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

**(dba GOLD COAST HEALTH PLAN)**

**NON-EMERGENCY TRANSPORTATION AND NON-MEDICAL TRANSPORTATION SERVICES AGREEMENT**

This Non-Emergency Transportation and Non-Medical Transportation Services Agreement (this “Agreement”) is made effective as of the \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2018 (the “Effective Date”), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, a public entity doing business as Gold Coast Health Plan (“Health Plan”), and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print) (“Provider”), a Medical Transportation services provider.

EFFECTIVE DATE of Agreement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
| **Provider:** |  | **Plan:** |
|  |  | VENTURA COUNTY MEDI-CAL  MANAGED CARE COMMISSION |
| *(List Provider Name Above)* |  | *Executed by:* |
| Signature |  | Signature |
|  |  |  |
| Printed Name |  | Printed Name |
|  |  |  |
| Title |  | Title |
|  |  |  |
| Date |  | Date |
|  |  |  |
| Address for Notices: |  | Address for Notices:  Gold Coast Health Plan |
|  |  | 711 E. Daily Drive, Suite 106  Camarillo, CA 93010-6082  Attn: Director Network Operations |

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION   
(dba GOLD COAST HEALTH PLAN)  
NON-EMERGENCY TRANSPORTATION AND NON-MEDICAL TRANSPORTATION SERVICES AGREEMENT

RECITALS

1. Health Plan is a County Organized Health System established pursuant to Welfare & Institutions Code Section 14087.54.
2. Health Plan entered into contracts with the State of California, Department of Health Care Services (“DHCS”) in accordance with the requirements of California Welfare & Institutions Code, Section 14200 et seq.; Title 22, California Code of Regulations, Section 53000 et seq.; and applicable federal and State laws and regulations, under which Ventura County Medi-Cal beneficiaries assigned to Health Plan as Members will receive Medi-Cal services (the “Medi-Cal Agreements”).
3. Health Plan arranges for the provision of health care services, including non-emergency medical transportation and non-medical transportation, to members assigned to Health Plan under the terms of the Medi-Cal Agreements by contracting with other health plans, hospitals, physicians, and other health care providers.
4. Health Plan has released a Request for Proposal (“RFP”) entitled Request for Proposal Number GCHP072718, to which Provider has responded;
5. Provider is eligible to participate in and certified to provide health care services under the California Medi-Cal Program and meets applicable requirements under Titles XVIII and XIX of the Social Security Act.
6. Provider desires to provide non-emergency medical transportation and non-medical transportation services to Plan’s eligible Members in connection with Health Plan’s contractual obligations under the terms of the Medi-Cal Agreements and has submitted a response to the RFP in the form of a proposal dated \_\_\_\_\_\_\_\_\_\_\_, 2018, and entitled “\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_” (“Proposal”), incorporated herein by this reference;
   1. **ARTICLE ONE - DEFINITIONS**
      1. “Covered Services” means those health care services within the normal scope of practice and licensure of Provider as described in Attachment A-1, Scope of Work, Non-Emergency Medical Transportation, and A-2, Non-Medical Transportation (collectively “SOW”) attached hereto and incorporated herein.
      2. Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B, Definitions, attached hereto and incorporated herein.
   2. **ARTICLE TWO - PROVIDER OBLIGATIONS**
      1. **Serving as a Panel Provider.** Provider shall serve on Health Plan’s panel of providers. Provider agrees that its practice information may be used in Health Plan’s provider directories, promotional materials, advertising and other informational material made available to the public and Members. Provider’s practice information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, and ability to accept new patients. Provider shall promptly notify Health Plan of any changes in this practice information.
      2. **Standards for Provision of Care.** 
         1. **Provision of Covered Services.** Provider shall provide and cause its subcontractors to provide Covered Services to Members, within the scope of Provider’s business and practice, in accordance with this Agreement, including Attachment A-1 and A-2, Health Plan’s policies and procedures, the terms and conditions of the Health Plan product which covers the Member, federal and State laws, and the requirements of any applicable government sponsored program, including, but not limited to, the Medi-Cal Agreement and any subsequent amendments.
         2. **Standard of Care.** Provider shall provide and cause its subcontractors to provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.
         3. **Facilities, Equipment, and Personnel.** Provider shall maintain and cause its subcontractors to maintain facilities, equipment, transportation vehicles, personnel, and administrative services at a level and quality as necessary to perform Provider’s duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements and the reasonable accommodation requirements (which includes reasonable accommodations for “service animals”, such as guide dogs, signal dogs, sensory signal dogs, seizure response dogs, and psychiatric service dogs) of the Americans with Disabilities Act. In addition, Provider shall permit Health Plan and its representatives reasonable access to such facilities and vehicles for onsite inspections and credentialing purposes. Provider agrees to provide at least a sixty (60)-day-notice to Health Plan prior to the opening of any new location and ninety (90)-day-notice to Health Plan prior to the closing of any location.
         4. **Prior Authorization**. Provider shall obtain the prior authorization of Health Plan for NEMT in accordance with Health Plan’s Provider Manual prior to rending Covered Services to Members. NMT services shall be authorized every twelve (12) months as set forth in Attachment A-2. Upon and following such prior authorization, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care. Health Plan may, at Health Plan’s option, deny payment for Covered Services rendered that were not prior authorized, if such prior authorization is required by Health Plan. In addition to any other right or remedy under this Agreement, Health Plan may, at Health Plan’s option, deny payment for Covered Services rendered that were not prior authorized, if required, by Health Plan, or retain from any amount owed to Provider an amount equal to the amount of money paid by Health Plan to the party or provider rendering non-Plan authorized referral services to Members.
         5. **Referrals.** Unless otherwise agreed to by Health Plan or set forth in Attachment A-2, Provider shall provide Covered Services to Members only upon receipt of an appropriate referral to provide such services from Medi-Cal Member’s Primary Care Physician or Health Plan, or upon receipt of such other service authorization as described in the Provider Manual.
         6. **Member Eligibility Verification.** Provider shall verify eligibility of Members prior to rendering services. Prior authorization from Health Plan or referral from a Primary Care Physician is not a guarantee of Member eligibility with Health Plan or eligibility in the Medi-Cal program.
         7. **Emergency Room Referral**. If Provider refers a Member to an emergency room, Provider shall provide notification to Health Plan within twenty-four (24) hours of the referral.
         8. **Non-Emergency Room Referral**. Provider has no authority to refer Members to other providers for any services except Emergency Services. Members should be directed to contact Health Plan or Member’s Primary Care Physician for services other than Covered Services and Emergency Services.
         9. **Availability of Services.** Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services, any Member need for Urgent Care Services and 24-hour pharmacy.
      3. **Subcontract Arrangements.**
         1. **Written Health Plan Approval.** Provider will not utilize the services of any subcontractors in providing the Covered Services required hereunder without Health Plan’s prior written approval for each named subcontractor (which consent Health Plan may grant or withhold in Health Plan’s sole and absolute discretion).
         2. **Binding to Agreement.** Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider’s subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services. All references to Provider in this Agreement in the context of providing Covered Services, where applicable, will also include Provider’s approved subcontractors.
         3. **Immediate Removal.** Provider may require the immediate removal of any of Provider’s subcontractors from assignment under this Agreement if Health Plan is not satisfied with the subcontractor’s performance or if the subcontractor violates any terms or conditions under this Agreement.
         4. **Provider Responsibility.** Provider shall remain the prime contractor for the Covered Services and be responsible for the conduct and performance of each approved subcontractor as if Provider had performed all of the subcontracted Covered Services.
         5. **Copies of Subcontracts.** Upon request by either Health Plan or DHCS, Provider shall provide the requesting party with copies of all subcontracts and/or subcontract templates (together with any general variations to be used in terms and provisions of such standard forms) for the provision of Covered Services.
         6. **Subcontract Requirements.** Provider shall ensure that all subcontracts are in writing and require that the subcontractor:
            1. Makes all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Agreement, available at all reasonable times for audit, inspection, examination, or copying by the DHCS, the Centers for Medicare and Medicaid Services (“CMS”), the Department of Health and Human Services (“DHHS”), the Inspector General, the Comptroller General, the federal and State Department of Justice (“DOJ”), and the California Department of Managed Health Care (“DMHC”), or their designees
            2. Retains all records and documents for a term minimum of at least ten (10) years from the close of the final date of the Agreement period or from the date of completion of any audit, whichever is later.
         7. **Reports**. Provider shall submit all reports required by Health Plan and shall cooperate with Health Plan by collecting and sharing all data that Health Plan is required to report to government agencies (including any reporting requirements under its Medi-Cal contract with DHCS), accreditation entities, and other third parties.
         8. **Oversight and Monitoring.** Nothing contained in this Agreement shall limit the right of Health Plan to perform its oversight and monitoring responsibilities of Provider or its subcontractors, as required by applicable State and Federal law, programmatic requirements, or its contract with DHCS. Provider shall comply with all monitoring provisions of this Agreement, including any RFP or SOW, and any monitoring requests by DHCS or Health Plan.
            1. Authorized State and federal agencies shall have the right to monitor all aspects of the Provider’s operation for compliance with the provisions of this Agreement and applicable Federal and State laws and regulations. Such monitoring activities shall include, but are not limited to, inspection and auditing of Provider and subcontractor facilities, management systems and procedures, and books and records as deemed appropriate, at any time, pursuant to 42 C.F.R. 438.3(h). The monitoring activities shall be either announced or unannounced.
            2. To assure compliance with this Agreement and for any other reasonable purpose, the State and its authorized representatives and designees shall have the right to premises access, with or without notice to the Provider. This will include the Management Information System operations site or such other place where duties under the Agreement are being performed.
            3. Staff designated by authorized State agencies shall have access to all security areas and the Provider shall provide, and shall require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access shall be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).
         9. **Disclosures**. In accordance with 42 C.F.R. 438.608(c), Provider and any subcontractors shall:
            1. Provide written disclosure of any prohibited affiliation under 42 C.F.R. 438.610.
            2. Provide written disclosures of information on ownership and control as required under 42 C.F.R. 455.104.
            3. Report to DHCS within 60 calendar days when it has identified the Capitation Payments or other payments in excess of the amounts specified in this Agreement.
         10. **Conflicts of Interest**. Provider shall ensure that its personnel do not have conflicts of interest with respect to Health Plan and the Services. “Conflict of Interest” includes activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to Health Plan, or the person’s objectivity in performing the contract work is or may be impaired, or a person has an unfair competitive advantage.
         11. **Hold Harmless.** Provider acknowledges and agrees that it shall be solely responsible for paying subcontractor(s) for all Covered Services provided by its subcontractor(s), and to indemnify and hold harmless Health Plan, Members and DHCS for any mistake, failure, or breach of this Agreement committed by subcontractor(s).
         12. **Litigation Assistance.** Provider shall make itself and any subcontractors, employees, or agents assisting in the performance of its obligations under this Agreement available to Health Plan at no cost to Health Plan to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Health Plan, its directors, officers or employees based upon claimed violation of contract or laws. Provider shall timely gather, preserve, and provide to Health Plan any records in Provider’s possession related to threatened or pending litigation by or against DHCS or Health Plan related to this Agreement. Provider shall use all reasonable efforts to immediately notify Health Plan of any subpoenas, document production requests, or requests for records received by Provider or its subcontractors related to this Provider subcontracts entered into under this Agreements.
      4. **Transportation Drivers.**
         1. **Competent Drivers and Vehicles.** All Covered Services involving Transportation will be performed by competent drivers under the supervision of Provider. All Transportation drivers and vehicles must meet Health Plan’s Transportation Credentialing Requirements, Attachment E, attached hereto and incorporated herein.
         2. **Licensed Drivers.** Provider shall require all Transportation drivers to maintain at all times valid California licenses and permits to provide transportation to Health Plan’s Members.
         3. **Immediate Removal.** Provider may require the immediate removal of any Transportation driver from assignment under this Agreement if Health Plan is not satisfied with the driver’s performance or if the driver violates any terms or conditions under this Agreement.
         4. **Provider Responsibility.** Provider shall be responsible for the conduct and performance of each driver as if Provider had performed all of the Covered Services performed by the drivers. All references to Provider in this Agreement in the context of providing Covered Services, where applicable, will also include Transportation drivers.
      5. **Promotional Activities.**At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities and in Medical Transportation vehicles as practical, and (b) shall cooperate with and participate in all reasonable Health Plan’s marketing efforts. Provider shall not use Health Plan’s name in any advertising or promotional materials without the prior written permission of Health Plan.
      6. **Member Discrimination Prohibition.** Provider shall not discriminate against Members or Eligible Beneficiaries because of race, color, national origin, creed, ancestry, religion, ancestry, language, age, marital status, sex, sexual orientation, national origin, age, sex, or physical or mental handicap gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code Section 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Agreement, discriminations on the grounds of race, color, national origin, creed, ancestry, religion, ancestry language, age, marital status, sex, national origin, marital status, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code Section 422.56 or physical or mental handicap include, but are not limited to, the following:
         1. Denying any Member any Covered Service;
         2. Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Agreement except where medically indicated;
         3. Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;
         4. Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;
         5. The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, of the participants to be served.

