all sums as a result of Coordination of Benefits efforts for Covered Services provided to Medi-Cal Members with Other Health Coverage.

5.5.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the Plan Operations Manual.

5.5.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the Medi-Cal Agreement with Plan.

5.5.3 Specialist Physician will report to Plan the discovery of third party insurance coverage for a Medi-Cal Member within ten (10) days of discovery.

5.5.4 Specialist Physician will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the Specialist Physician, but will be reported to the Plan on the encounter form or encounter tape.

5.6 Third Party Liability. In the event that Specialist Physician provides services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by Specialist Physician pursuant to the terms of this Agreement.

5.6.1 Specialist Physician will cooperate with the DHCS and Plan in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.

5.6.2 Specialist Physician will report to Plan the discovery of third party tort action or potential tort action for a Medi-Cal Member within ten (10) days of discovery.

SECTION 6 MEDICAL RECORDS

6.1 Medical Record. Specialist Physician shall ensure that a medical record will be established and maintained for each Medi-Cal Member who has received Covered Services. Each Medi-Cal Member's medical record will be established upon the first visit to Specialist Physician. The record will contain information normally included in accordance with generally accepted practices and standards prevailing in the professional community.

- 6.1.1 Specialist Physician will facilitate the sharing of medical information with other providers in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.
- 6.1.2 Specialist Physician will ensure records are available to authorized Plan personnel in order for Plan to conduct its Quality Improvement and Utilization Management Programs to the extent permitted by law.
- 6.1.3 Specialist Physician will ensure that medical records are legible.
- 6.1.4 Specialist Physician will maintain such records for at least seven (7) years from the close of the State's fiscal year in which this Agreement was in effect.

6.2 Records and Records Inspection Rights

- 6.2.1 Access to Records – Specialist Physician will permit Plan Medical Director, or officers or their designees, any agency having jurisdiction over Plan including and without limitation the Governmental Agencies, to inspect the premises, records and equipment of Specialist Physician and review all operational phases of the medical services provided to Medi-Cal Members.
 - a. Specialist Physician will make all of Specialist Physician’s books and records, and papers (“Records”) relating to the provision of goods and services to Medi-Cal Members, to the cost of such goods and services, and to payments received by Specialist Physician from Medi-Cal Members or from others on their behalf available for inspection, examination and copying by Plan and all other state and federal agencies with jurisdiction over Plan or this Agreement, including without limitation, Governmental Agencies, at all reasonable times at Specialist Physician’s place of business or at such other mutually agreeable location in California.
 - b. Plan will pay for the cost of copying Records, not to exceed \$0.10 per page. The ownership of Records will be controlled by applicable law and this Agreement.
 - c. Specialist Physician shall permit Plan, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review Specialist Physician’s work performed or being performed hereunder, Specialist Physician’s locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy Records and any other books, accounts and materials relevant to the provisions of services under this Agreement. Specialist Physician will provide all reasonable facilities, cooperation and assistance during such inspection and reviews, including for the safety and convenience of the authorized representatives in the performance of their duties. Specialist Physician shall allow such inspections and reviews for the Records retention time of seven years. The State reserves the right to conduct unannounced validation reviews to verify compliance with State and federal regulations and contract requirements.

6.2.2 Maintenance of Records. Specialist Physician will maintain records in accordance with GCHP.SPECIALIST.PHYSICIAN.7.2.11

the general standards applicable to such book and record keeping and in accordance with applicable law, and Plan directives.

- a. Records will include all encounter data, working papers, reports submitted to Plan, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Medi-Cal Members for a period of at least seven (7) years.
- b. Specialist Physician will retain all Records for a period of at least seven (7) years from the close of the State Department of Health Care Services' fiscal year in which this Agreement was in effect.
- c. Specialist Physician's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.
- d. The Specialist Physician will not charge the Medi-Cal Member for the copying and forwarding of their medical records to another provider.

6.3 Disclosure to Government Officials. Specialist Physician shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, Specialist Physician shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Healthcare Effectiveness Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the County of Ventura Human Services Agency, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Quality Improvement Organizations ("QIOs"), their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, "Government Officials") as may be necessary for compliance by Plan with the provisions of all state and federal laws and contractual requirements governing Plan, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at Specialist Physician's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. Specialist Physician shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Specialist Physician related to this Agreement.

6.4 Patient Confidentiality

- a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et. seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted thereunder.

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- b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Beneficiaries will be protected by the Specialist Physician and his/her staff from unauthorized disclosure.
- c. Specialist Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information.
- d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the Specialist Physician, the Specialist Physician (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the Plan all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than Plan the federal government including the Department of Health and Human Services and Comptroller General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities over the COHS program and contracts, without 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 thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the Plan or maintain such information according to written procedures sent the Plan by the Department of Health Care Services for this purpose.

SECTION 7 INSURANCE AND INDEMNIFICATION

- 7.1 Insurance. Throughout the term of this Agreement and any extension thereto, Specialist Physician will maintain appropriate insurance programs or policies as follows:
 - 7.1.1 Each participating Specialist Physician covered by this Agreement will secure and maintain, at its sole expense, liability insurance of at least One Million Dollars (\$1,000,000) per person per occurrence, and Three Million Dollars (\$3,000,000) in aggregate, including "tail coverage" in the same amount whenever claims made malpractice coverage is involved. Notification of Plan by Specialist Physician of cancellation or material modification of the insurance coverage or the risk protection program will be made to Plan at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to Plan upon execution of this Agreement.
- 7.2 General Liability Insurance. In addition to Subsection 7.1 above, Specialist Physician will also maintain, at its sole expense, a policy or program of comprehensive liability insurance with minimum coverage including and no less than Three Hundred Thousand Dollars (\$300,000) per person for Specialist Physician's property, together with a combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars (\$300,000). Documents evidencing such coverage will be provided to Plan upon request. The Specialist Physician will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.

- 7.3 Workers' Compensation. Specialist Physician's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing the foregoing coverage will be provided to Plan upon request. Specialist Physician will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.
- 7.4 Insurance. Plan, at its sole cost and expense, will procure and maintain a professional liability policy to insure Plan and its agents and employees, acting within the scope of their duties, in connection with the performance of Plan responsibilities under this Agreement.
- 7.5 Specialist Physician Indemnification. Specialist Physician shall indemnify, defend and hold harmless Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Specialist Physician and its officers, directors, shareholders agents, employees and Subcontractors acting alone or in collusion with others. Specialist Physician also agrees to hold harmless both the State and Members in the event that Plan cannot or will not pay for services performed by Specialist Physician pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.
- 7.6 Plan Indemnification – Plan shall indemnify, defend and hold harmless Specialist Physician its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Plan and its officers, directors, shareholders agents, employees and subcontractors (other than Specialist Physician). The terms of this section shall survive the termination of this Agreement.

SECTION 8 GRIEVANCES AND APPEALS

- 8.1 Appeals and Grievances
- 8.1.1 Specialist Physician may have complaints, concerns, or differences, which may arise as a health care provider under contract with Plan which will be resolved as outlined in the Plan Appeals and Grievance policies as set forth in the Plan Operations Manual. Specialist Physician and Plan agree to and will be bound by the decisions of Plan grievance and appeal mechanisms.
- 8.1.2 Specialist Physician will cooperate with Plan in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the Plan grievance procedure set forth in this Section 8 and the Plan Provider Manual.
- 8.2 Responsibility
- 8.2.1 It is the responsibility of the Plan's Chief Executive Officer for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system. The Chief Executive Officer will be assisted in this process by the staff of Plan's Health Services and Provider Relations Departments.
- 8.3 Dispute Resolution.

- 8.3.1 For disputes unresolved by the Plan provider appeals process, Plan and Specialist Physician agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, Specialist Physician shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a “Dispute”).
- 8.3.2 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee’s decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee’s then respective prevailing rates of compensation.
- 8.3.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.
- 8.3.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Ventura, State of California.
- 8.4 Peer Review and Fair Hearing Process. Specialist Physicians determined hereto to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to the Plan Peer Review Committee. The Specialist Physician will be afforded an opportunity to address the committee. The Specialist Physician will be notified in writing of the Peer Review Committee Recommendations and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict, or terminate the Specialist Physician’s affiliation, to institute a monitoring procedure, or to implement continuing educational requirements.

- 8.5 Credentialing – A Credentialing Committee will review all provider files to determine whether a provider meets the Plan credentialing or recredentialing requirements. The Specialist Physician will be afforded an opportunity to address this Committee if there is an adverse recommendation by the Committee regarding the provider’s credentials. The Specialist Physician will be advised in writing of the Credentialing Committee's recommendation and notified of their rights to the Fair Hearing process. The Credentialing Committee can recommend denial of a provider's initial application or can deny the recredentialing of a current provider.