Provider shall take affirmative action to ensure that Members are provided Covered Services without regard to of race, color, national origin,creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, except where medically indicated. For the purposes of this ¬§, 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 will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

* + - 1. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual’s ability to perform the duties of the particular job or position. Provider shall comply with the provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder.
    1. **Medical Record****s.**
       1. **Maintaining Member Medical Record.** Provider shall maintain and require its subcontractors to maintain a medical record for each Member to whom Provider renders Covered Services. Provider or Provider’s subcontractor shall open each Member’s medical record upon the Member’s first encounter with Provider or Provider’s subcontractor. The Member’s medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Such records shall be maintained in a current, detailed, organized, and comprehensive manner. Provider shall retain all such medical records for at least seven (7) years after rendering Covered Services and the records of a minor child shall be kept for a period of at least one (1) year after the minor has reached the age of eighteen (18) years, but in no event less than seven (7) years or such longer time period as may be required by law.
       2. **Confidentiality of Member Health Information.** Provider and each party with which Provider has, or will have, a contractual relationship to provide the Covered Services shall comply with all applicable state and federal laws, Health Plan’s policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members’ health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider’s obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.
       3. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan’s policies and procedures, applicable government sponsored health programs, Health Plan’s contracts with the government agencies, or third-party payers any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan’s Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.
       4. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members’ health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan’s policies and procedures.
    2. **Records and Audit.** Provider agrees to make all of its premises, facilities, equipment, books, records, documents, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement available for the purpose of an audit, inspection, evaluation, examination or copying at all reasonable times at the Provider’s place of business or at such other mutually agreeable location in California.
       1. **Books and Documents**. Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, encounter data and any other documentation pertaining to medical and non-medical services rendered to Members. These books and documents will disclose the quantity of Covered Services provided under this Agreement, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which the Provider administered its daily business, and the cost thereof.
       2. **Records Retention.** Provider shall maintain complete and accurate records to validate and document its (i) compliance with this Agreement, (ii) performance of the services, and (iii) charges for services, all in accordance with general standards applicable to such book or record keeping consistently applied. To the extent applicable, Provider shall also retain the following information: Member Grievance and Appeal records as required in 42 C.F.R. § 438.416; base data as defined in 42 C.F.R. § 438.5(c); Medical loss ratio reports as required in 42 C.F.R. § 438.8(k); and data, information, and documentation specified in 42 C.F.R. §§ 438.604, 606, 608, and 610. Notwithstanding any other records retention time period set forth in this Agreement, Provider and all of its Subcontractors shall maintain all of these records and documents for a minimum of ten (10) years from the final date of the Agreement term or from the date of completion of any audit, whichever is later.
       3. **Public Records.** Provider acknowledges that this Agreement, all information received in accordance with this Agreement, and all records created and maintained on behalf of Health Plan are governed by the California Public Records Act (Cal. Gov’t. Code §§ 6250 et seq.) and may be disclosed as public records except as specifically exempted in statute.
       4. **Audit and Inspection Rights**. Provider also agrees to the following:
          1. Through the end of the records retention period specified above, Provider shall allow authorized State and Federal agencies, including the DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, the DOJ, the Bureau of Medi Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS’ External Quality Review organization contractor to audit, inspect, monitor or otherwise evaluate (1) all aspects of the Provider’s operation for compliance with the provisions of this Agreement and applicable Federal and State laws and regulations; and (2) the quality, appropriateness, and timeliness of services performed under this Agreement, pursuant to 42 C.F.R. § 438.3(h). Provider shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives of State or federal agencies in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.
          2. To assure compliance with the Agreement and for any other reasonable purpose, authorized State and federal agencies and their designees shall have the right to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Provider and subcontractors pertaining to these services at any time during normal business hours. The monitoring activities will be either announced or unannounced. This will include any places where duties under the Agreement are being performed. Staff designated by authorized State agencies will have access to all security areas and Provider will provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider. The right to audit under this Section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.
          3. Provider shall, upon request from Health Plan, make available to Health Plan for audit and inspection all of its premises, facilities, equipment, books, and records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement.
          4. Upon request, through the end of the records retention period above, Provider shall furnish any record, or copy of it, to DHCS or any other entity listed in this ¬§, at Provider’s sole expense.
          5. If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a subcontractor at any time. . Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal program, seek recovery of payments made to Provider, impose other sanctions provided the Medi-Cal State Plan, and direct Health Plan to terminate this Agreement due to fraud.
       5. **Return of Documents.** Provider shall, upon request from Health Plan, make available to Health Plan for audit and inspection all of its premises, facilities, equipment, books, and records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement.
       6. **Survival.** The obligations as set forth in this Section shall survive any termination of this Agreement.
    3. **Program Participation.** 
       1. **Participation in Grievance Program.** Provider shall participate in Health Plan’s Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.
       2. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan’s Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.
       3. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan’s Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.
       4. **Participation in Credentialing.** Provider shall participate in Health Plan’s credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider’s credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or reassign Members to another provider. Provider shall accept delegation of credentialing responsibilities for Provider’s subcontractors at Health Plan’s request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider’s organization. If delegation of credentialing responsibilities to Provider is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider. Provider will successfully complete a facility site review by Health Plan, if deemed necessary by Health Plan in accordance with the Medi-Cal Agreement. Provider shall at all times comply with the credentialing requirements set forth in Attachment E.
       5. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan’s Provider Manual, which may be amended from time to time. Health Plan’s Provider Manual is incorporated in this Agreement by this reference.
       6. **Compliance with Plan Policies and Procedures.** Provider agrees to comply with all Health Plan policies and procedures, as may be modified from time to time by Health Plan in its sole discretion. In the event such Health Plan policies and procedures are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.
       7. **Compliance with DHCS Managed Care Program.** Provider agrees to comply with all applicable requirements established by DHCS and the Medi-Cal Managed Care Program.
       8. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan’s Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers and the State or Federal government. Provider shall ensure that Provider promptly delivers to Provider’s subcontracted providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.
       9. **Cultural and Linguistic Services.** Provider shall provide Covered 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 Health Plan’s language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 C.C.R. Section 1300.67.04 and shall cooperate with Health Plan by providing any information necessary to assess compliance. Health Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program.
       10. **Interpreter Services.** Provider shall have twenty-four (24) hour, seven (7) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in the Provider Manual. Provider shall arrange interpreter services as necessary for Members at all Provider facilities.
    4. **Licensure and Standing.** 
       1. **Licensure.** Provider shall maintain, and shall require its subcontractors to maintain, any licenses or certificates necessary, if any, to provide Covered Services, including but not limited to those required for the vehicle transport of Health Plan’s Members. Provider shall provide evidence of such licensure to Health Plan upon request. Provider and its subcontractors shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider’s licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.
       2. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs. Provider shall immediately notify Health Plan by certified mail if Provider’s unrestricted status under this subsection changes.
       3. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider’s financial soundness.
    5. **Liability Insurance.**
       1. **Coverage.** At its sole cost and expense, Provider shall at all times maintain in force and shall provide to Health Plan satisfactory evidence of insurance in the following amounts and coverages, with insurers satisfactory to Health Plan:
          1. General liability insurance in the minimum amount of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate. This policy shall (i) name as additional insured “VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, its officers, agents and employees”; (ii) provide that it is primary to any other insurance available to any additional insured, with respect to any claims arising out of this Agreement; and (iii) provide that it applies separately to each insured against whom claim is made or suit is brought. If there are sub-limits for Sexual Abuse and Molestation coverage, they must be listed on the certificate and must meet the minimum requirements above. If the policy is silent to Sexual Abuse and Molestation coverage, the certificate must state, “The General Liability policy contains no exclusions or sub-limits for Sexual Abuse or Molestation coverage”;
          2. Errors and omissions insurance/Professional liability insurance covering acts, errors, mistakes, omissions arising out of the Covered Services performed by Provider, or any subcontractor, driver, agent, or person employed by Provider each in the minimum amount of one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) annual aggregate;
          3. Umbrella/Excess liability insurance with a limit of liability not less than five million dollars ($5,000,000) each occurrence and annual aggregate;
          4. Workers’ Compensation maintained by Provider for the benefit of Health Plan with coverage in an amount required by applicable law (including, but not limited to, Section 3602(d) of the California Labor Code) with Employers’ Liability Limits but in no event, not less than one million dollars ($1,000,000) per incident;
          5. Automobile bodily injury and property damage liability insurance covering owned, non-owned, and hired automobiles or Medical Transportation vehicles, the limits of which shall not be less than one million dollars ($1,000,000) combined single limit per occurrence; and
          6. Privacy Liability and Network Security Insurance with coverage to include data breaches, security incidents, hacks, and ransomware attacks against Provider in amounts of no less than one million dollars ($1,000,000) per occurrence and five million dollars ($5,000,000) in the aggregate.
       2. **Subcontractor Coverage.** Provider shall require that its subcontractors and Medical Transportation drivers maintain, at their expense, automobile bodily injury and property damage liability insurance covering owned, non-owned, and hired automobiles or Medical Transportation vehicles, the limits of which shall not be less than one million ($1,000,000) combined single limit per occurrence.
       3. **Aggregate Limit.** If any policy includes an aggregate limit or provides that claims, investigation, or legal defense costs are included in such aggregate limit, the aggregate limit will be double the occurrence limits specified above.
       4. **Content.** Each liability policy described in Section 2.11 hereof will:
          1. Provide for at least thirty (30) days’ advance written notice to Health Plan of cancellation or material modification; and
          2. Be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best rating of A:VIII or better.
       5. **Length of Coverage.** Provider shall maintain such coverage set forth in this Section 2.11, without lapse, for a period of not less than two (2) years following termination of this Agreement; provided however if any policy is on a claims-made form, Provider shall maintain such coverage, without lapse, for a period of three (3) years after termination of this Agreement so that if any occurrence during the term of this Agreement gives rise to a claim made after such termination, such claim is covered.
       6. **Copies.** Provider shall promptly provide Health Plan with a certified copy of any required insurance policy within five (5) business days of a written request by Health Plan. Health Plan’s acceptance or approval of any insurance will not limit Provider’s liability under this Agreement.
       7. **Subrogation.** All insurance policies carried by Provider whether specified herein or otherwise shall contain endorsements waiving the insurer’s rights of subrogation against Health Plan.
       8. **Tail Coverage.** If the coverage is claims made or reporting, Provider agrees to purchase similar “tail” coverage upon termination of the Provider’s present or subsequent policy.
       9. **Claims.** Provider shall give Health Plan prompt written notice, but in no event later than fifteen (15) business days’ notice, of any claims against Provider’s coverage by or regarding a Health Plan Member.
       10. **Primary.** Any insurance provided by Provider or its subcontractors shall be primary to any coverage available to Health Plan. Any insurance or self-insurance maintained by Health Plan and its officials, officers, employees, agents or volunteers, shall be in excess of Provider’s insurance and shall not contribute with it.
       11. **No Limitation.** Procurement of insurance by Provider shall not be construed as a limitation of Provider’s liability or as full performance of Provider’s duties to indemnify, hold harmless and defend Health Plan under the terms of this Agreement.
    6. **Payment Requirements.** 
       1. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, deductibles and co-insurance, if any, provided for in the Member’s Health Plan product.
       2. **Recovery/Offset.** 
          1. In the event that Provider identifies an Overpayment, Provider shall report within sixty (60) calendar days of the date of identification of the Overpayment to Health Plan’s Compliance Officer at Gold Coast Health Plan, 711 E. Daily Drive, Suite #106 Camarillo, CA 93010-6082, Fax: (805) 437-5132, compliance@goldchp.org. The report shall include the amount of Overpayment identified and the reason for the Overpayment. Provider also shall make repayment to Health Plan within sixty (60) calendar days of the date of identification of the Overpayment.
          2. In the event that Health Plan determines that Provider has received an Overpayment, Health Plan shall notify Provider of the amount of Overpayment identified and the reason for the Overpayment. Such written notice shall identify the funds claimed to be overpaid with a reason as to why Health Plan believes such funds were overpaid. Provider shall make repayment of any undisputed Overpayment to Health Plan within sixty (60) calendar days of written notification from Health Plan.
          3. If Provider fails to make repayment of such Overpayments in accordance with subdivisions 1 and 2 above, then in addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider no less than thirty (30) calendar days’ notice. Health Plan may also offset or recoup amounts from current or future payment should DHCS, CMS or any other government agency demand, collect, recoup, or offset from Health Plan any amount of Overpayment attributable to Provider under the terms of this Agreement. As a material condition to Health Plan’sobligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.
       3. **Payments which are the Responsibility of a Subcontracted Plan.** Provider acknowledges that Health Plan maintains contracts with Subcontracted Plans which receive capitation from Health Plan for health care services and are responsible for arranging for Covered Services through subcontract arrangements. Provider agrees that if Provider is or becomes a party to a subcontract, agreement, or other arrangement with Subcontracted Plans pertaining to services under this Agreement, Provider shall accept payment under such subcontract, agreement, or other arrangement with such Subcontracted Plan as payment in full for Covered Services rendered to Members.
       4. **No Billing of Members**. Except as specifically provided for in this Section, Provider agrees to seek payment from only Health Plan, or a Subcontracted Plan if applicable pursuant to the terms of Section 2.12(c), for all Covered Services provided to a Member. In no event, including but not limited to, nonpayment by Health Plan or a Subcontracted Plan, insolvency by Health Plan or a Subcontracted Plan, or breach of the Agreement, shall Provider, or any person acting on Provider’s behalf, bill, charge, collect a deposit or surcharge from, seek compensation from, maintain an action in law, or have any other recourse against a Member, a person acting on the Member’s behalf, or a Government Agency for Covered Services provided pursuant to this Agreement. No co-payments, deductibles, or co-insurance obligations may be collected by a provider for any Medi-Cal Member. The Medi-Cal Program does not allow cost-sharing. Provider shall ensure that its subcontractors comply with this Section, including the following:
          1. Provider may seek payment from Member for services that are not Covered Services under the terms of this Agreement provided the payment is not for otherwise Covered Services which Health Plan determined not to be payable under the terms of this Agreement and provided the Member signs a written waiver that meets the following criteria:

(a) The waiver notifies the Member that the service is a non-Covered Service;

(b) The waiver notifies the Member of the service being provided and the date(s) of service;

(c) The waiver notifies the Member of the approximate cost of the service; and

(d) The waiver is signed by the Member prior to receipt of the service.

* + - * 1. If Provider erroneously bills a Member in violation of this provision, Provider will refund the amount of the charge to the Member within fifteen (15) days of the occurrence and will notify Health Plan of the action taken. Upon notice of such an erroneous billing by Provider, Health Plan may, at its sole discretion, repay the Member and deduct the amount of the expense incurred by Plan by way of offset against Provider’s future payments.
      1. **Survival.** This Section shall survive termination of this Agreement.
    1. **Financial Requirements.**
       1. **Compliance**. If required by California Health and Safety Code Section 1375.4, Provider shall meet the financial requirements in Section 1375.4, and Health Plan shall disclose information to Provider that enables Provider to be informed regarding the financial risk assumed under this Agreement. In cases where the Knox-Keene Act solvency regulations apply (28 C.C.R. §§ 1300.75.4 - 1300.75.4.8), Health Plan and Provider shall meet the requirements set forth in such regulations.
       2. **Financial Statements.** Provider shall prepare quarterly financial statements in accordance with Generally Accepted Accounting principles (“GAAP”). These quarterly financial statements shall be submitted to Health Plan no later than forty-five (45) calendar days after the close of each quarter. On an annual basis, Provider shall submit its financial statements, audited by an independent Certified Public Accounting Firm, to Plan within one hundred and fifty (150) calendar days after the close of the fiscal year. If applicable, Provider shall submit financial information consistent with the filing requirements of the Department of Managed Health Care (““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:.
          1. File monthly financial statements with DHCS upon request.
          2. Maintain at all times a positive Working Capital (current assets net of related party receivable less current liabilities).
          3. Maintain at all times a positive Tangible Net Equity as defined in Title 28, California Code of Regulations, Section 1300.76 (e).
          4. Maintain a “cash to claims ratio” of at least 0.75. Cash-to-claims ratio is Provider’s cash, readily available marketable securities and receivables, excluding all risk pool, risk-sharing, incentive payment programs and pay-for-performance receivables, reasonably anticipated to be collected within sixty (60) days divided by Provider’s unpaid claims liability. Unpaid claims liability is claims payable plus incurred but not reported claims (“IBNR”).
          5. Reimburse, contest, or deny at least ninety five percent (95%) of claims within contractual or regulatory timeframes.
          6. Estimate and document, on a monthly basis, Provider’s IBNR claims using an actuarial sound lag study as validated annually by external auditors.
       3. **Financial Resources and Solvency**. Provider must maintain adequate financial resources to meet its obligations as they become due. Provider shall be solvent at all times, and shall maintain the following minimum financial solvency standards:
       4. **Subcontractor Solvency**. Provider shall actively monitor its subcontractors to measure their financial stability. Copies of all reports, including findings, recommendations, corrective action plans, and other information regarding Provider’s monitoring of its subcontractors shall be provided to Health Plan within a reasonable time upon request.
       5. **Deficiency Reporting and Action**. Provider shall immediately notify Health Plan if Provider’s financial condition fails to meet the ratios or other standards set forth above. The notice to be provided hereunder shall be in writing, shall state the reason for the failure, and shall state the corrective action to be taken by Provider. If the proposed corrective action is unacceptable to the Health Plan, then Health Plan may terminate this Agreement immediately upon written notice to Provider or take such other action as may be reasonably required by Health Plan to ensure the continued provision of Covered Services to its Members, including, but not limited to, the withholding of capitation and de-delegation of functions in accordance with this Agreement.
    2. **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act. Provider acknowledges that all Covered Services are subject to the those laws applicable to the Medi-Cal program. Provider shall comply with the Medi-Cal Program Provisions, set forth in Attachment D, and all applicable provisions of the DHCS agreement with Health Plan. Provider further agrees to comply with any Health Plan policies and procedures that have been provided to Provider at least thirty (30) days in advance of implementation. Provider agrees to report any violation of law or Health Plan policies or procedures committed by Provider or its employees, agents, workforce members, or subcontractors in the performance of the Covered Services to Health Plan’s Ethics Hotline at (888) 866-1366 or Health Plan’s Ethics Officer at Health Plan’s address for Notices.
    3. **Provider Non-Solicitation Obligations.** Provider will not engage in any activities involving the direct marketing of Eligible Beneficiaries or Members without the approval of Health Plan and DHCS. Provider will not engage in direct solicitation of Eligible Beneficiaries for enrollment. Provider shall not unilaterally assign or transfer Members served under this Agreement to another provider without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. During the period of this Agreement and for a period of one (1) year after termination, Provider and Provider’s employees, agents, and subcontractors shall not solicit or attempt to persuade any Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which Provider rendered Covered Services to Member. In the event of breach of this Section 2.15, in addition to any other of Health Plan’s legal rights, Health Plan may at its sole discretion immediately terminate this Agreement. Nothing in this provision is intended to limit Provider’s ability to fully inform Members of all available health care treatment options or modalities.
    4. **Fraud and Abuse.** 
       1. **Reporting.** Provider shall report to Health Plan’s compliance officer all cases of suspected fraud, waste, and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within forty-eight (48) hours of the time when Provider first becomes aware of, or is on notice of, such activity. Provider shall immediately report to Health Plan any notices of investigations of Provider relating to fraud, waste, or abuse. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud, waste, and/or abuse in the provision of health care services under the Medi-Cal program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations. Provider shall comply with Health 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.
       2. **Compliance with State and Federal Fraud and Abuse Laws.** 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, the program integrity requirements of 42 C.F.R. Section 438.608, the Federal False Claims Act (31 U.S.C. § 3729 et seq.), Employee Education About False Claims Recovery (42 U.S.C. § 1396a(a)(68)), the California State False Claims Act (Cal. Gov’t Code § 12650 et seq.), and the anti-kickback statute (Social Security Act § 1128B(b).). Upon request by DHCS, Provider shall demonstrate compliance with this provision, which may include providing DHCS with copies of Provider’s applicable written policies and procedures and any relevant employee handbook excerpts.
       3. **Suspended, Excluded, or Ineligible Employees or Providers.** Provider shall comply with 42 C.F.R. Sections 438.608(a)(8) and 438.610. Additionally, Provider is prohibited from employing, contracting or maintaining a contract with persons or entities for the provision of services related to this Agreement that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. Provider shall notify Health Plan immediately upon discovery of employment or contract with a person or entity that is excluded, suspended, or terminated. A list of suspended and ineligible providers is updated monthly and available on line and in print at the DHCS Medi-Cal website (http://medi-cal.ca.gov). Lists of excluded individuals and entities are also available through the DHHS, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov), and the Federal System of Award Management (http://www.sam.gov). Provider is deemed to have knowledge of any persons or entities on these lists. Provider must notify Health Plan within ten (10) working days of removing a suspended, excluded, or terminated provider from its employment or subcontract and confirm that the individual or entity is no longer receiving payments in connection with the Medicaid program.
    5. **Federal Lobbying Certification.** 
       1. Provider shall comply with 31 U.S.C. § 1352, which prohibits the use of federal funds for lobbying. By signing this Agreement, the authorized agent executing this Agreement certifies that to the best of his or her knowledge and belief that:
          1. No federal appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person 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 this Agreement, federal grant, or cooperative agreement, and the extension continuations, renewal, amendment, or modification of this Agreement, grant, or cooperative agreement.
          2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Agreement, Provider shall complete and submit Standard Form L, “Disclosure of Lobbying Activities,” in accordance with its instructions.
       2. In the event the aggregate consideration under this Agreement is one hundred thousand dollars ($100,000) or more, then the language in this Section 2.17 shall be included in all subcontracts of Provider pertaining to this Agreement.
    6. **Drug Free Workplace.** Provider agrees to notify all persons who perform Covered Services under this Agreement of Health Plan’s policy concerning drug and alcohol use that prohibits (a) the use, possession, distribution, purchasing, or selling of drugs or alcohol on Health Plan’s premises or while engaged in Health Plan’s business and (b) reporting to and/or performing work for Health Plan while under the influence of same (except for authorized amounts of prescribed drugs required for health reasons).
    7. **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members’ health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider shall forward copies of the Member’s medical records to the new provider within ten (10) business days of receipt of the Health Plan’s or the Member’s request to transfer the records.
    8. **Responsibility for Deficiency Assessments.** Provider shall indemnify Health Plan against government agency assessed fines or penalties that result from acts or omissions of Provider, if (i) Health Plan has delivered to Provider a copy of the original notice of deficiency or noncompliance relating to such assessment within such reasonable period of time as is adequate for appropriate corrective action to be taken, and (ii) Provider has failed to perform or comply with the plan of correction developed and submitted by Plan in response to, and as required by, such government agency notice. Provider’s failure to perform or comply shall constitute a material breach of this Agreement.
  1. **ARTICLE THREE - HEALTH PLAN’S OBLIGATIONS**
     1. **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the Payment Schedule, set forth in Attachment C.
        1. **Funding:** Health Plan’s obligation to pay Provider is subject to Health Plan’s corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to Plan, as applicable. Health Plan will pay a capitation payment to Provider within forty-five (45) days following Health Plan’s receipt of its corresponding capitation payment from the DHCS, for Medi-Cal Members who are assigned to Provider based on the most current enrollment information as transmitted by DHCS. Provider will accept such Capitation Payments from Plan as payment in full and discharge of Health Plan’s financial liability for the provision of Covered Services by Provider.
        2. **Reconciliation.** Withinthirty (30) days of the receipt of the eligibility reports from DHCS, Provider’s 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.
        3. **Retroactive Adjustment.** Provider’s capitation payment may be increased to account for retroactive additions or reduced to account for retroactive deletions of Medi-Cal Members by DHCS, i.e., for persons who are retroactively added to or deleted from the list of eligible Medi-Cal Members assigned to Health Plan as of a date preceding the month for which that eligibility report is generated and Capitation Payments are made or deleted from the list of eligible Medi-Cal Members assigned to Health Plan as of a date preceding the month for which that eligibility report is generated and Capitation Payments are made.
        4. **Payment Policy.** HealthPlan has the sole authority to determine payment policies and methodology of reimbursement under this Agreement, which includes reduction of Provider’s capitation payment if rates from the State to Health Plan are reduced.
        5. **Changes in Payment.** Notwithstanding anything to the contrary set forth in this Agreement, Health Plan may adjust the rates or other compensation payable to Provider at any time or from time-to-time during the term of this Agreement as determined by Health 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 Health Plan, or any other change that results in decreases to the rates or level of funding paid to Health Plan. The amount of such adjustment shall be determined by Health Plan and need not be in proportion to or in the same amount as the adjustment to the rates or level of funding paid to Health Plan. Provider will receive notification of any such adjustment prior to its implementation.
        6. **Availability of Funds**. Payment to Provider is subject to Health Plan’s corresponding receipt of funding from DHCS, CMS, or any other governmental agency providing revenue to Health Plan, as applicable. If payments from federal or State governmental agencies are terminated or reduced, Health Plan may terminate the Agreement or adjust the rate of payment as set forth above. If Health Plan’s payment from federal or agencies is delayed, Health Plan may extend the time to make payment to Provider upon prompt written notification of such delay. Provider shall not suspend or terminate Health Plan due to a delay in receipt of payment if such delay results from a corresponding delay in Health Plan’s receipt of payment from federal or State governmental agencies, provided that such delays do not exceed ninety (90) days and Health Plan has notified Provider as set forth above. Within fifteen (15) days following Health Plan’s receipt of payment federal or State governmental agencies, Health Plan shall make payment to Provider for the applicable time period. Notwithstanding the foregoing, Provider shall receive payment for services rendered and obligations incurred prior to termination or amendment of the Agreement. Provider agrees to hold harmless both the State and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. This Agreement is subject to any restrictions, limitations, or conditions enacted by the Congress or State Legislature or any statute enacted by the Congress tor State Legislature that may affect the provisions, terms or funding of this Agreement in any manner.
     2. **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.
     3. **Prior Authorization Review.** Provider shall respond to requests for prior authorization and/or determination of Covered Services within twenty-four (24) hours for Urgent Care Services and within forty-eight (48) hours for Member transportation requests for standard office visits. Return transportation will not require a separate prior authorization, and Provider shall provide return transportation within thirty (30) minutes of Member notification or scheduled pick-up time.
     4. **Medical Necessity Determination.** Health Plan’s determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member’s health program shall govern. The primary concern with respect to all medical determination shall be the interest of the Member.
     5. **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a Primary Care Physician, processing Member complaints and grievances, informing Members of the Health Plan’s policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan’s Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.
     6. **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan’s policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan’s Provider Manual, the receipt of which is acknowledged by Provider in Attachment G, Disclosure Form, which is incorporated herein to this Agreement by this reference. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan’s policies and procedures.
     7. **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the (i) medical and (ii) medically-related scientific and technical aspects of Health Plan.
  2. **ARTICLE FOUR -CORRECTIVE ACTION/PERFORMANCE REMEDIES**
     1. **Performance Standards**. Upon Health Plan’s determination and pursuant to its reasonable discretion, that Provider’s actions have resulted in an administrative. financial, clinical and or other issue including but not limited to an issue related to the provision of Services that does, or threatens to, seriously and adversely impact quality or access to Services pursuant to either this Agreement including but not limited to, Health Plan policies and procedures and the Provider Manual incorporated into the Agreement, or applicable laws and regulations, Health Plan shall have the right and authority to impose Performance Penalties, as defined in Section 4.3. on Provider.
     2. **Corrective Action**. If a Provider deficiency or issue is determined with regards to Provider’s provision of Services under this Agreement or any SOW, Health Plan will notify Provider in writing, outline the area of deficiency and requesting the implementation of a corrective action plan within a specific time frame, not to be less than thirty (30) calendar days. Failure on the part of Provider to fully correct the deficiency or issue within the specified time frame, may lead to the imposition of a Performance Penalties listed in Section 4.3. performance penalties may be imposed in a manner consistent with the impact of the deficiency on Members:
        1. **Exigent Circumstances.** Notwithstanding the above, if there is an immediate threat to the health and safety of Members or their access to Services, Health Plan may impose performance penalties as set forth in this Section or Section 4.3, and or may terminate this Agreement in accordance with Section 5.5.
     3. **Performance Penalties.** Provider acknowledges and agrees that under the Agreement, Plan has the right to impose any of the performance penalties set forth herein singly or in any combination:
        1. **De-delegation.** If Health Plan has delegated function(s) or activity(s) under this Agreement, Health Plan may de-delegate a function assigned to Provider that has led to an administrative, financial, and/or other issue which does, or threatens to, seriously and adversely impact Member care or access to care. In addition to de-delegating a function, Health Plan shall reduce Provider’s payment based upon an agreed upon dollar amount associated with Health Plan’s costs to perform the previously delegated function;
        2. **Withhold Capitation:** Health Plan may withhold a portion of capitation payment based upon Health Plan's reasonable analysis of the impact of the cost associated with the impact of the performance deficiency or issue, including but not limited to costs incurred to mitigate the impact of the performance deficiency or issue. Any such capitation withhold, or portion thereof, may be restored to Provider upon Health Plan's determination of satisfactory correction of the performance deficiency or issue (with any interest on such withholding retained by Health Plan);
        3. **Monetary Penalties.** Health Plan may impose monetary sanctions for performance deficiencies or issues, in the same manner as provided in law, regulation and the Medi-Cal Agreement for non-performance or non-compliance of contractual or regulatory requirements, which may be deducted from payments at the discretion of Health Plan;
        4. **Termination of Agreement for Cause.** Provider may be terminated for cause as described in this Agreement and/or the SOW.
  3. **ARTICLE FIVE - TERM AND TERMINATION**
     1. **DHCS Approval.** Provider acknowledges that this Agreement, and any subsequent amendment to this Agreement, shall become effective only upon the written approval by DHCS, or by operation of law as follows: (i) for the initial Agreement, where DHCS has acknowledged receipt of the Agreement and neither approves or disapproves the Agreement within sixty (60) days of its receipt; (ii) for any amendment to the Agreement governing compensation, services, or term, where DHCS has acknowledged receipt of the amendment and neither approves or disapproves the amendment within thirty (30) days of its receipt. Provider acknowledges that this Agreement and all information received in accordance with this Agreement will be public records on file with DHCS except as specifically exempted in statute. Attachment D, Medi-Cal Program Provisions, will be attached to the Agreement when it is presented to DHCS.
     2. **Term.** This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement (“Effective Date”) and shall continue in effect for two (2) years; thereafter, Health Plan may renew annually for successive one (1) year terms with ninety (90) days advance notice, unless and until terminated by either party in accordance with the provisions of this Agreement, or unless and until the parties renegotiate terms of this Agreement including, but not limited to, term dates or methods of extension, through an amendment or change order to the Agreement in accordance with Section 9.19, Amendment.
     3. **Termination without Cause.** This Agreement may be terminated without cause and for convenience by either party upon at least sixty (60) days written notice to the other party.
     4. **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.
     5. **Immediate Termination with Cause.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:
        1. Health Plan determines that Provider’s facility, vehicles and/or equipment is insufficient to render Covered Services to Members;
        2. Health Plan determines that Covered Services are not being properly provided, or arranged for, and that such failure poses a threat to Members’ health and safety.
        3. Provider fails to remedy or cure a breach as required by the Corrective Action Plan within thirty (30) days.
     6. **Continuation of Services.** Should this Agreement be terminated, Provider will, at Health Plan’s option, continue to provide Covered Services to 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 Members, including but not limited to the transfer of Member’s medical records. Payment by Health 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.
     7. **Termination of Medi-Cal Agreement.** In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, Provider will allow DHCS and Health Plan to copy medical records of all Members in order to facilitate the transition of such 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 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 Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by Health Plan. Under no circumstances will a Member be billed for this service. The cost to Health Plan for Provider’s photocopying of such records will not exceed $.10 per page.
     8. **Transition.** Provider will assist Heath Plan in the orderly transfer of Members to the provider they choose or to whom they are referred after termination of this Agreement. Furthermore, Provider shall assist Health Plan in the transfer of care as set forth in the Provider Manual, in accordance with the Phase out Requirements set forth in the Medi-Cal Agreement. Upon request by Health Plan, Provider will allow the copying and transfer of Provider’s records for each Member to the provider assuming Covered Services for the Member at termination. Such copying of records will only be at Health Plan’s expense if termination was not for cause. Health Plan will continue to have access to records in accordance with the terms of this Agreement.
     9. **Survival of Obligations.** 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.
     10. **DHCS Notification.** Provider agrees to timely notify the Department of Health Care Services of the termination of this Agreement. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached.
  4. **ARTICLE SIX — CONFIDENTIALITY, PROTECTED HEALTH INFORMATION, INJUNCTIVE RELIEF**
     1. **Confidentiality**. Provider understands and agrees that, in the performance of the Covered Services under this Agreement, or in contemplation thereof, Provider (including Provider’s employees, drivers, subcontractors, agents or representatives) may be given access to information that (i) relates to Health Plan’s past, present and future research, development, business activities, products, services, technical knowledge, trade secrets, designs, methods, systems, and improvements, (ii) is private or confidential information concerning existing or prospective members or patients of Health Plan or other persons receiving services from or through Health Plan, whether disclosed by Health Plan or by the individuals themselves related to medical records, patient bills/statements, and any other Protected Health Information (PHI”) as defined under the Health Insurance Portability and Accountability Act of 1996 and attendant privacy and security regulations, as amended from time to time (collectively, “HIPAA”), or (iii) is any other non-public information about Health Plan’s business or activities that is proprietary and confidential, which information will include any and all business, all strategic and development plans, results of the Covered Services, business plans, information about parent, subsidiaries or sister companies, co-developer identities, data, business records, customer lists, policy information, personally identifiable information, personal financial information, product designs, test data, project records, market reports, investor information, know-how, discoveries, ideas, concepts, specifications, models, diagrams, methodologies, research, technical and statistical data, drawings, models, flow charts, work-flow, marketing, pricing, selling, distribution, database descriptions, software code, source code, object code, Intellectual Property, and any and all other tangible or intangible information, other than trade secrets, encompassed in any medium, which may be disclosed, whether or not in writing, whether or not marked as “Confidential” or “Proprietary” by the disclosing party or to which the receiving party may be provided access to by disclosing party in accordance with this Agreement, or which is generated or learned as a result of or in connection with the Services and is not generally available to the public. “Confidential Information” also includes proprietary or confidential information of any third party that may disclose such information to either party in the course of that party’s relationship with a party. The following subsections shall apply to Confidential Information (unless otherwise defined in this Agreement, capitalized terms in this Section 6.1 shall have the meaning as set forth in the HIPAA regulations):
     2. **Non-Disclosure.** Provider shall not disclose Confidential information, directly or indirectly, without the express written consent of Health Plan;
        1. **Limited Use and Reproduction.** The Confidential Information may be used by Provider only in connection with the Covered Services and may not be copied or reproduced without written consent, except for administrative or judicial requirements;
        2. **Same Protection.** Provider agrees to protect the confidentiality of the Confidential Information in the same manner that it protects the confidentiality of its own proprietary and confidential information;
        3. **Destruction.** All Confidential Information made available hereunder, including copies thereof, shall be returned or destroyed upon the first to occur of (a) completion of the Covered Services or (b) request by the discloser;
        4. **Business Associate Addendum.** Provider, in performing its obligations under this Agreement, will have access to PHI. Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality. Provider agrees to abide by the terms and conditions set forth in Attachment K, Business Associate Addendum, appended hereto and incorporated herein by this reference, which will be executed by both parties and remain in effect concurrent with this Agreement;
        5. **Other Business Associate Agreements.** Provider further understands that under some circumstances Health Plan may be the Business Associate of other entities whose PHI may be in the possession of Health Plan, and that such PHI of other entities could be disclosed by Health Plan in connection with the business purpose of this Agreement. To the extent that any PHI of other entities is disclosed to Provider, and to the extent that Health Plan serves as a Business Associate of such other entities, Provider agrees to the Business Associate restrictions and requirements of and of any separate Business Associate agreement that Health Plan may have with such other entities concerning the PHI in question;
           1. Reasonable and Necessary Restrictions. Provider acknowledges that the restrictions contained in this Article VI are reasonable and necessary to protect the legitimate interests of Health Plan and that any violation of these restrictions would result in irreparable injury to Health Plan. Provider agrees to indemnify, defend, protect and hold Health Plan harmless from and against any and all damage, loss or expenses, including attorneys’ fees, relating to any breach or threat of breach of Provider’s covenants set forth herein. Provider agrees that Health Plan shall be entitled, without waiving any additional rights or remedies otherwise available to Health Plan at law or in equity or by statute, to injunctive and other equitable relief in the event of a breach or intended or threatened breach by Provider of any of Provider’s covenants set forth herein. Each of Provider’s covenants set forth herein shall be construed as a separate agreement independent of any other provisions of this Agreement. The unenforceability of any of said covenants shall not preclude the enforcement of any other of said covenants or of any other obligations of Provider by Health Plan, predicated on this Agreement, and shall not constitute a defense to the enforcement by Health Plan of any of said covenants; and
           2. Additional Agreements. Provider and all of Provider’s personnel, staff, employees and agents, subcontractors, and drivers shall execute any additional agreements required by Health Plan to ensure compliance with this Article VI as a condition of providing Covered Services under this Agreement, and any such agreement shall become part of this Agreement and incorporated herein by reference
     3. **National Provider Identification (“NPI”).** In accordance with HIPAA, Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 C.F.R. Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System (“NPPES”) for itself or for any subpart of the Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan.
     4. **Enforcement and Injunctive Relief.** Notwithstanding any other provisions of this Agreement, Provider and Health Plan agree that if any party to this Agreement violates any of the provisions of this Article VI of this Agreement, that the aggrieved party shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Article VI, including injunctive relief, without posting bond. Provider acknowledges that any unauthorized use or disclosure of Confidential Information would result in damage to Health Plan that may be intangible but nonetheless real, and that is incapable of complete remedy by an award of damages. Accordingly, any such violation shall give Health Plan the right to a court-ordered injunction or other appropriate order to specifically enforce the provisions of this Agreement. Provider agrees to pay to Health Plan any reasonable expenses, including but not limited to attorneys’ fees, incurred in obtaining and collecting any remedies, relief, or damages.
     5. **Declaration of Confidentiality.** Provider, subcontractors, and any drivers shall execute the Declaration of Confidentiality, Attachment F, appended hereto and incorporated herein by this reference, prior to beginning any work under this Agreement which will involve access to Medi-Cal member PHI.
     6. **Survival.** The obligations in this Article VI shall survive the termination of this Agreement.
  5. **ARTICLE SEVEN – DEFAULT**
     1. **Default.** Provider will be in default if:
        1. Provider fails to perform any covenant (including a lapse in insurance coverage) required by this Agreement;
        2. Any representation or warranty made by Provider in conjunction with this Agreement is false or materially misleading;
        3. Provider files or is the subject of a petition for bankruptcy or insolvency; or
        4. Provider has a court-ordered receiver or trustee appointed with respect to Provider’s assets.
     2. **Remedies.** If a default under Section 7.1 has occurred and is continuing, Health Plan may, individually or in combination with any other remedy:
        1. Terminate this Agreement;
        2. Offset the amount of any outstanding liability of Health Plan against funds otherwise due and owing under this or any other agreement Provider has with Health Plan;
        3. Withhold funds due hereunder;
        4. Cure the default, in which event all amounts expended by Health Plan in effecting such cure will be payable upon demand, with interest from the date of incurrence at the maximum rate permitted by law; or
        5. Exercise any other remedy available by law.