SECTION 9
TERM, TERMINATION, AND AMENDMENT

- 9.1 Initial Term and Renewal. This Agreement will be effective as of the Effective Date and will automatically renew at the end of one year and annually thereafter unless terminated sooner as set forth below.
- 9.2 Termination Without Cause. Either party upon sixty (60) days prior written notice to the other party may terminate this Agreement without cause.
- 9.3 Immediate Termination for Cause by Plan. The Plan may terminate this Agreement immediately by written notice to the Specialist Physician upon the occurrence of any of the following events:
- 9.3.1 The suspension or revocation of Specialist Physician’s license to practice medicine in the State of California; the suspension or termination of Specialist Physician’s membership on the active medical staff of any hospital; or the suspension, revocation or reduction in Specialist Physician’s clinical privileges at any hospital; or suspension from the State Medi-Cal Program; or loss of malpractice insurance; or failure to meet Plan recredentialing criteria; or
- 9.3.2 Specialist Physician’s death or disability. As used in this Subsection, the term “disability” means any condition which renders Specialist Physician unable to carry out his/her responsibilities under this Agreement for more than forty-five (45) working days (whether or not consecutive) within any 12-month period; or
- 9.3.3 If Plan determines, pursuant to procedures and standards adopted in its Utilization Management or Quality Improvement Programs, that Specialist Physician has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of the Plan Operations Manual; or
- 9.3.4 Plan determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member; or
- 9.3.5 If Plan determines that Specialist Physician has filed a petition for bankruptcy or reorganization, insolvency, as defined by law, or Plan determines that Specialist Physician is unable to meet financial obligations as described in this Agreement; or the Specialist Physician closes his/her office and no longer provides Medically Necessary services; or

An immediate termination for cause made by Plan pursuant to this Section 9.3 will not be subject to the cure provisions specified in Section 9.4 Termination for Cause with Cure Period.

- 9.4 Termination for Cause With Cure Period. In the event of a material breach by either party other than those material breaches set forth in Section 9.3, Immediate Termination for Cause by Plan above of this Agreement, the non-breaching party may terminate this Agreement upon twenty (20) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach during the twenty (20) day period, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.
- 9.5 Continuation of Services Following Termination. Should this Agreement be terminated, Specialist Physician will, at Plan's option, continue to provide Specialist and Covered Services to Medi-Cal Members who are under the care of Specialist Physician at the time of termination in accordance with this Section and Specialist agrees to adhere to Plan policies and procedures. Medi-Cal Members are allowed to receive ongoing care for a chronic or acute medical condition for up to 90 days after the Specialist agreement has terminated. Members in their second or third trimester of pregnancy have access to Specialty care through the post partum period. Specialist Physician will ensure an orderly transition of care for Medi-Cal Members, including but not limited to the transfer of Member medical records. Payment by Plan for the continuation of services by Specialist Physician after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to the physician of photocopying such records will be reimbursed by the Plan at a cost not to exceed \$.10 per page.
- 9.6 Medi-Cal Member Notification Upon Termination. Notwithstanding Section 9.3, Immediate Termination for Cause by Plan, upon the receipt of notice of termination by either Plan or Specialist Physician, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, Specialist Physician will notify Members who have had at least two visits in the previous 6 months, 30 days prior to the effective date of termination. Plan at its option, may immediately inform Medi-Cal Members of such termination notice. Such Medi-Cal Members will be required to select another Specialist Physician prior to the effective date of termination of this Agreement. Medi-Cal Members are allowed to receive ongoing care with the Specialist Physician after termination of this Agreement for up to 90 days to treat an illness.
- 9.7 Survival of Obligations After Termination. Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of Specialist Physician will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 9.5, Continuation of Services Following Termination; 2) Section 6.2, Records and Records Inspection; and, 3) Sections 7.5 and 7.6, Specialist Physician and Plan Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between Specialist Physician and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. Specialist Physician will assist Plan in the orderly transfer of Medi-Cal Members to the Specialist Physician they choose or to whom they are referred. Furthermore, Specialist Physician shall assist Plan in the transfer of

care as set forth in the Provider Manual, in accordance with the Phaseout Requirements set forth in the Medi-Cal Contract.

- 9.8 Access to Medical Records Upon Termination. Upon termination of this Agreement and request by Plan, Specialist Physician will allow the copying and transfer of medical records of each Medi-Cal Member to the Physician assuming the Medi-Cal Member's care at termination. Such copying of records will be at Plan's expense if termination was not for cause. Plan will continue to have access to records in accordance with the terms hereof.
- 9.9 Termination or Expiration of Plan's Medi-Cal Agreement. In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, Specialist Physician will allow DHCS and Plan to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, Specialist Physician will assist DHCS in the orderly transfer of Medi-Cal Members' medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the Specialist Physician's Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. In no circumstances will a Medi-Cal Member be billed for this service.

SECTION 10 GENERAL PROVISIONS

- 10.1 Assignment. This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged or hypothecated in any way by the Specialist Physician and will not be subject to execution, attachment or similar process, nor will the duties imposed on Specialist Physician be set, contracted or delegated without the prior written approval of Plan and DHCS. Subcontractor's agreements that provide for any assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
- 10.2 Amendment. This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS, if required.
- 10.2.1 Notwithstanding the foregoing, Plan may amend this Agreement with prior written notice to Specialist Physician in order to maintain compliance with State and Federal Law and the Medi-Cal Agreement. Such amendment shall be binding upon Specialist Physician and shall not require the consent of Specialist Physician.
- 10.3 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.
- 10.4 Notices. All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement.

Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.

10.4.1 Plan will notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. Such written notice will be mailed to:

California Department of Health Care Services,
Medi-Cal Managed Care Division
1501 Capitol Avenue, Suite 71.4001
MS 4407, P.O. Box 997413
Sacramento, CA 95899-7413

- 10.5 Entire Agreement. This Agreement, together with the Exhibits and the Plan Operations Manual contains the entire agreement between Plan and Specialist Physician relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.
- 10.6 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 10.7 Governing Law. The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of Plan. Any provision required to be in this Agreement by law, regulation, or the Medi-Cal Agreement will bind Plan and Specialist Physician whether or not provided in this Agreement.
- 10.8 Affirmative Statement, Treatment Alternatives. Practitioners may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- 10.9 Reporting Fraud and Abuse. Specialist Physician is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by Plan contracted Physicians within ten (10) days to Plan for investigation.
- 10.11 Nondisclosure and Confidentiality. Specialist Physician will not disclose the payment provisions of this Agreement except as may be required by law.
- 10.12 Proprietary Information. With respect to any identifiable information concerning a Case Managed Member that is obtained by Specialist Physician or its Subcontractors, Specialist Physician and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to Plan all requests for disclosure of such information, except requests for medical records in accordance with applicable

law; will not disclose any such information to any party other than DHCS without Plan's prior written authorization, except as specifically permitted by this Agreement or the Plan Medi-Cal Agreement with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Agreement; and, will, at expiration or termination of this Agreement, return all such information to Plan or maintain such information according to written procedures provided by Plan for this purpose.

- 10.13 Non-Exclusive Agreement. To the extent compatible with the provision of Covered Services to Medi-Cal Members for which Specialist Physician accepts responsibility hereunder, Specialist Physician reserves the right to provide professional services to persons who are not Case Managed Members including Eligible Beneficiaries. Nothing contained herein will prevent Specialist Physician from participating in any other prepaid health care program.
- 10.14 Counterparts. This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.
- 10.15 HIPAA. Specialist Physician and Plan each acknowledge that it is a "Covered Entity" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the "HIPAA Privacy Rule"). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members' individually identifiable health information. If the Specialist Physician identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to Plan or Members, the Specialist Physician must notify Plan's Privacy Officer immediately.

SECTION 11 RELATIONSHIP OF PARTIES

- 11.1 Overview. None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent Specialist Physician from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, Specialist Physician will provide written assurance to Plan that any contract providing commitments to any other prepaid program will not prevent Specialist Physician from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.
- 11.2 Oversight Functions. Nothing contained in this Agreement will limit the right of Plan to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.
- 11.3 Physician-Patient Relationship. This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her Specialist Physician. Specialist Physicians will be responsible for maintaining the professional relationship with Medi-Cal

Members and are solely responsible to such Medi-Cal Members for all medical services provided. Plan will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of Specialist Physician.

SECTION 12 ADDITIONAL LEGAL REQUIREMENTS

12.1 Compliance With Laws.

12.1.1 Specialist Physician represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives 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, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used for the acquisition, operation or maintenance of computer software in violation of copyright laws.

12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are \$100,000 or more, Specialist Physician certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Specialist Physician, 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 the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are \$100,000 or more, Specialist Physician shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally 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 Agreement, Specialist Physician shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. Specialist Physician shall file

such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Specialist Physician. Specialist Physician shall require that the language of this certification be included in all subcontracts at all tiers which exceed \$100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.

- 12.1.3 Specialist Physician 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 Medicaid programs, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.
- 12.1.4 Specialist Physician shall immediately notify Plan of (i) investigations of Specialist Physician in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred. Specialist Physician shall comply with Plan's antifraud plan, including its policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. Specialist Physician 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).
- 12.1.5 If required by Health and Safety Code Section 1375.4, (1) Specialist Physician shall meet the financial requirements that assist Plan in maintaining the financial viability of arrangements for the provision of Covered Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) Specialist Physician shall abide by Plan's process for corrective action plans if there is a deficiency, and (3) Plan shall disclose information to Specialist Physician that enables Specialist Physician to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), Plan and Specialist Physician shall meet the requirements set forth in such Regulations. Members may request general information from Plan or Specialist Physician about any bonuses or incentives paid by Plan, if applicable.
- 12.1.6 Specialist Physician shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, Specialist Physician shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If Specialist Physician is required to file monthly financial statements with DMHC, then Specialist Physician shall simultaneously file monthly financial statements with DHCS. In addition, Specialist Physician shall file monthly financial statements with DHCS upon request.