Health Plan will have no obligation to exercise any of the foregoing remedies.

* 1. **ARTICLE EIGHT – PROVIDER GRIEVANCES AND DISPUTES**
     1. **Appeals and Grievances**
        1. **Process.** Provider complaints, concerns, or differences, which may arise as a health care Provider under contract with Health Plan will be resolved as outlined in the Health Plan’s appeals and grievance policies set forth in the Provider Manual. Provider and Health Plan agree to and will be bound by the decisions of the Health Plan’s grievance and appeal mechanisms.
        2. **Responsibility.** It is the responsibility of the Health Plan for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system.
     2. **Dispute Resolution**
        1. **Government Claims Act.** For disputes unresolved by Health Plan’s provider grievance and appeals process, Health 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 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”).
        2. **Judicial Reference.** A dispute between Provider and Health Plan arising out of this Agreement 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. The referee shall be determined by agreement between the parties, provided that in the absence of such agreement, the referee shall be appointed by the Ventura County Superior Court in accordance with California Code of Civil Procedure Section 640 (or any successor provision thereto, if applicable). The parties acknowledge, by their initials herein, that they forego any right to trial by jury in any judicial reference proceeding, and that each party shall be responsible for paying an equal share of all costs for the referee until such time as a judgment is entered. 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 non-prevailing party in any dispute shall be required to fully compensate the prevailing party for its payments to the referee for his or her services hereunder at the referee’s then respective prevailing rates of compensation.

Acknowledgement of Waiver of Jury and Payment of Referee Fees (Initials)

for Health Plan: for Provider:

* + - 1. **Limitations.** Provider must comply with the claim procedures set forth in the Government Claims Act (Government Code Section 900, et. seq.) prior to filing any legal proceeding, including judicial reference, against Health Plan. If no such Government Code claim is submitted, no action against Health Plan may be filed. 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 facts giving rise to a dispute occurred or such dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act, then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.
      2. **Cut-Off for Disputes Against Health Plan.** Within ninety (90) days of the expiration or termination of this Agreement or any SOW under this Agreement, Provider shall provide to Health Plan formal written notice of any unresolved disputes Provider has against Health Plan relating to this Provider to the applicable SOW. The formal written notice shall describe any unresolved dispute and identify the amount Provider demands in satisfaction of the dispute, and it shall include any supporting documentation. Provider’s failure to submit timely notice shall constitute a waiver of all unresolved disputes against Health Plan. To the extent a dispute arises after the time for providing notice, and Provider could not have timely discovered the dispute, Provider shall provide formal written notice within ten (10) days of discovery. Nothing herein shall modify Provider’s duty to comply with the Government Claims Act and Section 8.2.b above.
      3. **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.
  1. **ARTICLE NINE- GENERAL PROVISIONS**
     1. **Indemnity.**
        1. **Indemnification.** Provider shall indemnify, defend, and hold harmless Health Plan, its officers, directors, employees, agents, and representatives from any and all liabilities, losses, damages, claims, fines, settlements, judgements, and expenses of any kind, including costs and attorneys’ fees, which arise out of the duties and obligations of Provider and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.
        2. **Defense.** Health Plan agrees to notify Provider promptly in writing of any such claim, following actual knowledge of such Claim, provided however that the failure to give such notice shall not relieve Provider of its obligations hereunder except to the extent that Provider is materially prejudiced by such failure. In the event that any third-party Claim is brought, Health Plan shall have the option at any time to either (i) tender its defense to Provider, in which case Provider shall provide qualified attorneys, consultants, and other appropriate professionals to represent Health Plan’s interests at Provider’s expense, or (ii) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case Provider shall be responsible for and shall pay reasonable fees and expenses of such attorneys, consultants, and other appropriate professionals. Health Plan shall have the sole right and discretion to settle, compromise, or otherwise resolve any and all claims, causes of action, liabilities, or damages against it, notwithstanding that Health Plan may have tendered its defense to Provider. Any such resolution shall not relieve Provider of its obligation to indemnify Health Plan. Provider agrees that any settlement, compromise or resolution Provider enters into arising as a result of the Claims will not include any admission of wrongdoing by Health Plan. The indemnification requirements set forth herein shall survive the termination of this Agreement.
        3. **Survival.** The terms of this Section shall survive the termination of this Agreement.
     2. **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it 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. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan’s Members. Nor shall any third party have any right to enforce the terms of this Agreement.
     3. **Independent Provider.** Provider shall act as an independent contractor having responsibility for and control over the means and details of performing the services, and shall not act as an agent or employee of Health Plan. Accordingly, Provider, its staff, employees, drivers, and agents, and that of any subcontractor shall have no claim under this Agreement against Health Plan for vacation or sick leave, retirement benefits, Social Security, Workers’ Compensation benefits, disability or unemployment insurance benefits, or employee benefits of any kind. To the extent that Provider asserts that it is eligible for any benefit programs maintained by Health Plan (regardless of the timing of or reason for eligibility), Provider hereby waives its right to participate in such programs. Provider also agrees that consistent with its independent contractor status, it will not apply for any government sponsored benefits that are intended to apply to employees, including, but not limited to, unemployment benefits or workers’ compensation. The parties shall not make any commitments or incur any charges or expenses for or in the name of one another and shall, to the greatest extent possible, perform this Agreement in a manner consistent with Provider’s status as an independent contractor. Provider will pay to the appropriate governmental authority all taxes levied in connection with this Agreement or the Covered Services, including any self-employment, social security, income, unemployment, disability insurance, franchise, possessory interest, payroll, gross receipts and sales or use taxes. Provider hereby waives any claim against Health Plan with respect to, any and all federal, state and local taxes, contributions and other amounts which are payable in connection with or are levied or assessed with respect to any and all fees which it receives from Health Plan hereunder, including without limitation, all income taxes, social security taxes, disability taxes and unemployment insurance taxes, and any and all penalties and interest due thereon.
     4. **Immigration Compliance.** Provider warrants, represents and agrees that Covered Services will not be performed under this Agreement by any person who is an unauthorized alien under the Immigration and Reform and Control Act of 1986 (as the same has been or may be amended) or its implementing regulations. Provider shall ensure that each and every person performing Covered Services shall be a citizen or permanent resident of the United States, or have a valid United States visa authorizing employment in the United States, and shall be permitted to work for federal contractors, including but not limited to Medicare and Medicaid contractors.
     5. **Export Regulations.** Provider acknowledges its obligations to control access to technical data under the U.S. Export Laws and Regulations and agrees to adhere to such laws and regulations with regard to any technical data received under this Agreement.
     6. **Offshore Resources.** Provider or its agents or subcontractors shall not perform any Covered Services outside the United States of America without the prior written consent of Health Plan. If during the term of this Agreement, or at any time after the Effective Date of this Agreement, it is determined that Provider is in breach of this Section, Health Plan shall have, in its sole discretion, the right to immediately terminate this Agreement.
     7. **Clean Water and Air Acts.** 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 C.F.R. Part 30:
        1. **Clean Water.** Provider shall comply with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 1857 (h)), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 C.F.R. § 15).
        2. **Clean Air.** Provider shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. § 1251 et seq.), as amended.
     8. **Federal Equal Opportunity Requirements.**
        1. **Discrimination.** 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.
        2. **Posting.** Provider shall post in conspicuous places, available to employees and applicants for employment, a notice 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 U.S.C. § 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, “Amending Executive Order 11246 Relating to Equal Employment Opportunity,” and as supplemented by regulation at 41 Code of Federal Regulations part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor. 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. Provider will, in all solicitations or advertisements for employees placed by or on behalf of the Provider, state that it is an equal opportunity employer.
        3. **Labor Unions.** 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.
        4. **Books and Records.** 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.
        5. **Non-Compliance.** In the event of Provider’s noncompliance with the requirements of this Section 9.8,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 C.F.R. Part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
        6. **Subcontracts.** Provider will include the provisions of subsections 9.8.a through 9.8.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 C.F.R. Part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. § 4212) of the Vietnam Era Veteran’s Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. 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.
     9. **Disabled Veteran Business Enterprises (“DVBE”).** Provider shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.
     10. **Governing Law.** This Agreement shall, in all respects, be interpreted, construed, enforced and given effect according to the laws of the State of California, excluding its principles of conflicts of laws.
     11. **Use of Name; Publicity**. Except for its internal business use, as required by Law or to comply with the request of a governmental entity, neither party shall use the other party’s name, trademarks, service marks, logos or other identifiers (collectively, “Trademarks”), or make any reference to the other party or its Trademarks in any manner including, without limitation, client lists and press releases without the prior written approval of such other party.
     12. **Third-Party Beneficiaries.** Nothing contained in this Agreement shall confer on any party the position of third-party beneficiary of the obligations assumed by either party to this Agreement and no such individual shall have the right to enforce any such obligation.
     13. **Waiver.** No assent or waiver, express or implied, of any breach of any one or more of the covenants, conditions or provisions hereof shall be deemed or taken to be a waiver of any other covenant, conditions or provision hereof, or a waiver of any subsequent breach of the same covenant, condition or provision hereof.
     14. **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The Medi-Cal Agreement between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.
     15. **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 remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.
     16. **Precedence.** Any inconsistency in this Agreement shall be resolved by giving precedence in the following order: (1) the Business Associate Agreement; (2) this Agreement; (3) the SOW, unless a single separate and distinct section within the SOW or Change Order (a) is labeled as the “MSA Override” section, and (b) expressly identifies both the provision within this Agreement that is being overridden by the SOW or Change Order and in which case the provision within the SOW or Change Order that shall prevail over this Agreement; (4) the RFP to which Provider responded; and (5) Provider’s response to such RFP Proposal. Each document identified in this Section is a part of this Agreement and is incorporated herein by this reference. Any requirement or obligation of Provider set forth in the RFP shall be deemed a part of the general terms and conditions of this Agreement unless the Parties expressly agree to exclude any such requirement from this Agreement. Each document identified in this Section is a part of this Agreement and is incorporated herein by this reference.
     17. **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.
     18. **Non-Exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services. Health Plan retains the right at all times to negotiate terms and enter contracts with any other person or entity for services that are the same or similar to the Services without notice to Provider and without incurring any liability by virtue thereof.
     19. **Amendment.** Health Plan may, without Provider’s consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon thirty (30) business days’ notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend this Agreement only after thirty (30) business days prior written notice to Provider. Unless DHCS notifies Health Plan that it does not accept such amendment or unless Provider gives written notice of termination within sixty (60) days, as authorized by this Agreement, Provider agrees the amendment will become effective sixty (60) days after the date of Health Plan’s notice of proposed amendment and will be a part of the Agreement.
     20. **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Provider agrees assignment or delegation will be void unless prior written approval is obtained from Health Plan and DHCS. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.
     21. **Authority.** Provider represents and warrants that it has full right, power, and authority to execute and deliver this Agreement and to perform its obligations contemplated under its terms. In addition, Provider represents and warrants that all corporate acts or proceedings required to be taken by Provider to authorize the execution, delivery, and performance of this Agreement have been taken.

**Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:

**Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement

Attachment A-1 — Scope of Work, Non-Emergency Medical Transportation

Attachment A-2 — Scope of Work, Non-Medical Transportation

Attachment B — Definitions

Attachment C — Compensation Schedule

Attachment D — Medi-Cal and Medicaid Program Provisions

Attachment E — Transportation Credentialing Requirements

Attachment F — Declaration of Confidentiality

Attachment G — Disclosure Form

Attachment H — Certificate of Ownership

Attachment I — Oversight For Transportation Agreement

Attachment J — Acknowledgement of Provider Manual

Attachment K — Business Associate Addendum

* + 1. **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The notice addresses set forth on the first page of the Agreement shall be the particular party’s address for delivery or mailing of notice purposes.

The parties may change the names and addresses for notification through written notice in compliance with this Section. Any notice sent by registered or certified 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 United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

**ATTACHMENT A-1   
SCOPE OF WORK, NON-EMERGENCY MEDICAL TRANSPORTATION**

1. Non-Emergency Medical Transportation Services are covered benefits of the Medi-Cal program only if the following requirements are met:
2. The transportation is a covered benefit under Title 22, California Code of Regulations Section 51323, the Medi-Cal program, and the California Department of Health Care Services contract with Health Plan under which Ventura County Medi-Cal beneficiaries are assigned to Health Plan;
3. Transportation by ordinary means of public or private conveyance is contraindicated;
4. Transportation is required for the purpose of obtaining medically necessary Medi-Cal covered services;
5. A physician, dentist, or podiatrist issued a written prescription for the Health Plan Medi-Cal beneficiary to receive non-emergency medical transportation necessary for Medi-Cal program covered services;
6. Health Plan prior authorized the non-emergency medical transportation or the transportation is to transfer a Medi-Cal patient from an acute care hospital immediately following a stay as an inpatient at the acute level of care to a skilled nursing facility or an intermediate care facility licensed pursuant to Cal. Health and Safety Code §1250;
7. Transportation is only to the nearest facility capable of meeting the patient’s medical needs.
8. Member may have a parent, grandparent, grandchild, stepparent, spouse, son, daughter, stepson, stepdaughter, brother, sister, half-brother, or half-sister, with this relationship (either by consanguinity or direct affinity) accompany them on the ride.
9. The lowest cost type of medical transportation that is adequate for the patient’s medical needs, and is available at the time that transportation is required, shall be utilized as follows:
10. **LITTER VAN SERVICES**
    1. The patient’s medical and physical condition requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport;
    2. The patient’s medical and physical condition requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance; and
    3. The patient’s medical and physical condition does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
11. **WHEELCHAIR VAN SERVICES** 
    1. The patient’s medical and physical condition renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport;
    2. The patient’s medical and physical condition requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation;
    3. The patient’s medical and physical condition requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance; and
    4. The patient’s medical and physical condition does not require the specialized services, equipment and personnel provided in an ambulance, because the patient is in stable condition and does not need constant observation.
12. **AMBULANCE TRANSPORTATION**
    1. The patient’s medical condition contraindicates the use of other forms of medical transportation.
13. **AIR TRANSPORTATION**
    1. Transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible; and
    2. The necessity for transportation by air is substantiated by the content of a written order of a physician, podiatrist or dentist.
14. Litter Vans shall be operated, equipped and maintained in compliance with Title 22, California Code of Regulations, Section 51231.1.
15. Wheelchair Vans shall be operated, equipped and maintained in compliance with Title 22, California Code of Regulations, Section 51231.2.
16. NEMT Access Standards:

HEALTH PLAN and PROVIDER are contractually required to meet timely access standards. HEALTH PLANS that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 C.C.R. § 1300.67.2.2. The Member's need for NEMT services do not relieve the HEALTH PLAN and PROVIDER from complying with their timely access standard obligations.

**ATTACHMENT A-2  
SCOPE OF WORK, NON-MEDICAL TRANSPORTATION**

1. Non-Medical Transportation Services (NMT) are covered benefits of the Medi-Cal program as defined below:
2. NMT transportation is a covered benefit as amended under California Welfare and Institutions Code Section 14132(ad)(1) and the California Department of Health Care Services contract with HEALTH PLAN under which Ventura County Medi-Cal beneficiaries are assigned to HEALTH PLAN;
3. HEALTH PLAN and PROVIDER must coordinate and provide NMT services for all Medi-Cal services, including those not covered under HEALTH PLAN' s contract with PROVIDER, which include but are not limited to, specialty mental health, substance use disorder, dental and any other benefits delivered through the Medi-Cal fee-for-service delivery system.
4. NMT excludes transportation of the sick, injured, invalid, convalescent, or otherwise incapacitated Members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. NMT may be authorized by physicians for HEALTH PLAN Members if they are currently using a wheelchair; however, the limitation is such that the Member is able to ambulate without assistance from the driver.
5. The NMT requested must be the least costly method of transportation that meets the Member's needs.
6. At a minimum, NMT services are to be provided as follows:
7. Round trip NMT services for a Member by passenger car, taxicab, or any other form of public or private conveyance, as well as mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by Member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
   1. Round trip NMT services are available for the following:
      1. Medically necessary covered services.
      2. Members picking up drug prescriptions that cannot be mailed directly to the Member. Members picking up medical supplies, prosthetics, orthotics and other equipment.
   2. NMT services must be provided in a form and manner that is accessible, in terms of physical and geographic accessibility for the Member and consistent with applicable state and federal disability laws.
8. Conditions for Non-Medical Transportation Services:
   1. NMT coverage includes transportation for the Member and one attendant, such as parent, guardian, or spouse, to accompany the Member.
      1. Plan shall use authorization processes for approving NMT services and re-authorize every 12 months as necessary.
      2. With written consent of a parent or guardian, Health Plan prior authorized non-medical transportation for a minor who is unaccompanied by a parent or guardian is covered. Transportation, when state or federal law does not require parental consent for the minor's service, is covered.
      3. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
      4. The member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:

* Has no valid driver’s license.
* Has no working vehicle available in the household.
* Is unable to travel or wait for medical or dental services alone.
* Has a physical, cognitive, mental, or developmental limitation.

1. NMT Private Vehicle Authorization Requirements:
   1. The HEALTH PLAN must authorize the use of private conveyance (private vehicle) when no other methods of transportation are reasonably available to the Member or provided by the HEALTH PLAN. Prior to receiving approval for the use of a private vehicle, the Member must exhaust all other reasonable options and provide an attestation to the HEALTH PLAN stating other methods of transportation are not available.
   2. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

* Valid driver's license
* Valid vehicle registration
* Valid vehicle insurance  
  1. HEALTH PLANS are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

1. NMT Authorization:

HEALTH PLAN is required to authorize NMT for each member prior to the member using NMT services. The HEALTH PLAN is responsible for developing a process to ensure that Members can request authorization and be approved for NMT in a timely manner. The HEALTH PLAN's prior authorization process must be consistently applied to medical/surgical, mental/surgical, mental health and substance use disorder services as required by DMS-2333-F.

1. NMT Access Standards:

HEALTH PLAN and PROVIDER are contractually required to meet timely access standards. HEALTH PLANS that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 C.C.R. § 1300.67.2.2. The Member's need for NMT services do not relieve the HEALTH PLAN and PROVIDER from complying with their timely access standard obligations.

**ATTACHMENT B**

**Definitions**

1. **Administrative Members** are Medi-Cal Members enrolled with Plan who have not been assigned to a Primary Care Physician for administrative reasons.
2. **Advance Directive** is a Member’s written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
3. **Agreement** means this Provider Services Agreement, all Attachments, and incorporated documents or materials.
4. **Covered Service(s)** means those health care services within the normal scope of practice and licensure of Provider as described in Attachment A, Scope of Work.
5. **DHCS** is the State of California Department of Health Care Services.
6. **Eligible Beneficiary(ies)** means 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 Health Plan’s 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.
7. **Emergency Medical Condition** is a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: i) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; ii) serious impairment to bodily functions; or iii) serious dysfunction of any bodily organ or part.
8. **Emergency Services** are those health services needed to evaluate or stabilize an Emergency Medical Condition.
9. **Government(al) Agencies** means 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 and any other agency which has jurisdiction over Health Plan or Medi-Cal (Medicaid).
10. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.
11. **Health Plan** means VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, a public entity doing business as Gold Coast Health Plan.
12. **HEDIS Studies** means Health Employer Data and Information Set.
13. **Medi-Cal Agreement** shall mean the agreement entered into by and between Health Plan and DHCS under which Health Plan has agreed to arrange for or provide health benefits under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in Health Plan’s Medi-Cal Managed Care Program. The required elements of this Agreement will, among other things, conform to the Medi-Cal Agreement.
14. **Medi-Cal Managed Care Program** or **Medi-Cal** shall mean the federal and state funded health care program established by Title XIX of the Social Security Act, as amended, which is administered in the State of California by DHCS.
15. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member’s medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member’s family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.
16. **Medical Transportation** 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.
17. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.
18. **Member(s)** is an Eligible Beneficiary who is enrolled in Health Plan.
19. **Nonmedical Transportation** **(NMT)** includes, at a minimum, round trip transportation for a beneficiary to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance, and mileage reimbursement when conveyance is in a private vehicle arr**a**nged by the beneficiary and not through a transportation broker, bus passes, taxi vouchers, or train tickets. Nonmedical transportation does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated beneficiaries by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations.
20. **Non-Emergency Medical Transportation (NEMT):** Transportation services required to access medical appointments and to obtain other medically necessary covered services by members who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, C.C.R., Section 51323.
21. **Overpayment** means any payment made by Health Plan to Provider to which the Provider is not entitled to under Title XIX of the Act.
22. **Primary Care Physician or PCP** is a physician who has 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 Medi-Cal program. The Primary Care Physician is responsible for supervising, coordinating, and providing initial and 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. A resident or intern will not be a Primary Care Physician.
23. **Primary Care Services** are those services defined in the Medi-Cal Agreement to be 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
24. **Provider** means the person(s) and/or entity identified as Provider this Agreement. Provider means and includes all constituent physicians, allied health professionals, subcontractors, drivers and staff persons who provide Covered Services to Members by and/or through Provider. All of said persons are bound by the terms of this Agreement.
25. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.
26. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.
27. **Service Area (or County)** is the County of Ventura and/or nearest facility in surrounding area capable of meeting the patient's medical needs.
28. **Subcontracted Plan(s)** means any person, as defined in Health & Safety Code Section 1345(j), who undertakes to arrange for the provision of health care services to Members, or to pay for or to reimburse any part of the cost of those services, in return for a prepaid or periodic charge paid by or on behalf of the Members by Health Plan through a written agreement between Health Plan and the Subcontracted Plan.
29. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.
30. **Urgent Care Services** are 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).

**ATTACHMENT C  
COMPENSATION SCHEDULE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ shall be entitled to receive the following amounts due for each month on behalf of each Member in the amount specified below:

1. **Compensation**. For Services rendered as outlined herein, Provider shall be compensated based on a per member per month (PMPM) capitation methodology that encompasses in county and out of county transports for NMT and NEMT, and gurney transports. The total annual PMPM compensation shall be comprised of (1) a base capitation amount that shall be 90% of the total PMPM amount, and (2) a performance compensation amount that shall be 10% of the total PMPM amount. The 10% performance compensation amount shall be withheld from the PMPM amount and shall be payable to Provider on an annual basis, conditional upon Provider’s achievement of the performance metrics below for the year. Provider’s performance will be reviewed and evaluated by Health Plan.

2. **Capitation Payment**: The per member per month (PMPM) to Provider for the delivery of the Services outlined herein is, $\_\_\_\_\_\_\_\_\_\_\_\_, less the 10% withhold as referenced above.

3. **Performance Metrics:** Provider shall be responsible for meeting the following metrics as part of their total compensation package. Based on the withhold methodology described above, Provider shall be paid up to 10% of the total annual PMPM compensation if Provider meets the following performance milestones. Achievement of each performance milestone shall be worth 2% of the 10% withhold from the total PMPM annual capitation payment. Health Plan shall pay Provider the remaining 10% of the withheld PMPM annual payment in accordance with the following:

|  |  |  |
| --- | --- | --- |
| **Performance Milestone** | **Metric** | **Payment to Provider** |
| **Grievance and Appeals:**  Member Complaints: The number of transportation related grievance and appeals received during the year divided by the total number of accessibility grievance and appeals received for the year: Less than 1 % | Member Complaints less than 1% for the year | 1.25% of the withheld payment to provider |
| **Timeliness** | Achieve annual average of 95% of all rides on time | 1.5% of the withheld payment to provider |
| **Safety and Security**  **-** Health Plan security risk assessment  - Bi-annual review of safety and cleanliness of vehicle | Demonstrate security management appropriate to address security risks  Must meet 100% of audit requirements | 1.5% of the withheld payment to provider  1.5% of the withheld payment to provider |
| **Denial rate** | Achieve average of less than 3% for the year | 1.25% of the withheld payment to provider |
| **Call Center:**  - Abandonment rate-the number of calls abandoned after they are in queue for a CSR to answer during the year, divided by the total number of calls that have made it to the queue during the year    -  Average Speed of Answer- yearly average of ASA for all calls answered during the year.    -  Quality Audit: *Health Plan will review audit criteria for validation of expectations* | Less than or equal to 5%       Less than or equal to 30 seconds  Greater than or equal to 95% | 1.0% of the withheld payment to provider  1.0% of the withheld payment to provider  1.0% of the withheld payment to provider |

**4. Payment Schedule**: No later than upon the first seven (7) business days of the following month. The per member per month payment shall be calculated based on the HEALTH PLAN's current month's enrollment.

PAYMENT SCHEDULE: 1st 6 MONTHS: 1st week of the month

AFTER 1ST 6 MONTHS: 3rd week of the month

RECONCILIATION: Monthly based on membership changes between prior month and current month.

NOTICE: The amount due under this agreement is subject to change upon renewal, upon change of the Payment Schedule, or upon material change to any term or condition of the Plan or its Medi-Cal Agreement with DHCS. Any such change affecting this Agreement must be reduced to writing as an amendment and signed by both parties to this Agreement.

Before the two-year anniversary of the Effective Date as noted in the preceding table, and upon contract renewal thereafter, Health Plan and Provider shall negotiate and implement rates through a mutually agreed upon executed Amendment to this Attachment. If the Parties fail to mutually agree upon new rate terms by ninety (90) days prior to the two-year anniversary of the Effective Date and annually thereafter as evidenced by executed Amendment(s) and if no Party provides notice of intent to terminate the Agreement, the rate payable to Provider, the rates then in effect shall renew for a period of one (1) year.

**ATTACHMENT D**

**Medi-Cal and Medicaid Program Provisions**

The following provisions apply exclusively to Covered Services provided and activities engaged in under a subcontract pursuant to the Medi-Cal Program contract requirements and the rules set forth in Title 22, California Code of Regulations and Title 42 of the Code of Federal Regulations:

1. All Medi-Cal covered services to be furnished by Provider are set forth in this Agreement and the Provider Manual. (22 CCR § 53250(c)(1); 42 C.F.R. § 438.230(c)(1); DHCS Contract, § 14.B.(1).)
2. This Agreement shall be governed by and construed in accordance with all laws, regulations, and contractual obligations incumbent upon the Health Plan under its agreement with DHCS. (22 CCR § 53250(c)(2); 42 C.F.R. § 438.230(c)(2); DHCS Contract, § 14.B.(2).)
3. This Agreement shall become effective upon approval by the Department of Health Care Services (“DHCS”) in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within 60 days of receipt. (22 CCR § 53250(c)(3); DHCS Contract, § 14.B.(3).)
4. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later. (22 CCR § 53250(c)(3); DHCS Contract, § 14.B.(3).)
5. The term of this Agreement and the methods of extension, renegotiation, and termination are as set forth herein. (22 CCR § 53250(c)(4); DHCS Contract, § 14.B.(4).)
6. Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan. (22 CCR § 53250(c)(5); DHCS Contract, § 14.B.(6).)
7. Provider shall comply with all monitoring provisions of this Agreement, the monitoring provisions in the Health Plan’s agreement with DHCS (as applicable), and any monitoring requests of DHCS. (DHCS Contract, § 14.B.(7).)
8. Provider shall make all of its premises, facilities, equipment, books and records, contracts, computer and other electronic systems, pertaining to the goods and services furnished under the terms of this Agreement, available for audit, inspection, evaluation, examination or copying:
   1. By the DHCS, the United States Department of Health and Human Services, the Inspector General, the Comptroller General, the DMHC, and the Department of Justice; or their designees;
   2. At all reasonable times, at Provider’s place of business or at such other mutually agreeable location in California;
   3. In a form maintained in accordance with the general standards applicable to such book or record keeping;
   4. For a term of at least ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.
   5. Including all encounter Data for a period of at least ten (10) years.
   6. DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
   7. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct Provider to terminate their Subcontract due to fraud, the close of the fiscal year in which the date of service occurred, in which the record or data was created or applied, and for which the financial record was created. (22 CCR § 53250(e)(1); 42 C.F.R. § 438.230(c)(3); DHCS Contract, § 14.B.(8).)
9. The method and amount of compensation to be received by Providers is set forth in this Agreement. (22 CCR § 53250(e)(2); DHCS Contract, § 14.B.(9).)
10. Provider shall maintain and make available to the DHCS, upon request, copies of all subcontracts. All subcontracts shall be in writing and require that:
    1. Provider make all applicable premises, facilities, equipment, books, records, contracts, computer, or other electronic systems related to this Agreement available at all reasonable times for audit, inspection, examining or copying by the DHCS, the U.S. Department of Health and Human Services, the Inspector General, at the Comptroller General, the DMHC, and the Department of Justice. (42 C.F.R. § 438(h); DHCS Contract, § 14.B.(10).)
    2. Provider agree to retain the records and documents for a minimum of at least ten (10) years from the close of the final date of the contract period or from the date of completion of any audit, whichever is later, including but not limited to (as applicable) enrollee grievance and appeal records in § 438.416, base data in § 438.5(c), MLR reports in § 438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610. (42 C.F.R. § 438.3(u); DHCS Contract, § 14.B.(10).)
11. Provider agrees to notify DHCS in the event that 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. .(22 CCR § 53250(e)(4); DHCS Contract, § 14.B.(13).)
12. Provider shall assist Health Plan in the transfer of care in the event Health Plan’s Medi-Cal Agreement expires or terminates. Provider shall assist Health Plan in the transfer and care in the event this Agreement expires or terminates for any reason. Provider shall require its subcontractors to assist Health Plan in the transfer of care in the event of the termination of the subcontract for any reason. (DHCS Contract, § 14.B.(11)-(12).)
13. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (22 CCR § 53250(e)(5); DHCS Contract, § 14.B.(14).)
14. Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. (22 CCR § 53250(e)(6); DHCS Contract, § 14.B.(15).)
15. Upon request by DHCS, Provider shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider’s possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan’s contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in Health Plan’s contract with DHCS. (DHCS Contract, § 14.B.(16).)
16. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites. (DHCS Contract, § 14.B.(17).)
17. Provider has a right to submit a grievance in accordance with Health Plan’s formal process to resolve Provider Grievances. (DHCS Contract, § 14.B.(18).)
18. Provider agrees to participate and cooperate in Health Plan’s Quality Improvement System. (DHCS Contract, § 14.B.(19)-(20).)
19. Provider agrees to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. (DHCS Contract, § 14.B.(21).)
20. Provider agrees to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Health Plan determine that Provider has not performed satisfactorily. (DHCS Contract, § 14.B.(22).)
21. To the extent that the Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use as they are able for the purpose of Member care coordination. (DHCS Contract, § 14.B.(23).)
22. Health Plan shall inform Provider of prospective requirements added by DHCS to this Agreement before the requirement would be effective, and obtain Provider’s agreement to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS and to the extent possible. (DHCS Contract, § 14.B.(24).)
23. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers’ compensation. Provider shall report to Health Plan for reporting to DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers’ compensation award. (22 CCR §53222(b).)
24. Information received in accordance with this Agreement will be public records on file with Health Plan and DHCS, except as specifically exempted in statute. Health Plan and DHCS shall ensure the confidentiality of information and contractual provisions filed with Health Plan and DHCS which are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. ((DHCS Contract, § 14.B.(E).)
25. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (Cal. Welf & Inst. Code § 14452(a).)
26. Provider agrees to provide Health Plan with the disclosure statement set forth in Title 22, California Code of Regulations Section 51000.35 (which incorporates the requirements of 42 C.F.R. § 455.104) prior to commencing services under this Agreement. (42 C.F.R. § 438.608(c)(2).)
27. In accordance with 42 C.F.R. § 438.608(c), Provider and any subcontractors shall provide written disclosure of any prohibited affiliation under 42 C.F.R. § 438.610. (42 C.F.R. § 438.608(c)(1).)

**ATTACHMENT E**

**Transportation Credentialing Requirements**

|  |  |
| --- | --- |
| Driver Age | Drivers must be current — min age 18. Driver license must not be expired. |
| Social Security Card | Drivers must submit a copy of their social security. If the driver does not have a valid social security card, a temporary social security receipt printed from a social security office will be accepted. |
| Drug Screen | Any drivers must pass a drug screen. The drug screen must be performed by an outside vendor staffed with a Medical Review Officer (MRO) to review any positive results. |
| Criminal Background Check | Drivers must submit a National, State, and County level check criminal background check prior to performing Covered Services and annually.  Drivers should not have any convictions for felony, sex crime, abuse, drug possession or sale, or other crimes of violence.  Provider must receive acceptable results from initial background check prior to driver performing Covered Services and annually. |
| National Sex Offender Check | Drivers must not be listed on a state or national sex offender list. The Sex Offender List check must be performed prior to driver performing Covered Services and annually. |
| Motor Vehicle Record (MVR) | Drivers must provide an annual MVR (DMV) pull with 5 year history.  Commercial drivers may have no more than one suspension or revoked license within the past 5 years. For suspensions or revoked licenses due to child support. The driver license must not be currently suspended and the driver must be current with payments for 90 days after his license is reinstated. A driver with two or more suspensions due to non-payment of child support will be permanently prohibited from transporting Members. |
| OIG Exclusion | Persons with at least 5% ownership of subcontractors and drivers must not be on the OIG list of excluded persons. |
| EMT, Paramedics, and Other Medical Personnel | Must submit EMT License as well as DL. EMTs and Paramedics are credentialed by the county that they operate in. |
| Audit Rights | Health Plan has the right to driver records to ensure compliance to applicable driver credentialing standards identified herein. |
| Defensive Driving Test | Commercial drivers must pass the National Safety Council Defensive Driver’s Course (NSCDDC) prior to performing Covered Services and renew their training upon expiration on the date of the certificate. |
| First Aid / CPR / AED | Drivers must pass the National Safety Council FirstAid/CPR/AED prior to performing Covered Services and renew their training upon expiration on the date of the certificate. |
| CTAA Pass Basic including Blood Borne Pathogens | Drivers must pass the Community Association of America ­CTAA PASS Basic including Blood Borne Pathogens and Passenger Sensitivity Training- prior to performing Covered Services and renew their training upon expiration on the date of the certificate. |
| CTAA Pass Wheelchair and Gurney Securement  Vehicle Registration | Drivers must pass the Wheelchair/Stretcher Securement (CTAA PASS Hands On) prior to performing Covered Services and renew their training upon expiration on the date of the certificate.  The 4th training will be required for all drivers that offer wheelchair or stretcher level of service.  Vehicles must have and maintain a valid and current vehicle registration. |
| Vehicle Inspection | Commercial vehicles must pass a vehicle inspection.  Ambulance providers must have CHP Inspection / Certification in lieu of inspections. |
| Vehicle Safety Restraints | All vehicles must be equipped to allow each rider to be properly restrained by a functional safety belt during transport and to comply with all state and federal laws governing use of safety belts or other safety restraint devices including, but not limited to, Cal. Vehicle Code Section 27315. |
| Vehicle — Litter Van Requirements | All Litter Vans must be operated, equipped and maintained so as to comply with Title, 22, California Code of Regulations, Section 51231.1. |
| Vehicle — Wheelchair Van Requirements | All Wheelchair Vans must be operated, equipped and maintained so as to comply with Title, 22, California Code of Regulations, Section 51231.2. |

**ATTACHMENT F**

**DECLARATION OF CONFIDENTIALITY**

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (“DHCS”) and VENTURA.

COUNTY MEDI-CAL MANAGED CARE COMMISSION, a public entity doing business as Gold Coast Health Plan, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to Gold Coast Health Plan authorized employees who require the information in the performance of their duties, State and federal personnel who require the information in the performance of their duties, and to such others as may be authorized by Gold Coast Health Plan.

I acknowledge that I have received a copy of Exhibit G of Client’s contract with DHCS, and I agree to the restrictions and conditions therein.

I recognize that unauthorized release of confidential information may subject me to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

**ATTACHMENT G   
DISCLOSURE FORM**

(Welfare and Institutions Code Section 14452(a))

Name of Subcontractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned hereby certifies that the following information regarding (the “Organization”)

is true and correct as of the date set forth below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. | Officers/Directors General Partners: | | | | | |
|  |  | | | | | |
|  |  | | | | | |
| 2. | Co-Owners: | | | | | |
|  |  | | | | | |
| 3. | Stockholders owning more than ten percent (10%) of the stock of the Organization: | | | | | |
|  |  | | | | | |
| 4. | Major creditors holding more than five percent (5%) of Organization’s debt: | | | | | |
|  |  | | | | | |
| 5. | Form of Organization (Corporation, Partnership, Sole Proprietorship, Individual): | | | | | |
|  |  | | | | | |
| 6. | If not already disclosed above, is Organization, either directly or indirectly, related to or affiliated with the Health Plan? Explain: | | | | | |
|  |  | | | | | |
| By: | |  | | |
|  | | Print Name: | | |
|  | |  | | |
| Dated: | |  |  |  | |
|  | |  |  | Title | |

**ATTACHMENT H**

**CERTIFICATE OF OWNERSHIP**

**ATTACHMENT I**

**OVERSIGHT FOR TRANSPORTATION AGREEMENTS**

**1. Reporting:** At a minimum, Provider must be able to provide the following reports at the frequency and file type listed below. Provider must be able to provide separate reporting for NEMT and NMT. Provider will submit the below reports to Health Plan by way of Secure File Transfer Protocol (SFTP).

|  |  |  |  |
| --- | --- | --- | --- |
| **File Name** | **Frequency** | **Format** | **Received by** |
| Missed Dialysis Report | Daily | Excel | Compliance, Health Services |
| Call Log/Call Center Summary Report | Weekly | Excel | Compliance |
| Denial Authorizations Report | Weekly | Excel | Compliance, Network Operations |
| Encounter Claims Volume Summary report: | Weekly | Word | Compliance |
| Encounter Data File | Monthly | Excel | Compliance, Network Operations, Decision Support Services |

**1.1. Missed Dialysis Report:**

* + - * Date
      * Member Name
      * Member Last Name
      * Member ID#
      * DOB
      * Telephone Number
      * Treatment
      * Date of Scheduled Transportation
      * Reason Declined Service

|  |  |
| --- | --- |
| **Field Name** | **Description** |
| **Date** | Date of Denial Entered |
| **Member Name** | Member First Name |
| **Member Last Name** | Member Last Name |
| **Member ID#** | GCHP Member ID# |
| **DOB** | Member Date of Birth |
| **Telephone Number** | Member Phone Number |
| **Treatment** | Dialysis Treatment Location Name |
| **Date of Scheduled Transportation** | Date of Scheduled Transportation |
| **Reason Declined Service** | Notes explaining reason for missed transport |