12.1.7 If payments under this Agreement are in excess of \$100,000, Specialist Physician shall comply with the following provisions unless this Agreement is exempt under 40 CFR Part 30. (i) Specialist Physician shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) Specialist Physician shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

ATTACHMENT A

DISCLOSURE FORM (Welfare and Institutions Code Section 14452)

TAX I.D. # _____

Name of Specialist Physician

The undersigned hereby certifies that the following information regarding the Specialist Physician is true and correct as of the date set forth below:

Form of Specialist Physician (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

If a proprietorship, Co-Owner(s). If a partnership, partners.

If a corporation, stockholders owning more than ten percent (10%) of the stock of the Provider

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

Stockholders owning more than ten percent (10%) of the stock of the Provider:

Major creditors holding more than five (5) percent of Provider debt:

If not already disclosed above, is Specialist Physician, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

Dated: _____

Signature: _____

Name: _____

(Please type or print)

Title: _____

(Please type or print)

**ATTACHMENT B
FACILITY LOCATIONS**

List each Specialist Physician name, Ventura County location(s) and hours of operation, mid-level practitioners supervised and languages spoken that shall apply to this Agreement.

ATTACHMENT C
SPECIALIST PHYSICIAN RATES

The following rates shall apply to professional services rendered for Covered Services to eligible Plan Members:

Specialty Type: Anesthesiology

Rate: Prevailing Medi-Cal fee-for-service rates as determined by the California Department of Health Care Services.

HEALTH CARE SERVICES AGREEMENT

Between

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION

And

HEALTH CARE SERVICES PROVIDER

This Health Care Services Agreement (this "Agreement") is made effective as of the First day of July, 2011 (the "Effective Date"), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity, hereinafter referred to as "Plan" and _____(please print) hereinafter referred to as "PROVIDER", a medical and/or health care services, supplies, or equipment provider licensed in the State of California, as applicable, who is eligible to participate in and certified to provide services under the California Medi-Cal (Medicaid) program, and meets applicable requirements under Titles XVIII and XIX of the Social Security Act.

IN WITNESS WHEREOF, the subsequent Agreement between Plan and Health Care Services Provider is entered into by and between the undersigned parties.

PROVIDER:

Plan:

*(Please Print Health Care Services
Provider Name Above)*

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

Executed by:

Signature

Signature

Printed Name

Earl Greenia
Chief Executive Officer

Title

Date

Date

Address for Notices:

Address for Notices:

GOLD COAST HEALTH PLAN
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-8294

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
HEALTH CARE SERVICES AGREEMENT**

TABLE OF CONTENTS

RECITALS3

SECTION 1 – DEFINITIONS3

SECTION 2 – QUALIFICATIONS, OBLIGATIONS AND COVENANTS8

SECTION 3 – SCOPE OF SERVICES11

SECTION 4 – EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES14

SECTION 5 – PAYMENTS AND CLAIMS PROCESSING16

SECTION 6 – RECORDS, ACCOUNTS, REPORTING AND RECOVERIES19

SECTION 7 – INSURANCE AND INDEMNIFICATION21

SECTION 8 – TERM, TERMINATION, AND AMENDMENT22

SECTION 9 – GENERAL PROVISIONS.....24

SECTION 10 – GRIEVANCES AND APPEALS27

SECTION 11 – RELATIONSHIP OF PARTIES28

SECTION 12 – ADDITIONAL LEGAL REQUIREMENTS 29

ATTACHMENT A – OFFICERS, OWNERS, AND STOCKHOLDERS.....34

ATTACHMENT B – FACILITY LOCATIONS.....35

ATTACHMENT C – PROVIDER SERVICES AND RATES SCHEDULE..... 36

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
HEALTH CARE SERVICES AGREEMENT**

RECITALS

- A. WHEREAS, Plan is a County Organized Health System established pursuant to Welfare & Institutions Code §14087.54.
- B. Whereas Plan 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 the Plan.
- C. Whereas Plan will arrange for Covered Services for its Medi-Cal Members under the case management of designated Primary Care Physicians chosen by or assigned to Medi-Cal Members, and all healthcare services will be delivered only with authorization from Plan if services being provided require prior authorization.
- D. Whereas PROVIDER will participate in providing Covered Services to Medi-Cal Members and will receive payment from Plan for the rendering of those Covered Services.
- E. Whereas PROVIDER desires to provide health care services for such Medi-Cal Members.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the parties set forth in this Agreement agree and covenant as follows:

**SECTION 1
DEFINITIONS**

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

- 1.1 Administrative Member. Medi-Cal Members enrolled with Plan who have not been assigned to a Primary Care Physician for administrative reasons.
- 1.2 Agreement. This agreement and all of the Exhibits attached hereto and incorporated herein by reference.
- 1.3 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.
- 1.4 Authorization Request Form (ARF). The form approved by Plan for the provision of Outpatient Services set forth in the Provider Manual.

- 1.5 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.
- 1.6 Capitation Payment. The prepaid monthly amount that Plan pays to Primary Care Physicians (PCP) as compensation for those Covered Medical Services which are set forth in Attachment C, attached to and incorporated within the PCP Medical Services Agreement with Plan.
- 1.7 Case Managed Members. Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care.
- 1.8 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.
- 1.9 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.
- 1.10 Complex Case. Members requiring comprehensive care management and coordination of services. Such Members may be identified through pre-certification requests by utilization management and inpatient concurrent review, those with complex psychosocial 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.
- 1.11 Contract Year. The 12-month period following the effective date of this Agreement between PROVIDER and Plan 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 Plan operational date will apply.
- 1.12 County Organized Health System (COHS). A plan serving either a single or multiple county areas.
- 1.13 Covered Medical Services. Those Covered Services that are set forth in the Member Handbook some of which are to be provided to, or arranged for, Members by PROVIDER, within the scope of its licensure, pursuant to this Agreement and for which PROVIDER is to be compensated by Plan in accordance with Attachment C of this Agreement.
- 1.14 Covered Services. All Medically Necessary services to which Members are entitled from Plan as set forth in the Member Handbook, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services. Covered Services includes Covered Medical Services.
- 1.15 DHCS. The State of California Department of Health Care Services.

- 1.16 Direct Referral Authorization Form (DRAF). The Plan's form, evidencing referral by PCP or Medical Director, or designee for initial specialist consultation or return follow-up within forty-five (45) days.
- 1.17 Eligible Beneficiary. Any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the Plan 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.
- 1.18 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.
- 1.19 Emergency Services. Those health services needed to evaluate or stabilize an Emergency Medical Condition.
- 1.20 Encounter Form. The CMS-1500 or UB-04 claim form used by PROVIDER to report to the Plan provision of covered services to Medi-Cal Members.
- 1.21 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the Plan.
- 1.22 Excluded Services. Those services for which the Plan is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.
- 1.23 Fee-For-Service Payment (FFS). (1) The maximum Fee-For-Service rate determined by DHCS for services provided under the Medi-Cal Program; or (2) the rate agreed to by Plan and the PROVIDER. All Covered Services authorized by Plan pursuant to this Agreement will be compensated by Plan as described in Attachment C.
- 1.24 Fiscal Year. The 12 month period starting July 1.
- 1.25 Governmental Agencies. Any agency that has legal jurisdiction over Plan, Medi-Cal or Medicaid, such as: the Department of Managed Health Care ("DMHC"), DHCS, United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General.
- 1.26 Hospital. Any acute general care or psychiatric hospital licensed by DHCS.
- 1.27 Identification Card. The card that is prepared by the Plan which bears the name and symbol of Plan and contains: a) Member name and identification number, b) Member's Primary Care Physician, and c) other identifying data. The card is not proof of Member eligibility with Plan or proof of Medi-Cal eligibility.
- 1.28 Limited Service Hospital. Any hospital which is under contract to the Plan, but not as a Primary Hospital.

- 1.29 Medical Director. The Medical Director of Plan or his/her designee, a physician licensed to practice medicine in the State of California, employed by Plan to monitor the quality assurance and implement Quality Improvement Program of Plan. Also called Chief Medical Officer.
- 1.30 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. These services will be in accordance with professionally recognized standards of medical practice and not primarily for the convenience of the Member or the participating provider.
- 1.31 Medi-Cal Managed Care Program. The program that Plan operates under its Medi-Cal Agreement with the DHCS for the Service Area.
- 1.32 Medi-Cal Provider Manual. The Medical Services Provider Manual of the DHCS, issued by the DHCS Fiscal Intermediary.
- 1.33 Medical Transportation. "Medical transportation services" means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, specially equipped 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.
- 1.34 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the Plan.
- 1.35 Member Handbook. The Plan 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 Plan and the Medi-Cal Member.
- 1.36 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.
- 1.37 Non Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.
- 1.38 Operations Manual. The Manual of Operational Policies and Procedures for the Plan Medi-Cal Managed Care Program. Also called Provider Manual.
- 1.39 Other Services. Other covered services not included in the list of services to be reimbursed by Plan to PROVIDER as described in this Agreement.
- 1.40 Out-of-Area. The geographic area outside Ventura County.
- 1.41 Participating Referral Provider. Any health professional or institution contracted with Plan that meets the Standards for Participation in the State Medi-Cal Program to render medical services to Medi-Cal Members.

- 1.42 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with Plan and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program and who has contracted with Plan to provide medical services to Medi-Cal members.
- 1.43 Physician Patient Load Limitation. The maximum number of Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the Plan. Such limit may be changed by mutual agreement of the parties.
- 1.44 Plan. The Medi-Cal Managed Care Program governed by the Ventura County Medi-Cal Managed Care Commission and serving Ventura County Medi-Cal Eligible Beneficiaries. Also called Gold Coast Health Plan.
- 1.45 Primary Care Physician or PCP. A physician duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing Primary Care Services to Members; initiating referrals; 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, and pediatricians but may or may not include Obstetrician-Gynecologists depending on their scope of practice.
- 1.46 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.
- 1.47 Primary Hospital. Any hospital located within Ventura County that has entered into an Agreement with the Plan.
- 1.48 Provider Manual. The Plan's Manual describing operational policies and procedures relevant to Providers. Also called Operations Manual.
- 1.49 Quality Improvement Program (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and Plan Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.
- 1.50 Referral Physician. Any qualified physician, duly licensed in California who meets the Standards of Participation, has been enrolled in the State Medi-Cal Program in accordance with Article 3, Title 22, CCR. Exception to this requirement must be authorized by Plan CEO and/or Medical Director. A Referral Physician must have an Agreement with Plan or authorized by a subcontracted Plan provider. Primary Care Physician may refer any Member for consultation or treatment to a Referral Physician.
- 1.51 Referral Services. Covered services, which are not Primary Care Services, provided by physicians on referral from the Primary Care Physician or provided by the Primary Care Physician as a non-capitated service.
- 1.52 Service Area. The County of Ventura.

- 1.53 Treatment Authorization Request or TAR. The Plan's form for the provision of inpatient Non-Emergency Services as set forth in the Provider Manual.
- 1.54 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).
- 1.55 Utilization Management Program. The program(s) approved by Plan, which are designed to review and monitor the utilization of Covered Services. Such program(s) are set forth in the Plan's Provider Manual.
- 1.56 Vision Care. Routine basic eye examinations, lenses and frames provided every 24 months.

SECTION 2 QUALIFICATIONS, OBLIGATIONS AND COVENANTS

- 2.1 PROVIDER is responsible for:
 - 2.1.1 Standards of Care – Provide Covered Services for those complaints and disorders of Medi-Cal Members that are within the PROVIDER's professional competence and licensure, as applicable, with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.
 - 2.1.2 Licensure – Warrant that PROVIDER has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license, certification or registration in the State of California, as applicable, to provide the Covered Services rendered. Warrant that PROVIDER has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by Plan. Warrant that the PROVIDER has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in the Medi-Cal Program in accordance with the program Standards of Participation contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations.
 - 2.1.3 Covered Services – Provide the Medically Necessary Covered Services for those medical complaints and disorders that are within his/her professional competence and in accordance with Section 2.1.5 of this Agreement.
 - 2.1.4 Accessibility and Hours of Service – Providing Covered Services to Medi-Cal Members on a readily available and accessible basis in accordance with Plan policies and procedures as set forth in the Plan Provider Manual during normal business hours at PROVIDER's usual place of business
 - 2.1.5 Referrals – Unless otherwise agreed to by Plan, and except for Emergency Services and Urgent Care Services, PROVIDER shall provide Covered Services to Medi-Cal Members, only upon receipt of an appropriate referral to provide such services from Medi-Cal Member's Primary Care Physician, Plan, or such other treatment authorization as described in the Plan Provider Manual.

- 2.1.6 Case Management – Cooperate with Medi-Cal Member’s Referring Physician and Plan in the monitoring, coordination, and case management of the Medi-Cal Member’s healthcare services. PROVIDER will promptly furnish a complete written report of the services rendered to a Medi-Cal Member to the Medi-Cal Member’s Referring Physician and, upon Plan’s request, to Plan, on such form as may be prescribed in the Plan Operations Manual.
- a. PROVIDER agrees to abide by the Case Management Protocols which are included in the Plan Operations Manual.
 - b. PROVIDER agrees to abide by the Plan Operations Manual policies and procedures, which may be amended from time to time with thirty (30) days notice to PROVIDER.
 - c. PROVIDER and any Attending Physician or Referral Physician to whom the Primary Care Physician has delegated the authority to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.
 - d. PROVIDER acknowledges that Plan’s Medical Director will assist in the management of Complex Cases. PROVIDER will fully cooperate with Plan’s Medical Director by providing information that may be required in the care of Complex Cases, including but not limited to, prompt notification of known or suspected Complex Cases.
- 2.1.7 Officers, Owners and Stockholders – Providing information regarding officers, owners and stockholders as set forth in Attachment A, attached to and incorporated herein.
- 2.1.8 Credentialing – Provide Plan with a completed credentialing form, accreditation, licensure and/or certification documents, as applicable, and will use best efforts to notify Plan in advance of any change in such information. PROVIDER will successfully complete a facility site review, if deemed necessary by Plan in accordance with DHCS Medi-Cal Agreement.
- 2.1.9 Actions Against PROVIDER – PROVIDER will adhere to the requirements as set forth in the Plan Operations Manual and notify Plan by certified mail within five (5) days of PROVIDER’s learning of any action taken which results in restrictions for a medical disciplinary cause or reason as defined in Division 3 Chapter 3 Article 3 Title 22, CCR, commencing with Sections 51000 et.seq. regardless of the duration of the restriction or exclusion from participating in the Medi-Cal Program.
- 2.1.10 Financial and Accounting Records – Maintain, in accordance with standard and generally accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Submit reports as required by Plan or DHCS.
- 2.1.11 Compliance with Member Handbook – PROVIDER acknowledges that PROVIDER is not authorized to make nor will PROVIDER make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.

- 2.1.12 Promotional Materials – PROVIDER will consent to be identified as a PROVIDER in written materials published by Plan, including without limitation, marketing materials prepared and distributed by Plan and display promotional materials provided by Plan within his/her office.
- 2.1.13 Facilities, Equipment and Personnel – Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement. PROVIDER agrees to provide at least 60 days notice to Plan prior to the opening of any new location and 90 days prior to the closing of any location.
- 2.1.14 PROVIDER shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Agreements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. PROVIDER shall also provide, as applicable, the “Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions” and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.
- 2.1.15 Compliance with Plan Policies and Procedures. PROVIDER agrees to comply with all policies and procedures set forth in the Plan Provider Manual. Plan may modify Provider Manual from time to time. In the event the provisions of the Provider Manual are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail. Plan will submit the Provider Manual to PROVIDER for its inspection prior to the effective date of this Agreement.
- 2.1.16 Cultural and Linguistic Services. PROVIDER shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. PROVIDER shall recognize and integrate Members’ practices and beliefs about disease causation and prevention into the provision of Covered Services. PROVIDER shall comply with Plan’s language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with Plan by providing any information necessary to assess compliance. Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. PROVIDER has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in Plan Provider Manual.
- 2.1.17 PROVIDER will verify Medi-Cal Member eligibility with Plan prior to rendering Covered Services. Prior Authorization from Plan or referral from a Primary Care Physician is not a guarantee of Medi-Cal Member eligibility with Plan or eligibility in the State Medi-Cal Program.
- a. Member eligibility is available via telephone or electronic media. Plan makes best efforts to update Medi-Cal eligibility daily from DHCS eligibility tapes.

- b. Plan will maintain (or arrange to have maintained) records and establish and adhere to procedures as will reasonably be required to accurately ascertain the number and identity of Medi-Cal Members.

2.2 Plan is responsible for:

2.2.1 Member Assignment – Assigning Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician.

- a. The Medi-Cal Member can select from the Primary Care Physicians contracting with Plan.
- b. The Medi-Cal Member will seek all medical services, except those outlined in Section 4 from their assigned Primary Care Physician or Referring Physician.
- c. If the Medi-Cal Member does not select a Primary Care Physician, Plan will assign Members to a Primary Care Physician in a systematic manner as the Plan deems appropriate and/or in accordance with Medi-Cal protocols.

2.2.2 Listing – Plan will enter the name of each contracted PROVIDER onto a list or provider directory from which Medi-Cal Members may choose to receive healthcare services. Such a list may contain the following information concerning the PROVIDER.

- a. Name
- b. Address(es) and telephone number(s)
- c. Office hours
- d. Scope of services (specialty or provider type)

2.2.3 Payment for Authorized Service Only – The Plan will reimburse PROVIDER for Covered Services that are authorized by the Plan Medical Director (or his/her Designee) or for Covered Services provided to an Administrative Member. Payment will be made based on required authorization and claim billing requirements as identified in the Plan Provider Manual.

SECTION 3 SCOPE OF SERVICES

3.1 Prior Authorization(s) – With the exception of Excluded Services described in Section 4 of this Agreement, a Referral Authorization Form (RAF) from a Referring Physician and prior authorization(s) from the Plan’s Medical Director or his/her designee is required before rendering Covered Services in accordance with Plan’s policies and procedures and Operations Manual to the extent permitted by the statewide Medi-Cal Program, including:

- 3.1.1 Ambulance (Medical Transportation) Services when Medically Necessary and in accordance with Title 22, CCR, Section 51323 and Plan Operations Manual policies and procedures. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.
- 3.1.2 Other necessary durable medical equipment rental, and medical supplies determined by Referring Physician to be Medically Necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member.

- 3.1.3 A Treatment Authorization Request (TAR) approved by Plan's Medical Director shall be obtained for Covered Services in accordance with Plan's policies and procedures as outlined in the Plan Provider Manual. All services and goods required or provided hereunder will be consistent with sound professional principles, community standards of care, and Medical Necessity.
- 3.2 Prescription Drugs – To the extent applicable, PROVIDER shall comply with the Plan drug formulary as approved by Plan policies and subject to the restrictions on the Plan's Drug Formulary regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals, in conformance with generally accepted medical and surgical practices and standards prevailing in the professional community.
- 3.2.1 If for medical reasons, the PROVIDER believes a generic equivalent should not be dispensed, the PROVIDER agrees to obtain prior authorization from the Plan Pharmacy Director.
- 3.2.2 PROVIDER acknowledges the authority of Plan's participating pharmacists to substitute generics for trade name drugs, as specified in Section 4073 of the California Business & Professions Code, and Title 22 CCR Section 51313 unless otherwise indicated.
- 3.2.3 The Plan Pharmacy and Therapeutic Committee is a professional advisory group of participating providers that meets quarterly and makes recommendations for changes to the drug formulary.
- 3.3 Non-Discrimination
- 3.3.1 Medi-Cal Members – PROVIDER will provide services to Medi-Cal Members in the same manner as such services are provided to other patients of PROVIDER, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Managed Care Program. Subject to the foregoing, PROVIDER will not subject Medi-Cal Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan, or filing a complaint as a Member of Plan, in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination will include but is not limited to: denying any Medi-Cal Member any Covered Service or availability of a Facility; providing to a Medi-Cal Member any Covered Service which is different, or is provided in a different manner or as a different time from that provided to other Medi-Cal Members under this Contract except where medically indicated; subjecting a Medi-Cal Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Medi-Cal Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered Services, treating a Medi-Cal Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national

origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.

3.3.2 For the purpose 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 affects on the carrier. Such genes include, but are not limited to, Tay-Sach trait, sickle-cell trait, Thallassemia trait, and X-linked hemophilia.

3.3.3 General Compliance. Pursuant to the requirements of this Section of the Medi-Cal Agreement, the PROVIDER will not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of Plan, or filing a complaint as a Member of Plan, and denial of family care leave. PROVIDER will ensure the evaluation and treatment of PROVIDER's employees and applicants for employment are free from discrimination and harassment. PROVIDER will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et.seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4, Chapter 5 are incorporated into this Agreement by reference and made a part hereof as set forth in full. PROVIDER will give notice of his/her obligations under this Section to labor organizations with which he/she has a collective bargaining or other agreement. PROVIDER shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.

3.4 Quality Improvement and Utilization Management Programs – PROVIDER agrees to cooperate and to participate in Plan's Quality Improvement and Utilization Management Programs including credentialing and recredentialing, peer review and any other activities required by Plan, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. In addition, the PROVIDER will participate in the development of, and implement, corrective action plans for any areas that fall below Plan standards and ensuring medical records are readily available to the Plan staff as requested.

a. PROVIDER recognizes the possibility that Plan, through the utilization management and quality assurance process, may be required to take action requiring consultation with its Medical Director or with other physicians prior to authorization of services or supplies or to terminate this Agreement.

b. In the interest of program integrity or the welfare of Medi-Cal Members, Plan may from time to time introduce additional utilization controls as may be necessary as determined by Plan.

c. In the event of such change, a thirty (30) day notice will be given to the PROVIDER. PROVIDER will be entitled to appeal such action to the appropriate Reviewing Committee whose determinations shall be final.

- 3.5 Interpreter Services – Arrange interpreter services as necessary for Members at all facilities at Plan expense.
- 3.6 Nothing expressed or implied herein shall require the PROVIDER to provide to or order on behalf of the Medi-Cal Member, Covered Services which, in the professional opinion of the Primary Care Physician or PROVIDER, are not Medically Necessary for the treatment of the Medi-Cal Member’s disease or disability.

SECTION 4
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

- 4.1 Exclusions. Members in need of services, which are not Covered Services, as described in the Member Handbook, will not be reimbursed by the Plan. The PROVIDER will not bill and expect reimbursement by the Plan for the following excluded services provided to Medi-Cal Members:
- 4.2 Services Neither Covered nor Compensated. Subject to any additional exclusions from Covered Services as set forth in the Medi-Cal Agreement, PROVIDER understands that PROVIDER will not be obligated to provide Medi-Cal Members with, and the Plan will not be obligated to reimburse PROVIDER for, the following Excluded Services pursuant to this Agreement (services for which Plan does not receive capitation payment from the DHCS.)
- (a) Dental Services, as defined in Title 22 CCR Section 51307 and Early Periodic Screening Diagnosis and Treatment supplement dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;
 - (b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.
 - (c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted: (i) outpatient mental health services within the PROVIDER’s scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member’s mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.
 - (d) California Children’s Services (“CCS”) are not covered in Ventura County as set forth in the State Medi-Cal Contract.

- (e) Services rendered in a State or Federal governmental hospital;
- (f) Laboratory services provided under the State serum alpha-fetoprotein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;
- (g) Fabrication of optical lenses;
- (h) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;
- (i) Direct Observed Therapy for tuberculosis;
- (j) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;
- (k) Childhood lead poisoning case management services provided by the Local Health Department;
- (l) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the State Medi-Cal Contract; and
- (m) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 United States Code (“USC”) Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.
- (n) Other services as may be determined by the DHCS and the Plan, and as noticed to PROVIDER. In the event of such a change, a thirty (30) day notice will be given to the PROVIDER.

4.3 Restricted Services/Special Reimbursement.

4.3.1 PROVIDER will ensure that services provided to Medi-Cal Members will be in conformance with the limitations and procedures listed in the Medi-Cal Provider Manual and the Plan Operations Manual unless PROVIDER is notified of the modification to that policy by DHCS or Plan.

- a. Prior authorization for restricted and/or limited service will be provided only through the Medical Director of Plan or his/her designee.
- b. The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization which are subject to the limitations specified therein.

4.3.2 Primary Care Physician Referral or prior authorization from Plan is not required for reimbursement by Plan to providers of the following services:

- a. The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.
- b. Family Planning Services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 Code of Federal Regulations Section 441.20. Family Planning services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.

- 4.3.3 Primary Care Physician referral is not required for beneficiaries designated as Administrative Members.
- 4.3.4 California Children's Services (CCS) must be authorized by the Ventura County CCS Program.
- 4.3.5 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program.

**SECTION 5
PAYMENTS AND CLAIMS PROCESSING**

- 5.1 Payment – Plan will reimburse PROVIDER for Covered Services provided which have been authorized by the Plan in accordance with Plan policies and procedures and upon submission of a complete CMS-1500 or UB-04 claim form along with evidence of prior authorization, if required, submission of complete data through electronic transfer, as described in Section 5.3 herein. The following conditions must be met in addition to the above requirements for reimbursement of Covered Services:
 - 5.1.1 The Medi-Cal Member is eligible for Program benefits with Plan at the time the Covered Service is rendered by PROVIDER on the first day of the month for which Plan receives capitation based on the most current enrollment information from DHCS.
 - 5.1.2 The service is a Covered Service under the State Medi-Cal Program according to DHCS contract with Plan, Plan Operations Manual and policies and procedures, and State and federal regulations in effect at that time.
 - 5.1.3 All CMS-1500 or UB-04 claim forms and/or encounter data should be submitted to the Plan within six (6) months of the date the service was provided.
 - 5.1.4 A summary report will accompany each check identifying those Medi-Cal Members who received Covered Services from PROVIDER and the appropriate amount of reimbursement.
- 5.2 Entire Payment – PROVIDER will accept from Plan compensation as payment in full and discharge of Plan's financial liability. Covered Services provided to Medi-Cal Members by PROVIDER will be reimbursed as set forth in this Agreement and in accordance with Plan's Operations Manual and policies and procedures. PROVIDER will look only to Plan for such compensation. Plan has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to Plan are reduced by DHCS.
 - 5.2.1 Fee-For-Service (FFS) – The Plan will reimburse the PROVIDER at the prevailing State of California Medi-Cal Fee-for Service Rates in accordance with Attachment C to this Agreement for all properly documented Medi-Cal Covered Services provided to:
 - a. Plan enrolled Medi-Cal Members that present with prior authorized Covered Services, which have been properly authorized in accordance with Plan Operations Manual if services being provided require prior authorization.
- 5.3 Claim Submission – The PROVIDER will obtain, complete, and submit CMS-1500 or UB-04

claim forms, or submit through electronic transfer, claims for all services rendered to Medi-Cal Members including capitated services as described in the Plan Operations Manual.

- 5.3.1 Upon submission of a complete and uncontested clean claim payment will be reimbursed within thirty (30) days after receipt by Plan. An uncontested clean claim will include all information needed to process the claim.
- 5.3.2 CMS-1500 or UB-04 forms or electronic transfer are to be used for the submission to the Plan of encounter data as documentation of Covered Services provided to Medi-Cal Members by the PROVIDER. All forms submitted should contain the data elements as outlined in the Plan Operations Manual.
- 5.4 Medi-Cal Member Billing – PROVIDER will not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal Member, unless authorized share of cost, or from other persons on behalf of the Medi-Cal Member, for any service included in the Medi-Cal program's Covered Services in addition to a claim submitted to the Plan for that service.
- 5.5 Coordination of Benefits – Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. PROVIDER must bill the Other Health Coverage (primary) carrier before billing Plan for reimbursement of Covered Services, and, with the exception of authorized share of cost payments, will at no time seek compensation from Medi-Cal Members or the DHCS. The PROVIDER may look to the Member for non-covered services.
 - 5.5.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the Plan Operations Manual.
 - 5.5.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the Medi-Cal Agreement with Plan.
 - 5.5.3 PROVIDER will report to Plan the discovery of third party insurance coverage for a Medi-Cal Member within ten (10) days of discovery.
 - 5.5.4 PROVIDER will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the PROVIDER, but will be reported to the Plan on the CMS-1500 or UB-04 encounter claim form or electronic transfer tape.
- 5.6 Third Party Liability – In the event that PROVIDER renders services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by PROVIDER pursuant to the terms of this Agreement.
 - 5.6.1 PROVIDER will cooperate with the DHCS and Plan in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.
 - 5.6.2 PROVIDER will report to Plan the discovery of third party tort action for a Medi-Cal Member within ten (10) days of discovery.
- 5.7 Subcontracts.

- 5.7.1 All subcontracts between PROVIDER and PROVIDER's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Agreement, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.
- 5.7.2 All subcontracts and their amendments will become effective only upon written approval by Plan and DHCS, if required, and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the PROVIDER. PROVIDER will notify DHCS and Plan when any subcontract is amended or terminates. PROVIDER will make available to Plan and Governmental Agencies, upon request, copies of all agreements between PROVIDER and Subcontractor(s) for the purpose of providing Covered Services.
- 5.7.3 All agreements between PROVIDER and any Subcontractor will require Subcontractor to comply with the following:
- a. Records and Records Inspection – Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least seven (7) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to PROVIDER and Plan all reports required by PROVIDER, Plan or DHCS, and timely gather, preserve and provide to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recovery for Litigation.
 - b. Surcharges – Subcontractor will not collect a Surcharge for Covered Services for a Medi-Cal Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Medi-Cal Member within fifteen (15) days of the occurrence and will notify Plan of the action taken. Upon notice of any Surcharge, Plan will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge.
 - c. Notification – Notify DHCS and Plan in the event the agreement with Subcontractor is amended or terminated. Notice will be given in the manner specified in Section 9.4 Notices.
 - d. Assignment – Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS and Plan.
 - e. Additional Requirements – Be bound by the provisions of Section 8.7, Survival of Obligations after Termination, and Sections 7.5 and 7.6, PROVIDER and Plan Indemnification.
 - f. Domestic Partners – Any subcontracting health facility, licensed in accordance with California Health & Safety Code Section 1250 will ensure that Medi-Cal Members are permitted to be visited by the Medi-Cal Member's domestic partner, the children of the Medi-Cal Member's domestic partner, and the domestic partner of the Medi-Cal Member's parent or child.

SECTION 6 MEDICAL RECORDS

- 6.1 Medical Record – PROVIDER shall ensure that a medical record will be established and maintained for each Medi-Cal Member who has received Covered Services. Each Medi-Cal Member’s medical record will be established upon the first visit to PROVIDER. The record will contain information normally included in accordance with generally accepted practices and standards prevailing in the professional community.
- 6.1.1 PROVIDER will facilitate the sharing of medical information with other PROVIDERS in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.
- 6.1.2 PROVIDER will ensure records are available to authorized Plan personnel in order for Plan to conduct its Quality Improvement and Utilization Management Programs.
- 6.1.3 PROVIDER will ensure that medical records are legible.
- 6.1.4 PROVIDER will maintain such records for at least seven (7) years from the close of the State's fiscal year in which this Agreement was in effect.
- 6.2 Records and Records Inspection Rights.
- 6.2.1 Access to Records – PROVIDER will permit Plan’s Medical Director, or officers or their designees, any agency having jurisdiction over Plan, including and without limitation the Governmental Agencies, to inspect the premises, records and equipment of PROVIDER and review all operational phases of the medical services provided to Medi-Cal Members.
- a. PROVIDER will make all of PROVIDER’s books and records, and papers (“Records”) relating to the provision of, pertaining to the goods and services to Medi-Cal Members, to the cost of such goods and services, and to payments received by PROVIDER from Medi-Cal Members or from others on their behalf, available for inspection, examination and copying by Plan and all other state and federal agencies with jurisdiction over Plan or this Agreement, including without limitation, Governmental Agencies, at all reasonable times at PROVIDER’s place of business or at such other mutually agreeable location in California.
- b. Plan will pay for the cost of copying Records, not to exceed \$0.10 per page. The ownership of Records will be controlled by applicable law and this Agreement.
- c. PROVIDER shall permit Plan, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review PROVIDER’s work performed or being performed hereunder, PROVIDER’s locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy records and any other books, accounts and materials relevant to the provisions of Covered Services under this Agreement. PROVIDER will provide all reasonable facilities, cooperation and assistance during such inspection and reviews, including for the safety and convenience of the authorized representatives in the performance of

their duties. PROVIDER shall allow such inspections and reviews for the Records retention time of seven years. The State reserves the right to conduct unannounced validation reviews to verify compliance with State and federal regulations and contract requirements.

6.2.2 Maintenance of Records – PROVIDER will maintain records in accordance with the general standards applicable to such book and record keeping and in accordance with applicable law, and Plan directives.

- a. Records will include all encounter data, working papers, reports submitted to Plan, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Medi-Cal Members for a period of at least seven (7) years.
- b. PROVIDER will retain all Records for a period of at least seven (7) years from the close of the State Department of Health Care Services' fiscal year in which this Agreement was in effect.
- c. PROVIDER's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.
- d. The PROVIDER will not charge the Medi-Cal Member for the copying and forwarding of their medical records to another PROVIDER.

6.3 Disclosure to Government Officials. PROVIDER shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, PROVIDER shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Healthcare Effectiveness Data Information Set (“HEDIS”) auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the County of Ventura Human Services Agency, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Quality Improvement Organizations (“QIOs”), their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, “Government Officials”) as may be necessary for compliance by Plan with the provisions of all state and federal laws and contractual requirements governing Plan, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at PROVIDER's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. PROVIDER shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by PROVIDER related to this Agreement.

6.4 Patient Confidentiality.

- a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42 CFR, Section 431.300 et. seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted thereunder.
- b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Beneficiaries will be protected by the PROVIDER and his/her staff from unauthorized disclosure.
- c. PROVIDER may release Medical Records in accordance with applicable law pertaining to the release of this type of information.
- d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the PROVIDER, the PROVIDER (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the Plan all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than Plan, the federal government including the Department of Health and Human Services and Comptroller General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities the COHS program and contracts, without 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 thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the Plan or maintain such information according to written procedures sent the Plan by the Department of Health Care Services for this purpose.

SECTION 7 INSURANCE AND INDEMNIFICATION

- 7.1 Insurance – Throughout the term of this Agreement and any extension thereto, PROVIDER will maintain appropriate insurance programs or policies as follows:
- 7.1.1 PROVIDER will carry, at its sole expense, liability insurance in the amounts of at least Five Hundred Thousand Dollars (\$500,000) per person per occurrence in aggregate, including “tail coverage” in the same amounts whenever claims made malpractice is involved. Notification of Plan by PROVIDER of cancellation or material modification of the insurance coverage or the risk protection program will be made to Plan at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to Plan upon execution of this Agreement.
- 7.2 Other Insurance Coverage. In addition to Section 7.1.1 above, PROVIDER will also maintain, at its sole expense, a policy or program of general liability insurance with minimum coverage including no less than One Hundred Thousand Dollars (\$100,000) per person for the protection of the interest and property of PROVIDER’s property together with a Combined Single Limit Body Injury Liability and Property Damage Insurance of not less than One Hundred Thousand Dollars (\$100,000) for its members and employees, Plan Members, Plan and third parties, namely,

personal injury on or about the premises of the PROVIDER, and general liability. Documents evidencing such coverage will be provided to Plan upon request. PROVIDER will arrange with the insurance carrier to have automatic notification of insurance coverage termination or modification given to Plan.

- 7.3 Workers' Compensation. PROVIDER's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to Plan upon request.
- 7.4 Plan Insurance – Plan, at its sole cost and expense, will procure and maintain a professional liability policy to insure Plan and its agents and employees, acting within the scope of their duties, in connection with the performance of Plan's responsibilities under this Agreement.
- 7.5 PROVIDER Indemnification – PROVIDER shall indemnify and hold harmless Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of PROVIDER and its officers, directors, shareholders agents, employees and Subcontractors acting alone or in collusion with others. PROVIDER also agrees to hold harmless both the State and Members in the event that Plan cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.
- 7.6 Plan Indemnification – Plan shall indemnify, defend and hold harmless PROVIDER its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of Plan and its officers, directors, shareholders agents, employees and subcontractors (other than PROVIDER). The terms of this section shall survive the termination of this Agreement.

SECTION 8 TERM, TERMINATION, AND AMENDMENT

- 8.1 Initial Term and Renewal – This Agreement will be effective as of the Effective Date and will automatically renew at the end of one year and annually thereafter unless terminated sooner as set forth below.
- 8.2 Termination Without Cause – Either party upon sixty (60) days prior written notice to the other party may terminate this Agreement without cause.
- 8.3 Immediate Termination for Cause by Plan – The Plan may terminate this Agreement immediately by written notice to PROVIDER upon the occurrence of any of the following events:
- 8.3.1 The suspension or revocation of PROVIDER's license or certification to provide the applicable Covered Services under this Agreement in the State of California; or the suspension, revocation or reduction in PROVIDER's clinical privileges at any hospital, if applicable; or suspension from the State Medi-Cal Program; or loss of malpractice insurance; or failure to meet Plan's recredentialing criteria.
- 8.3.2 PROVIDER's death or disability. As used in this Subsection, the term "disability" means

any condition which renders PROVIDER unable to carry out his/her responsibilities under this Agreement for more than forty-five (45) working days (whether or not consecutive) within any 12-month period.

- 8.3.3 If Plan determines, pursuant to procedures and standards adopted in its Utilization Management or Quality Improvement Programs, that PROVIDER has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of the Plan Operations Manual.
- 8.3.4 If Plan determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member.
- 8.3.5 If Plan determines that PROVIDER has filed a petition for bankruptcy or reorganization, insolvency, as defined by law or Plan determines that PROVIDER is unable to meet financial obligations as described in this Agreement; or the PROVIDER closes his/her office and no longer provides Medically Necessary Covered Services.
- 8.3.6 If PROVIDER breaches Article 9.10, Marketing Activity and Patient Solicitation.

An immediate termination for cause made by Plan pursuant to this Section 8.3 will not be subject to the cure provisions specified in Section 8.4 Termination for Cause with Cure Period.

- 8.4 Termination for Cause With Cure Period – In the event of a material breach by either party other than those material breaches set forth in Section 8.3, Immediate Termination for Cause by Plan above of this Agreement, the non-breaching party may terminate this Agreement upon twenty (20) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach during the twenty (20) day period, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.
- 8.5 Continuation of Services Following Termination – Should this Agreement be terminated, PROVIDER will, at Plan's option, continue to provide Covered Services to Medi-Cal Members who are under the care of PROVIDER at the time of termination until the services being rendered to the Medi-Cal Members by PROVIDER are completed, unless Plan has made appropriate provision for the assumption of such services by another physician and/or provider. PROVIDER will ensure an orderly transition of care for Medi-Cal Members, including but not limited to the transfer of Medi-Cal Member medical records. Payment by Plan for the continuation of services by PROVIDER after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to the PROVIDER of photocopying such records will be reimbursed by the Plan at a cost not to exceed \$.10 per page.
- 8.6 Medi-Cal Member Notification Upon Termination – Notwithstanding Section 8.3, Immediate Termination for Cause by Plan, upon the receipt of notice of termination by either Plan or PROVIDER, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, Plan at its option, may immediately inform Medi-Cal Members of such termination notice. Such Medi-Cal Members will be required to select another PROVIDER prior to the effective date of termination of this Agreement.

- 8.7 Survival of Obligations After Termination – Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of PROVIDER will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 8.5, Continuation of Services Following Termination; 2) Section 6.2, Records and Records Inspection; and, 3) Sections 7.5 and 7.6, PROVIDER and Plan Indemnification. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between PROVIDER and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. PROVIDER will assist Plan in the orderly transfer of Medi-Cal Members to the PROVIDER they choose or to whom they are referred. Furthermore, PROVIDER shall assist Plan in the transfer of care as set forth in the Provider Manual, in accordance with the Phaseout Requirements set forth in the Medi-Cal Contract.
- 8.8 Access to Medical Records Upon Termination – Upon termination of this Agreement and request by Plan, PROVIDER will allow the copying and transfer of medical records of each Medi-Cal Member to the Physician and/or PROVIDER assuming the Medi-Cal Member’s care at termination. Such copying of records will be at Plan’s expense if termination was not for cause. Plan will continue to have access to records in accordance with the terms hereof.
- 8.9 Termination or Expiration of Plan’s Medi-Cal Agreement – In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, PROVIDER will allow DHCS and Plan to copy medical records of all Medi-Cal Members, at DHCS’ expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, PROVIDER will assist DHCS in the orderly transfer of Medi-Cal Member’s medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the PROVIDER’s Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. Under no circumstances will a Medi-Cal Member be billed for this service.

SECTION 9 GENERAL PROVISIONS

- 9.1 Assignment – This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged, or hypothecated in any way by PROVIDER and will not be subject to execution, attachment or similar process, nor will the duties imposed on PROVIDER be set, contracted or delegated without the prior written approval of Plan and DHCS. Subcontractor’s agreements must state that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
- 9.2 Amendment – This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS, if required. This Agreement may be amended by the Plan upon thirty (30) days written notice to the PROVIDER.

- 9.2.1 If PROVIDER does not give written notice of termination within sixty (60) days, as authorized by Section 8.2, PROVIDER agrees that any such amendment by Plan will be a part of the Agreement.
- 9.2.2 Unless PROVIDER or DHCS notifies Plan that it does not accept such amendment, the amendment will become effective sixty (60) days after the date of Plan's notice of proposed amendment.
- 9.2.3 Amendments to the compensation, services or term provisions of this Agreement, will be forwarded to DHCS.
- 9.2.4 Notwithstanding the foregoing, Plan may amend this Agreement with prior written notice to PROVIDER in order to maintain compliance with State and Federal Law and the Medi-Cal Agreement. Such amendment shall be binding upon PROVIDER and shall not require the consent of PROVIDER.
- 9.3 Severability – If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.
- 9.4 Notices – All notices required or permitted to be given by this Agreement shall be in writing and may be delivered personally, by certified or registered U.S. Postal Service mail, return receipt requested, postage prepaid, or by U.S. Postal Service Express mail, Federal Express or other overnight courier that guarantees next day delivery, and shall be deemed sufficiently given if served in the manner specified in this Section. Notices shall be delivered or mailed to the parties at the addresses set forth beneath their respective names on the signature page of this Agreement. Each party may change its address by giving notice as provided in this Section. Notices given by certified or registered mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the U.S. Postal Service, Federal Express or overnight courier.
- 9.4.1 Plan will notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. The written notice will be mailed as first-class registered mail to:
- California State Department of Health Care Services,
Medi-Cal Managed Care Division
1501 Capitol Avenue, Suite 71.4001
MS 4407, P.O. Box 997413
Sacramento, CA 95899-7413
- 9.5 Entire Agreement – This Agreement, together with the Attachments and the Plan Operations Manual and policies and procedures, contains the entire agreement between Plan and PROVIDER relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

- 9.6 Headings – The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.
- 9.7 Governing Law – The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of Plan. Any provision required to be in this Agreement by law, regulation, or the Medi-Cal Agreement will bind Plan and PROVIDER whether or not provided in this Agreement.
- 9.8 Affirmative Statement, Treatment Alternatives. Practitioners may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.
- 9.9 Reporting Fraud and Abuse – PROVIDER is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR Section 455.2 where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by Plan contracted Physicians or PROVIDERS, within 10 days to Plan for investigation.
- 9.10 Marketing Activity and Patient Solicitation – PROVIDER will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of Plan and DHCS.
- 9.10.1 PROVIDER will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.
- 9.10.2 During the period of this Agreement and for a one year period after termination of this Agreement, PROVIDER and PROVIDER's employees, agents or Subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which PROVIDERS render contracted services to Plan Members.
- 9.10.3 In the event of breach of this Section 9.10, in addition to any other legal rights to which it may be entitled, Plan may at its sole discretion, immediately terminate this Agreement. This termination will not be subject to Section 8.4, Termination for Cause with Cure Period.
- 9.11 Nondisclosure and Confidentiality – PROVIDER will not disclose the payment provisions of this Agreement except as may be required by law.
- 9.12 Proprietary Information – With respect to any identifiable information concerning a Medi-Cal Member that is obtained by PROVIDER or its Subcontractors, PROVIDER and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to Plan all requests for disclosure of such information, except requests for medical records in accordance with applicable law; will not disclose any such information to any party other than DHCS without Plan's prior written authorization, except as specifically permitted by this Agreement or the Plan's Medi-Cal Agreement with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Agreement; and, will, at expiration or termination of this Agreement, return all such

information to Plan or maintain such information according to written procedures provided by Plan for this purpose.

- 9.13 Non-Exclusive Agreement – To the extent compatible with the provision of Covered Services to Medi-Cal Members for which PROVIDER accepts responsibility hereunder, PROVIDER reserves the right to provide professional services to persons who are not Medi-Cal Members including Eligible Beneficiaries. Nothing contained herein will prevent PROVIDER from participating in any other prepaid health care program.
- 9.14 Counterparts – This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.
- 9.15 HIPAA. PROVIDER and Plan each acknowledge that it is a “Covered Entity” as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services, as modified (the “HIPAA Privacy Rule”). Each party shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and Federal Laws governing the confidentiality of Members’ individually identifiable health information. If the PROVIDER identifies any inappropriate uses of or breach of the HIPAA Privacy Rule with respect to Plan or Members, the PROVIDER must notify Plan’s Privacy Officer immediately.

SECTION 10 GRIEVANCES AND APPEALS

- 10.1 Appeals and Grievances.
- 10.1.1 PROVIDER complaints, concerns, or differences, which may arise as a health care PROVIDER under contract with Plan will be resolved as outlined in this Section, Section 8, and the Plan Appeals and Grievance policies set forth in the Plan Operations Manual. PROVIDER and Plan agree to and will be bound by the decisions of Plan's grievance and appeal mechanisms.
- 10.1.2 PROVIDER will cooperate with Plan in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the Plan grievance procedure set forth in the Plan Provider Manual.
- 10.2 Responsibility – It is the responsibility of the Plan’s Chief Executive Officer for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system. The Chief Executive Officer will be assisted in this process by the Directors of Provider Relations and Health Services.
- 10.3 Dispute Resolution.
- 10.3.1 For disputes unresolved by the Plan provider appeals process, Plan and PROVIDER agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, PROVIDER shall be required to comply with the provisions of the Government Claims Act (Government Code Section 900, et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the

subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a “Dispute”).

- 10.3.2 Judicial Reference. At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the courts of general jurisdiction of the State of California located in Ventura County. The parties reserve the right to contest the referee’s decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee’s then respective prevailing rates of compensation.
- 10.3.3 Limitations. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code Section 900, et. seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.
- 10.3.4 Venue. Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Ventura, State of California.
- 10.4 Peer Review and Fair Hearing Process – Providers determined hereto to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to the Plan Peer Review Committee. The PROVIDER will be afforded an opportunity to address the Committee. The PROVIDER will be notified in writing of the Peer Review Committee's recommendation and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict, or terminate the PROVIDER’s affiliation, to institute a monitoring procedure, or to implement continuing educational requirements.
- 10.5 Credentialing – The Plan Credentialing Committee will review all PROVIDER files to determine whether a PROVIDER meets the Plan credentialing or recredentialing requirements or, as applicable, provider licensure and compliance with the State Medi-Cal Program Standards of Participation. If the Committee deems otherwise, the PROVIDER will be afforded an opportunity to address this Committee. The PROVIDER will be advised in writing of the Credentialing Committee's recommendation and notified of his/her rights to the Fair Hearing

process. The Credentialing Committee can recommend denial of a PROVIDER's initial application or can deny the recredentialing of a current PROVIDER.

SECTION 11 RELATIONSHIP OF PARTIES

- 11.1 Overview – None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent PROVIDER from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, PROVIDER will provide written assurance to Plan that any contract providing commitments to any other prepaid program will not prevent PROVIDER from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of Covered Services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.
- 11.2 Oversight Functions – Nothing contained in this Agreement will limit the right of Plan to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.
- 11.3 PROVIDER-Patient Relationship – This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her PROVIDER. PROVIDERS will be responsible for maintaining the professional relationship with Medi-Cal Members and are solely responsible to such Medi-Cal Members for all medical services provided. Plan will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of PROVIDER.

SECTION 12 ADDITIONAL LEGAL REQUIREMENTS

- 12.1 Compliance With Laws.
- 12.1.1 PROVIDER represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable local, State and federal laws and regulations as they become effective, including, but not limited to, those (i) regarding licensure and certification, (ii) necessary for participation in the Medicare and Medi-Cal programs, including the antifraud and abuse laws and regulations and the patient self-determination amendments of the Omnibus Budget Reconciliation Act of 1990, (iii) regarding advance directives 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, (iv) regulating the operations and safety of facilities, including but not limited to, Title 22 CCR Section 53230, (v) regarding federal and State Occupational Health and Safety Administration (OSHA) standards, (vi) regarding communicable disease and immunization reporting, (vii) regarding not allowing smoking within any portion of any indoor facility used for the provision of health services for children as specified in the U.S. Pro-Children Act of 1994 (20 United States Code Section 6081 and following), (viii) regarding the provision of

information to Members concerning Prostate Specific Antigen testing consistent with the standard set forth in California Business and Professions Code Section 2248, (ix) regarding provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations, and provisions of the California Confidentiality of Medical Information Act, (x) set forth in Public Contract Code Section 6108 relating to the Sweat-free Code of Conduct, and (xi) relating to copyright laws. Payment under this Agreement will not be used for the acquisition, operation or maintenance of computer software in violation of copyright laws.

- 12.1.2 As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are \$100,000 or more, PROVIDER certifies to the best of its knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of PROVIDER, 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 the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are \$100,000 or more, PROVIDER shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally 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 Agreement, PROVIDER shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions. PROVIDER shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by PROVIDER. PROVIDER shall require that the language of this certification be included in all subcontracts at all tiers which exceed \$100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.
- 12.1.3 PROVIDER 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 Medicaid programs, for the provision of any Services to Members, including but not limited to, health care services, utilization review, medical social work, or administrative services with respect to Members.
- 12.1.4 If PROVIDER uses economic profiling information related to any of its individual 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, PROVIDER, upon request, shall make available to Plan its policies and procedures related to economic profiling used by PROVIDER. The term "economic profiling" as used in this Section 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 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.
- 12.1.5 PROVIDER shall immediately notify Plan of (i) investigations of PROVIDER in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there

is reason to believe that an incident of fraud, waste or abuse has occurred. PROVIDER shall comply with Plan's antifraud plan, including its policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. PROVIDER 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).

12.1.6 If required by Health and Safety Code Section 1375.4, (1) PROVIDER shall meet the financial requirements that assist Plan in maintaining the financial viability of arrangements for the provision of Covered Services in a manner that does not adversely affect the integrity of the contract negotiation process, (2) PROVIDER shall abide by Plan's process for corrective action plans if there is a deficiency, and (3) Plan shall disclose information to PROVIDER that enables PROVIDER to be informed regarding the financial risk assumed under this Agreement. In cases where the Solvency Regulations apply (28 CCR Sections 1300.75.4 through 1300.75.4.8), Plan and PROVIDER shall meet the requirements set forth in such Regulations. Members may request general information from Plan or PROVIDER about any bonuses or incentives paid by Plan, if applicable.

12.1.7 PROVIDER shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations. If applicable, PROVIDER shall submit financial information consistent with the filing requirements of DMHC unless otherwise specified by DHCS. If PROVIDER is required to file monthly financial statements with DMHC, then PROVIDER shall simultaneously file monthly financial statements with DHCS. In addition, PROVIDER shall file monthly financial statements with DHCS upon request.

12.1.8 If payments under this Agreement are in excess of \$100,000, PROVIDER shall comply with the following provisions unless this Agreement is exempt under 40 CFR Part 30. (i) PROVIDER shall comply with all applicable standards, orders or requirements issued under section 306 of the Clean Air Act (42 USC Section 1857 (h)), section 508 of the Clean Water Act (33 USC Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR Part 15). (ii) PROVIDER shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC Section 1251 et seq.), as amended.

12.2 Federal Equal Opportunity Requirements.

(a) PROVIDER will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. PROVIDER will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or

mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship.

- (b) PROVIDER shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor. Such notices shall state PROVIDER's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- (c) PROVIDER 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 PROVIDER's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- (d) PROVIDER will comply with and furnish all information and reports required by items described above in items (a) through (c) above 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.
- (e) In the event of PROVIDER's noncompliance with the requirements of this Section 12.2, which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement 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 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.

- (f) PROVIDER will include the provisions of subparagraphs (a) through (e) in every subcontract 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 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 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. PROVIDER will take such action with respect to any subcontract 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 PROVIDER becomes involved in, or is threatened with litigation by any subcontractor as a result of such direction by DHCS, PROVIDER 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.

ATTACHMENT A
DISCLOSURE FORM (Welfare and Institutions Code Section 14452)

TAX I.D. # _____

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:

Form of PROVIDER (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

If a proprietorship, Co-Owner(s). If a partnership, partners.

If a corporation, stockholders owning more than ten percent (10%) of the stock of the PROVIDER

If a corporation, President, Secretary, Treasurer, Directors and Other Officers:

Stockholders owning more than ten percent (10%) of the stock of the PROVIDER:

Major creditors holding more than five (5) percent of PROVIDER debt:

If not already disclosed above, is PROVIDER, or a co-owner, partner, stockholder, director or officer either directly or indirectly related to or affiliated with Plan? Please explain:

Dated: _____

Signature: _____

Name: _____

(Please type or print)

Title: _____

(Please type or print)

**ATTACHMENT B
FACILITY LOCATIONS**

Please list for Ventura County only the PROVIDER name, location(s) and hours of operation, mid-level practitioners supervised and languages spoken that shall apply to this Agreement.

ATTACHMENT C

ANCILLARY HEALTH CARE PROVIDER SERVICES AND RATES

The following rates shall apply to ANCILLARY PROVIDER services rendered for Covered Services to eligible Plan Members.

PROVIDER Services for Covered Members: [Provide narrative description or list of CPT-4 codes]

Rate: Prevailing Medi-Cal fee-for-service rates as determined by the California Department of Health Care Services