**1.2 Call Log/ Call Center Summary Report:**

* + - * Day and Date
      * Calls Offered
      * Calls Handled
      * Calls Abandoned
      * Percent of Calls Answered
      * Abandoned Percent
      * Avg Call Waiting
      * Avg Speed Answer
      * Average Talk Time
      * Average Hold Time
      * Average Handle Time
      * Hold Time Over Ten
      * Average Calls Daily
      * Staffed Hours

|  |  |  |
| --- | --- | --- |
| **ID** | **Field Name** | **Description** |
| **1** | **Day and Date** | Date of Call |
| **2** | **Calls Offered** | # Calls made in (ID #3 + ID #4) |
| **3** | **Calls Handled** | # Calls answered |
| **4** | **Calls Abandoned** | # Calls abandoned |
| **5** | **Percent of Calls Answered** | % of calls answered (#3 / #2) |
| **6** | **Abandoned Percent (SLA 5%)** | % of calls abandoned (#4 / #2) |
| **7** | **Avg Call Waiting (in min)** | Avg Time Caller is waiting for answer |
| **8** | **Avg Speed Answer (in min)** | Avg Time provider takes to answer |
| **9** | **Average Talk Time (in min)** | Avg length of call |
| **10** | **Average Hold Time (in min)** | Avg time caller is put on hold |
| **11** | **Average Handle Time (in min)** | Avg time caller is on the phone |
| **12** | **Hold Time over Ten (10 minutes)** |  |
| **13** | **Average Calls Daily** | Average calls per day |
| **14** | **Staffed (Hours)** | How many hours staffed |

**1.3 Denial/Authorization Report:**

* + - * Date
      * Operator
      * Member Number
      * NMT/NEMT
      * Members First Name
      * Members Last Name
      * Type of appointment
      * Appointment Location
      * Previous denials(y/n)
      * Previous late calls (# amount)
      * Reason for Denial
      * Explanation

|  |  |
| --- | --- |
| **Field Name** | **Description** |
| **Date** | Date of Authorization |
| **Operator** | Provider representative Name |
| **Member Number** | GCHP Member ID |
| **NMT/NEMT** | Transport Type |
| **Members First Name** | Members First name |
| **Members Last Name** | Members Last name |
| **Type of appointment** | Destination's provider type (PCP, specialty, etc) |
| **Appointment Location** | Provider street address |
| **Previous denials(y/n)** | Did member have previous denials? |
| **Previous late calls (# amount)** |  |
| **Reason for Denial** | Denial reason |
| **Explanation** | Provider explanation |

**3.2.5.6.1.4 Encounter Claims:**

* + - * Claim Number
      * Gold Coast Member ID
      * First Name
      * Last Name
      * Code
      * Date of Service
      * NMT/NEMT
      * Appointment Type
      * Origin Destination
      * Origin Zip
      * Destination Location
      * Destination Zip

|  |  |
| --- | --- |
| **Field name** | **Description** |
| **[Claim Number]** | Claim Number |
| **[Gold Coast #]** | GCHP Member ID |
| **[First Name]** | GCHP Member First Name |
| **[Last Name]** | GCHP Member Last Name |
| **[Code]** | Procedure Code |
| **[Date of Service]** | Date of service |
| **[NMT/NEMT]** | Transportation Type |
| **[Appointment Type]** | Service Appointment Type: |
| **[Origin Destination]** | Starting Point Street Address |
| **[Origin Zip]** | Starting Point Zip Code |
| **[Destination Location]** | End Point Street Address |
| **[Destination Zip]** | End Point Zip Code |

**1.6. Encounter Claims Volume Summary Report**:

**Number of trips by type**

* Non-Emergency Ambulatory Sedan/Van Trip
* Wheelchair Trips
* Stretcher Trips
* Taxi

**Number of Beneficiaries**

**Accessibility Standards**

* Urgent Care Transportation Compliance (%)
* Routine appointments (%)
* Member pick-up within 30 min of schedule (%)
* Member return transportation within 30 min of schedule (%)

**2.**

**ATTACHMENT J**

**Acknowledgement of Receipt of Provider Manual**

Provider hereby acknowledges receipt of Health Plan’s Provider Manual.

Date of receipt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials of authorized representative of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTACHMENT K**

**BUSINESS ASSOCIATE AGREEMENT**

This BUSINESS ASSOCIATE AGREEMENT (“BAA”) is entered into effective the \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_ (the “Effective Date”) by and between Ventura County Medi-Cal Managed Care Commission doing business as Gold Coast Health Plan (“Health Plan”) and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (“Business Associate”), each a “Party” and collectively the “Parties”.

RECITALS

1. Health Plan is a Covered Entity as defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and is therefore subject to HIPAA and its implementing regulations, including the Standards for Privacy of Individually Identifiable Health Information (the “Privacy Rule”), the Breach Notification Rule, and the Security Standards for the Protection of Electronic Protected Health Information (the “Security Rule”) codified at 45 C.F.R. Parts 160, 162, and 164 and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (“HITECH”) (collectively, HIPAA, the Privacy Rule, Security Rule, Breach Notification Rule, and HITECH and shall be referred to herein as the “HIPAA Rules”).
2. Business Associate performs Services for or on behalf of Health Plan described in any underlying agreement or agreements between the parties (the “Underlying Agreement”) or in this BAA, and in performing said Services, Business Associate creates, receives, maintains, or transmits Protected Health Information.
3. To the extent that an Underlying Agreement is a subcontract of a California Department of Health Care Services contract (“DHCS Subcontract”), Business Associate will be subject to certain California Department of Health Care Services (“DHCS”) information privacy and security requirements.

Health Plan and Business Associate wish to set forth their understandings with regard to the Use and Disclosure of PHI by Business Associate so as to comply with the HIPAA Rules and Health Plan’s contract with DHCS.

AGREEMENTS

For valuable consideration received and the above referenced Recitals which are incorporated herein as if set forth in full and the mutual conditions, terms and promises set forth in these Agreements below, the parties agree as follows:

* 1. Defined Terms. Capitalized terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Rules:

Specific Definitions:

* + 1. “Breach” shall have the meaning given to such a term under 45 C.F.R. § 164.402.
    2. “Protected Health Information” and “PHI” shall mean any Individually Identifiable Health Information received, created, transmitted, or maintained for or on behalf of Health Plan by Business Associate, whether oral or recorded in any form or medium, that: (a) relates to the past, present or future physical or mental health or condition of an Individual; the provision of health care to an Individual, or the past, present or future payment for the provision of health care to an individual; (b) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (c) shall have the meaning given to such term under the Privacy Rule at 45 C.F.R. § 160.103. Protected Health Information includes electronic PHI or e-PHI.
    3. “Personal Information” and “PI” shall have the meaning of such a term under California Civil Code § 1798.29.
    4. “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system, and shall have the meaning given such term under the Security Rule, including, but not limited to, 45 C.F.R. § 164.304.
    5. “Services” shall mean the services for or functions on behalf of Health Plan performed by Business Associate pursuant to the Underlying Agreement or Agreements, or, if no such written agreements are in effect, then the services or functions performed by Business Associate as described in this BAA that constitute a Business Associate relationship, as set forth in 45 C.F.R. § 160.103.
    6. “State Breach” shall mean any unauthorized access, use, acquisition or disclosure of PI that would trigger a notification obligation under applicable state security breach notification laws.
  1. Business Associate’s Obligations and Permitted Activities.

Business Associate agrees to the following:

* + 1. Applicability. That this BAA shall apply to all agreements between and among Health Plan and Business Associate.
    2. Permitted Uses and Disclosures. Not to Use or Disclose PHI other than as permitted to perform the Services set forth in this BAA, any Underlying Agreement, or as Required by Law. Business may Use PHI for the proper management and administration of Business Associate, and to carry out the legal responsibilities of Business Associate. Business Associate may Disclose PHI for Business Associate’s proper management and administration or to carry out Business Associate’s legal responsibilities only if the Disclosure is Required by Law, or Business Associate obtains reasonable assurances from the person or organization to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person or organization, and the person or organization notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. Business Associate may perform Services, including Data Aggregation for the Health Care Operations purposes of Health Plan, if required by any Underlying Agreement. Business Associate shall not de-identify PHI without the advance written permission of Health Plan.
    3. Adequate Safeguards. To comply with Subpart C of 45 C.F.R. § 164 with respect to electronic PHI to prevent Use or Disclosure of PHI other than as provided for by this BAA and any Underlying Agreement, and to develop, implement, maintain and use appropriate administrative procedures, and physical and technical safeguards, to preserve and protect the confidentiality, integrity and availability of electronic PHI.
    4. Non-Permitted Use or Disclosure. Without reasonable delay, and no later than forty-eight (48) hours after becoming aware, Business Associate shall notify Health Plan of any Use or Disclosure of PHI or PI that is not permitted by this BAA, including Breaches or State Breaches, in accordance with the notice provisions herein.
    5. Security Incident. Business Associate shall notify Health Plan about any Security Incident involving PHI or PI, no later than twenty four (24) hours after Business Associate’s discovery of such incident, in accordance with the notice provisions herein. Notwithstanding the foregoing, Business Associate and Health Plan acknowledge the ongoing existence and occurrence of attempted but ineffective Security Incidents that are trivial in nature, such as pings and other broadcast service attacks, and Health Plan acknowledges and agrees that no additional notification to Health Plan of such ineffective Security Incidents is required, as long as no such incident results in unauthorized access, Use or Disclosure of PHI or PI.
    6. Investigation. Business Associate shall investigate each Security Incident or non-permitted Use or Disclosure of PHI or PI that it discovers to determine whether such Security Incident or non-permitted Use or Disclosure constitutes a reportable Breach or State Breach. Business Associate shall take prompt corrective action and any action required by applicable state or federal laws and regulations relating to any such Security Incident or non-permitted Use or Disclosure. If Business Associate or Health Plan determines that such Security Incident or non-permitted Use or Disclosure constitutes a Breach or State Breach, then Business Associate shall comply with the additional requirements of Section 2.(g) below, as applicable.
    7. Breach Report. Business Associate shall provide a written report to Health Plan without unreasonable delay but no later than five (5) business days after discovery of the Breach or State Breach. To the extent that information is available to Business Associate, Business Associate’s written report to Health Plan shall be in accordance with 45 C.F.R. §164.410(c). Business Associate shall cooperate with Health Plan in meeting Health Plan’s obligations under the HIPAA Rules and applicable State law with respect to such Breach or State Breach. Health Plan shall have sole control over the timing and method of providing notification of such Breach or State Breach to the affected individual(s), the Secretary of the Department of Health and Human Services (the “Secretary”) and, if applicable, the media. Business Associate shall reimburse Health Plan for its reasonable and actual costs and expenses in providing the notification, including, but not limited to, any administrative costs associated with providing notice, printing and mailing costs, public relations costs, and costs of mitigating the harm (which may include the costs of obtaining credit monitoring services and identity theft insurance) for affected individuals whose PHI or PI has or may have been compromised as a result of the Breach.
    8. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of the requirements of this BAA.
    9. Use of Subcontractors. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Business Associate agrees to ensure that any of his agents or subcontractors that create, receive, maintain, or transmit PHI or PI agree to the same restrictions, conditions, and requirements as those that apply to Business Associate, through this BAA and any Underlying Agreement with respect to such PHI or PI.
    10. Availability of Internal Practices, Books, and Records to Government. Business Associate shall make its internal policies, procedures, and records related to the Use and Disclosure of PHI available to the Secretary, State regulatory authorities, and/or to Health Plan upon request and in a time and manner designated by the Secretary or such State authorities, as necessary or required to assess Business Associate’s, subcontractors, or Health Plan’s compliance with the HIPAA Rules or applicable State privacy or security law.
    11. Access. Business Associate shall, within ten (10) business days of a request by Health Plan, make available PHI in a Designated Record Set on behalf of Health Plan as necessary to satisfy Health Plan’s obligations under 45 C.F.R. § 164.524.
    12. Amendment. Business Associate shall, within ten (10) business days of a request by Health Plan, make any amendments to such PHI in a Designated Record Set as directed or agreed to by Health Plan pursuant to 45 C.F.R. § 164.526, or take other measures as necessary to satisfy Health Plan’s obligations under 45 C.F.R. § 164.526.
    13. Accounting. Business Associate shall maintain and make available to Health Plan the information required to provide an accounting of disclosures as necessary to satisfy Health Plan’s obligations under 45 C.F.R. § 164.528 within twenty (20) business days, including recording for each required accounting: (i) the disclosure date, (ii) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the disclosure; and Business Associate shall have available for Health Plan such disclosure information for the six (6) years preceding Health Plan’s request for the disclosure information (except Business Associate need have no disclosure information for disclosures occurring before the Effective Date of this BAA).
    14. Delegated Responsibilities. To the extent Business Associate is to carry one or more of Health Plan’s obligations(s) under Subpart E of 45 C.F.R. § 164 under this BAA or any Underlying Agreement, comply with the requirements of Subpart E that apply to a Covered Entity in the performance of such obligations.
    15. Data Ownership. Business Associate acknowledges that Business Associate has no ownership rights with respect to the PHI or PI.
    16. Minimum Necessary. Business Associate (and its Subcontractors) shall, to the extent practicable, limits its request, Use, or Disclosure of PHI to the minimum amount of PHI necessary to accomplish the purpose of the request, Use or Disclosure.
    17. Acknowledgement. Business Associate acknowledges that it is obligated by law to comply, and represents and warrants that it shall comply, with the HIPAA Rules. Business Associate shall comply with all applicable state privacy and security laws, to the extent that such state laws are not preempted by the HIPAA Rules.
  1. DHCS Contract Requirements. To the extent the Underlying Agreement is a subcontract of a DHCS Contract, Business Associate agrees to the following:
     1. General Security Controls.
        1. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of Health Plan, or access or disclose PHI or PI must complete information privacy and security training, at least annually, at Business Associate’s expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member’s name and the date on which the training was completed.
        2. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.
        3. Confidentiality Statement. All Business Associate workforce members shall sign a confidentiality statement supplied by Business Associate. The statement shall include, at a minimum, general use, security and privacy safeguards, unacceptable use, and enforcement policies. The statement shall be signed by the workforce member prior to access of PHI or PI. The statement shall be renewed annually.
        4. Background Check. Before a member of the Business Associate’s workforce may access PHI or PI, Business Associate shall conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data.
     2. Technical Security Controls
        1. Workstation/Laptop/Remote Access Encryption. All processes that provide remote access to PHI or PI, and all workstations and laptops that process and/or store PHI shall be encrypted in accordance with the U.S. Department of Health and Human Services (“DHHS”), Guidance to Render Unsecured Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals, or any superseding guidance issued by DHHS. Such guidance may be found at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brguidance.html. The internet link provided above is provided for the convenience of the parties and is subject to change. All remote access must be limited to the minimum necessary and least privilege principles.
        2. Server Security. Servers containing unencrypted PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.
        3. Minimum Necessary. Business Associate shall download only the minimum necessary amount of PHI to a laptop or hard drive, and shall do so only when absolutely necessary for business purposes.
        4. Removable Media Devices. All electronic files that contain PHI must be encrypted by Business Associate when stored on any removable media type device (e.g., USB thumb drives, floppies, CD/DVD, etc.).
        5. Antivirus Software. Business Associate shall install a commercial third-party anti-virus software solution with a minimum daily automatic update on all workstations, laptops and other systems that process and/or store PHI.
        6. Email Security. All emails that include PHI or PI shall be sent by Business Associate in an encrypted method using encryption processes for data in motion complying, as applicable, with National Institute of Standards and Technology (“NIST”) Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (“TLS”) Implementations; 800-77, Guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or other encryption processes which are Federal Information Processing Standards (“FIPS”) 140-2 validated.
        7. Patch Management. Business Associate shall have security patches applied and up-to-date on all workstations, laptops and other systems that process and/or store PHI or PI.
        8. User IDs and Password Controls. All of Business Associate’s users of electronic PHI or PI must be issued a unique user name for accessing electronic PHI or PI. Passwords shall: (1) not to be shared, (2) be at least eight characters, (3) be a non-dictionary word, (4) not be stored in readable format on the computer, (5) be changed every 60 days, (6) be changed if revealed or compromised, and (7) be composed of characters from at least three of the following four groups from the standard keyboard: upper case letters, lower case letter, arabic numerals or non-alphanumeric characters (punctuation symbols).
        9. Data Destruction. Except as otherwise provided in subsection 5(c)(ii) below, all PHI or PI shall be returned or destroyed using Department of Defense standard methods for data destruction when the PHI or PI is no longer needed.
        10. System Timeout. Business Associate’s workstations with access to PHI or PI shall provide an automatic timeout after no more than 20 minutes of inactivity.
        11. Warning Banners. Business Associate systems processing or maintaining PHI or PI shall display a warning banner stating that data is confidential, system access is logged, and system use is for business purposes only. Users shall be directed to log off the system if they do not agree with these requirements.
        12. System Logging. Business Associate systems maintaining or processing PHI or PI shall log success and failures of user authentication at all layers. Such systems shall log all system administrator/developer access and changes, and shall log all user transactions at the database layer if such database maintains or processes PHI or PI.
        13. Access Controls. Business Associate systems maintaining or processing PHI or PI shall use role based access controls for all user authentication, applying the principle of least privilege.
        14. Transmission Encryption. All Business Associate transmissions of electronic PHI or PI shall be encrypted end-to-end using encryption processes conforming with those specified in Section 3(a)(vi) of this Agreement.
        15. Host Based Intrusion Detection. All Business Associate systems maintaining or processing PHI or PI that are accessible via the Internet shall use a comprehensive third-party real-time host based intrusion detection and prevention program.
     3. Audit Controls.
        1. System Security Review. All Business Associate systems maintaining or processing PHI or PI shall have at least an annual system security review. Reviews shall include administrative and technical vulnerability scanning tools.
        2. Log Reviews. All Business Associate systems maintaining or processing PHI or PI shall apply a routine procedure to review system logs for unauthorized access. Log records of each access occurrence shall be maintained for six years.
        3. Change Control. All Business Associate systems maintaining or processing PHI or PI shall have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.
     4. Business Continuity / Disaster Recovery Controls.
        1. Emergency Mode Operation Plan. Business Associate shall establish a written plan to enable continuation of critical business processes and protection of the security of electronic PHI or PI in the event of an emergency.
        2. Data Backup Plan. Business Associate shall have established written procedures to backup data to maintain retrievable copies electronic PHI or PI maintained by Business Associate. The plan shall include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and the amount of time to restore data should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of data.
     5. Paper Document Controls.
        1. Supervision of Data. Business Associate shall have a policy that:
           1. PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information.
           2. PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.
        2. Escorting Visitors. Business Associate shall escort visitors in areas where PHI or PI is contained. PHI or PI shall be kept out of sight while visitors are in the area, unless the visitors are authorized to view the PHI or PI.
        3. Confidential Destruction. PHI or PI in paper form, when disposed of by Business Associate, shall be disposed of through confidential means, such as shredding and pulverizing.
        4. Removal of Data. PHI or PI shall not be removed by Business Associate from Business Associate’s premises except for necessary business purposes.
        5. Faxing. Faxes containing PHI or PI shall not be left unattended by Business Associate and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified by Business Associate before sending faxes.
        6. Mailing. PHI or PI shall only be mailed by Business Associate using secure methods. Large volume mailings of PHI or PI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted.
     6. Member Contact Information. Business Associate shall document and provide to Health Plan a list of third parties to which Business Associate discloses Members’ names and contact information. This list of third parties shall be provided within thirty (30) calendar days of the execution of this Agreement and annually thereafter.
  2. Health Plan’s Obligations.
     1. Health Plan shall not request Business Associate to Use or Disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Health Plan.
     2. Health Plan shall make reasonable efforts not to provide Business Associate with more PHI than that which is minimally necessary for Business Associate to provide the Services.
     3. Health Plan shall notify Business Associate of any restrictions on, or change in or withdrawal of the consent or authorization of an Individual regarding the Use or Disclosure of PHI to the extent that such change or withdrawal may affect Business Associate ‘s Use or Disclosure of PHI.
  3. Term and Termination.
     1. Term. This BAA shall be effective as of the date first written above, and shall terminate when all PHI is destroyed or returned to Health Plan. If Business Associate determines, in accordance with subsection 4(d)(ii) below, that it is infeasible to return or destroy PHI, the protections of this BAA with respect to such PHI shall remain in effect until such PHI is returned or destroyed. The obligations of Business Associate under this BAA shall survive the termination of any Underlying Agreement.
     2. Termination for Material Breach. Upon a party’s knowledge of a material breach by the other party, the non-breaching party shall either:
        1. Provide an opportunity for the breaching party to cure the breach or end the violation within a period of time specified by the non-breaching party. If the breaching party does not cure or end the violation in the specified period of time, the non-breaching party may terminate this BAA.; or
        2. Immediately terminate this BAA if the breaching party has breached a material term of this BAA and cure is not possible.
     3. Termination for Violation of HIPAA. Health Plan may terminate this BAA, effective immediately, if Business Associate is named as a defendant in a criminal proceeding for a violation of the HIPAA Rules, or other security or privacy laws, or a finding or stipulation that the Business Associate has violated any standard or requirement of the HIPAA Rules or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.
     4. Effect of Termination.
        1. Except as otherwise provided in subsection 4(d)(ii) below, within 30 days of termination of this BAA for any reason, Business Associate shall either return or destroy all PHI, as requested by Health Plan. If Health Plan requests that Business Associate return the PHI, Business Associate shall return such PHI in the form and format requested by Health Plan, or in an mutually agreeable form and format, at no charge to Health Plan. This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate
        2. If the parties determine upon reasonable consultation that returning or destroying any or all PHI is infeasible, the protections of this BAA shall continue to apply to such PHI, and Business Associate shall limit further Uses and Disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate, maintains such PHI. Health Plan hereby acknowledges and agrees that infeasibility includes Business Associate need to retain PHI for purposes of complying with its work product documentation standards and Business Associate, shall:
        3. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or carry out its legal responsibilities;
        4. Return to Health Plan the remaining PHI that Business Associate still maintains in any form;
        5. Continue to use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to prevent Use or Disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;
        6. Not Use or Disclose PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in Section 2, above, which applied prior to termination; and
        7. Return to Health Plan, if not destroyed, the PHI retained by Business Associate, when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.
  4. Miscellaneous.
     1. Regulatory References. A reference in this BAA to a section in the HIPAA Rules means the section as in effect or as amended, and for which compliance is required.
     2. Amendment. Upon the effective date of any final regulation or amendment to the HIPAA Rules, this BAA shall be deemed automatically amended so that the obligations it imposes on the parties remain in compliance with such regulations. Following amendment of the BAA in this manner, the parties shall, as necessary, work together to clarify their respective obligations with respect to any new requirements under the modified HIPAA Rules.
     3. Notice. Any notice, report or other communication to Health Plan by Business Associate required or permitted in this BAA shall be in writing and shall be deemed to have been given on the day of service if served personally or by facsimile transmission with confirmation, or three (3) days after mailing if mailed by registered or certified mail, or two (2) days after delivery by a nationally recognized overnight courier, to the Health Plan Compliance Officer at the address noted below or to such other person or address as Health Plan may designate in writing from time to time:

Gold Coast Health Plan  
711 E. Daily Drive, Suite #106   
Camarillo, CA 93010-6082

Fax: (805) 437-5132  
compliance@goldchp.org

* + 1. Interpretation. The terms and conditions of this BAA shall be interpreted as broadly as necessary to implement and comply with the HIPAA Rules and applicable state laws. The Parties agree that any ambiguity in the terms and conditions shall be resolved in favor or a meaning that complies with and is consistent with the HIPAA Rules and applicable State law.
    2. Independent Contractors. Business Associate and Health Plan are independent contractors and this BAA will not establish any relationship of partnership, joint venture, employment, franchise or agency between Business Associate and Health Plan.
    3. Conflicts. In the event that any terms of this BAA are inconsistent with the terms of any Underlying Agreement, then the terms of this BAA shall control. Otherwise, this BAA shall be construed under, and in accordance with, the terms of such Underlying Agreement, and shall be considered a supplement to such Underlying Agreement.
    4. Entire Agreement. This BAA shall constitute the entire agreement of the parties hereto with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties hereto relating to such subject matter.
    5. Governing Law. This BAA shall be governed and construed in accordance with the laws of the State of California, without regard to its conflict of laws rules.
    6. Waiver of Provisions. Any waiver of any terms and conditions hereof must be in writing and signed by the Parties hereto. A waiver of any of the terms and conditions hereof shall not be construed as a waiver of any other term or condition hereof.
    7. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than Health Plan, Business Associate, and their respective successor or assigns, any rights, remedies, obligations, or liabilities whatsoever.
    8. Equitable Relief. Business Associate understands and acknowledges that any Disclosure or misappropriation of any PHI or PI in violation of this BAA may cause Health Plan irreparable harm, the amount of which may be difficult to ascertain, and therefore agrees that Health Plan shall have the right to apply to a court of competent jurisdiction for specific performance and/or an order restraining and enjoining any such further Disclosure or Breach and for such other relief as Health Plan shall deem appropriate. Such right of Health Plan is to be in addition to the remedies otherwise available to Health Plan at law or in equity. Business Associate expressly waives the defense that a remedy in damages will be adequate and further waives any requirement in an action for specific performance or injunction for the posting of a bond by Health Plan.
    9. Insurance. In addition to any general and/or professional liability insurance required of Business Associate, Business Associate agrees to obtain and maintain, at its sole expense, liability insurance on an occurrence basis, covering any and all claims, liabilities, demands, damages, losses, costs and expenses arising from the security and privacy obligations of Business Associate, its officers, employees, agents and Subcontractors under this BAA. Such insurance coverage will be maintained for the term of this BAA, and a copy of such policy or a certificate evidencing the policy shall be provided to Health Plan at Health Plan’s request.
    10. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any Subcontractors or members of its Workforce assisting Business Associate in the performance of its obligations under this BAA available to Health Plan, at no cost to Health Plan, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Health Plan, its directors, officers or employees based upon a claim of violation of the HIPAA Rules or other applicable laws relating to privacy or security that involves Business Associate’s performance under this BAA.
    11. Indemnification. Notwithstanding anything to the contrary which may be contained in any Underlying Agreement, including but not limited to any limitations on liability contained therein, Business Associate hereby agrees to indemnify, defend, and hold harmless Health Plan and its respective officers, directors, managers, members, employees and agents from and against any and all losses, damages, fines, penalties, claims or causes of action and associated expenses (including, without limitation, costs of judgments, settlements, court costs and attorney’s fees) arising out of or resulting from the performance of Business Associate (including its employees, directors, officers, agents, or other members of its Workforce, and its Subcontractors) under this BAA, including but not limited to a Breach or State Breach, violation of the terms of this BAA, or failure of Business Associate to perform its obligations under this BAA or to comply with the HIPAA Rules or applicable state privacy or security law.
        1. Right to Tender or Undertake Defense. If Health Plan is named a party in any judicial, administrative, or other proceeding arising out of or in connection with a breach of this BAA or a violation the HIPAA Rules or other security or privacy laws by Business Associate or any subcontractor or agent under Business Associate’s control, Health Plan will have the option at any time to either (a) tender its defense to Business Associate, in which case Business Associate will provide qualified attorneys, consultants, and other appropriate professionals to represent Health Plan’s interests at Business Associate’s expense, or (b) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case Business Associate will be responsible for and shall pay reasonable fees and expenses of such attorneys, consultants, and other appropriate professionals.
        2. Right to Control Resolution. Health Plan shall have the sole right and discretion to settle, compromise, or otherwise resolve any and all claims, causes of action, liabilities, or damages against it, notwithstanding that Health Plan may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Health Plan.
    12. Audits and Enforcement. To the extent Health Plan determines that an examination of Business Associate’s security practices is necessary to comply with Health Plan’s legal obligations regarding PHI or PI, Health Plan or its authorized agents or contractors may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this BAA. Upon request of Health Plan, Business Associate agrees to certify its compliance with the HIPAA Security Rule. Provide a copy of a third party audit of Business Associate’s HIPAA security compliance and assessment of risks, complete a Health Plan security questionnaire, or provide other information that would assist Health Plan in assessing Business Associate’s compliance with the HIPAA Rules. Health Plan’s failure to inspect or request information does not relieve Business Associate of its responsibility to comply with this BAA, nor does Health Plan’s failure to detect non-compliance waive Health Plan’s rights under this BAA.
    13. Legal Actions. Promptly, but no later than five (5) business days after notice thereof, Business Associate shall advise Health Plan of any actual or potential action, proceeding, regulatory or governmental orders or actions, or any material threat thereof that becomes known to it that may affect the interests of Health Plan or jeopardize this BAA, and of any facts and circumstances that may be pertinent to the prosecution or defense of any such actual or potential legal action or proceeding, except to the extent prohibited by law.
    14. Notice of Request or Subpoena for Data. Business Associate agrees to notify Health Plan promptly, but no later than five (5) business days after Business Associate’s receipt of any request or subpoena for PHI or PI or an accounting thereof. Business Associate shall promptly comply with Health Plan’s instructions for responding to any such request or subpoena, unless such Health Plan instructions would prejudice Business Associate. To the extent that Health Plan decides to assume responsibility for challenging the validity of such request, Business Associate agrees to reasonably cooperate with Health Plan in such challenge.
    15. Requests from Secretary. Promptly, but no later than five (5) calendar days after notice thereof, Business Associate shall advise Health Plan of any inquiry by the Secretary or other State regulatory authorities concerning any actual or alleged violation of the HIPAA Rules or applicable State privacy or security law with respect to PHI or PI or PI under this BAA. Business Associate shall cooperate fully with Health Plan in responding to any such inquiry and shall provide Health Plan with a copy of any information that Business Associate submits to such authorities concurrently with such submission.

IN WITNESS WHEREOF, the parties have caused this BAA to be executed as of the effective date of the Underlying Agreement.

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| Ventura County Medi-Cal Managed Care  Commission d.b.a. Gold Coast Health Plan | |  | | [Business Associate] |
| By: |  |  | By: |  |
| Title: |  |  | Title: |  |
| Date: |  |  | Date: |  |

By: By:

Title: Chief Executive Officer Title: