RESOLUTION No. 23-572

OF THE BOARD OF SUPERVISORS OF THE COUNTY OF NEVADA

RESOLUTION APPROVING EXECUTION OF AN AGREEMENT WITH PARTNERSHIP HEALTHPLAN OF CALIFORNIA FOR REIMBURSEMENT OF COVERED SERVICES PROVIDED TO MEMBERS AND FOR COORDINATION OF SERVICES WITH THE AGREEMENT TERM COMMENCING JANUARY 1, 2024 AND REMAINING IN EFFECT UNTIL TERMINATED PURSUANT TO THIS AGREEMENT

WHEREAS, Partnership HealthPlan of California (PHC) contracts with the California Department of Health Care Services (DHCS) to provide Medi-Cal benefits to eligible persons; and

WHEREAS, as a Medi-Cal Managed care contractor, PHC is required to contract with local health departments to make available covered services to eligible persons; and

WHEREAS, by entering into this Agreement the County's Public Health Department will become a participating provider in the PHC provider network and will be able to receive reimbursement from PHC when the Department provides covered services to PHC members.

NOW, THEREFORE, BE IT HEREBY RESOLVED by the Board of Supervisors of the County of Nevada, State of California, that the Agreement with the Partnership HealthPlan of California for reimbursement of covered services at the established rate(s) provided to members and for coordination of services with the Agreement term commencing January 1, 2024, and remaining in effect until terminated be and hereby is approved, and that the Chair of the Board of Supervisors be and is hereby authorized to execute the Agreement on behalf of the County of Nevada.

Funds to be deposited into revenue accounts: 1589-40114-492-2431 / 452140; 1589-40114-492-4102 / 452140; 1589-40114-492-4104 / 452140; 1589-40114-492-5104 / 452140

PASSED AND ADOPTED by the Board of Supervisors of the County of Nevada at a regular meeting of said Board, held on the 5th day of December, 2023, by the following vote of said Board:

Ayes: Supervisors Heidi Hall, Edward C. Scofield, Lisa Swarthout, Susan Hoek and Hardy Bullock.

Noes: None.

Absent: None.

Abstain: None.

ATTEST:

JULIE PATTERSON HUNTER
Clerk of the Board of Supervisors

By: _____, Deputy COB

Edward C. Scofield, Chair

HEALTH CARE SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

And

HEALTH CARE SERVICE PROVIDER

This Health Care Services Agreement ("Agreement") is entered into this January 1, 2024 by and between Partnership HealthPlan of California, a public entity (**"PARTNERSHIP"** or **"PLAN"**), and County of Nevada, a medical and/or health care services, supplies, equipment or transportation provider, licensed in the State of California (**"PROVIDER"**).

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

PROVIDER

County of Nevada

Signature: Ed C. Scofield

Printed Name: Ed Scofield

Title: Chairman of the Board

Date: 12/11/2023

PROVIDER Address for Notices:

500 Crown Point Circle, Suite 110

Grass Valley, CA 95945

Attn: Kathy Cahill, Public Health Director

PLAN

Partnership HealthPlan of California

Signature:

Printed Name: Sonja Bjork

Title: Chief Executive Officer

Date: 12/11/23

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
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HEALTH CARE SERVICES AGREEMENT

RECITALS

A. WHEREAS, PARTNERSHIP has entered into and will maintain contracts with (the "Medi-Cal Agreements") the California Department of Health Care Services ("DHCS") in accordance with the requirements of Title 10, CCR, Section 1300 et. seq.; Welfare & Institutions ("W&I") Code, Section 14200 et. seq.; Title 22, CCR, Section 53250; and applicable federal and State laws and under which Medi-Cal beneficiaries assigned to PARTNERSHIP as Member(s) receive all medical services hereinafter defined as "Covered Services" through PARTNERSHIP.

B. WHEREAS, PARTNERSHIP will arrange for Covered Services for its Medi-Cal Members under the case management of designated Primary Care Providers chosen by or assigned to Medi-Cal Members, and all healthcare services (with the exception of emergency services) will be delivered only with authorization from PARTNERSHIP.

C. WHEREAS, PROVIDER will participate in providing Covered Services to Medi-Cal Members and will receive payment from PARTNERSHIP for the rendering of those Covered Services.

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

SECTION 1
DEFINITIONS

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

1.1 Accreditation Organization – Any organization, including, without limitation, the National Committee for Quality Assurance (NCQA) and/or other entities engaged in accrediting, certifying and/or approving PARTNERSHIP, PROVIDER, and/or their respective programs, centers or services.

1.2 Agreement – This Agreement and all of the Attachments hereto and incorporated herein by reference.

1.3 Applicable Requirements - To the extent applicable to this Agreement and the duties, right, and privileges hereunder, all federal, State, County, and local statutes, rules, regulations, and ordinances, including, but not limited to, W&I Code and its implementing regulations; the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations; the Social Security Act and its implementing regulations; the Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations; the Health Information Technology for Economic and Clinical Health ("HITECH") Act; the Deficit Reduction Act of 2005 and its implementing regulations; the Federal Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, "Affordable Care Act"); the California Consumer Privacy Act of 2018 and its implementing regulations; the California Confidentiality of Medical Information Act; the Medi-Cal Agreement; DHCS Medi-Cal Provider Manual; all Governmental Agency guidance, executive orders, instructions, letters, bulletins, and policies; and all standards, rules and regulations of Accreditation Organizations.

1.4 Attending Physician – (a) Any physician who is acting in the provision of Emergency Services to meet the medical needs of the Medi-Cal Member or (b) any physician who is, through referral from the Medi-Cal Member's PCP, actively engaged in the treatment or evaluation of a Member's condition or (c) any physician designated by the Medical Director to provide services for Direct Members.

1.5 California Children's Services (CCS) Program – A public health program providing Medically Necessary Covered Services to Members under the age of 21 years who have CCS eligible conditions, as specified in Title 22, CCR, Section 41515.1 *et seq.*

1.6 Clean Claim - A claim that can be processed without obtaining additional information from the provider of the service or from a third party.

1.7 Coordination of Benefits or "COB" - refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.8 County Organized Health System (COHS) – A plan serving either a single or multiple county area formed pursuant to California Welfare and Institutions Code Section 14087.54.

1.9 Covered Services –Those health care services set forth in Welfare and Institutions Code Sections 14000 et seq. and 14131 et seq., Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6800 et seq., except for excluded and limited services outlined in Section 4.2 of this Agreement.

1.10 Direct Members - Medi-Cal Members enrolled with PARTNERSHIP who have not been assigned to a PCP for administrative or medical reasons, e.g. CCS, ESRD, LTC, out-of-area Members, organ transplant cases, or Medi-Cal Members that the Medical Director has determined can remain unassigned to a PCP because of a long term physician/patient relationship.

1.11 Downstream Subcontractor - An individual or entity that has a subcontractor agreement with a Subcontractor.

1.12 Eligible Beneficiary – Any Medi-Cal Beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement between PARTNERSHIP and DHCS, and who is certified as eligible for Medi-Cal by the State of California.

1.13 Emergency Medical Condition – A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably expect to result in one or more of the following: i) placing the health of the individual in serious jeopardy; ii) serious impairment to bodily functions; iii) serious dysfunction of any bodily organ or part; or iv) death.

1.14 Emergency Services – Those inpatient and outpatient Covered Services that are furnished by a qualified and needed to evaluate or stabilize an Emergency Medical Condition as defined in 42 CFR section 438.114 and Health & Safety Code section 1317.1(a)(1).

1.15 Encounter Data – The information that describes health care interactions between Members and PROVIDER relating to the receipt of any item(s) or service(s) by a Member under this Agreement and subject to the standards of 42 CFR section 438.242 and 438.818.

1.16 Encounter Form - The CMS-1500 or UB-04 claim form used by PROVIDER to report to PARTNERSHIP regarding the provision of Covered Services to Medi-Cal Members.

1.17 Enrollment - The process by which an Eligible Beneficiary selects or is assigned to PARTNERSHIP.

1.18 Excluded Services - Those services which are non-Medi-Cal benefits or services PARTNERSHIP is not responsible for pursuant to its Medi-Cal Agreement.

1.19 Fee-For-Service Payment (FFS) - (1) The maximum Fee-For-Service rate determined by DHCS for the service provided under the Medi-Cal Program, or (2) the rate agreed to by PARTNERSHIP and PROVIDER. All Covered Services that are non-capitated services, and authorized by PARTNERSHIP per PARTNERSHIP Provider Manual, and compensated by PARTNERSHIP pursuant to this Agreement will be compensated by PARTNERSHIP at the lowest allowable Fee-For-Service rate unless otherwise identified in Section 5 of this Agreement.

1.20 Fraud, Waste and Abuse – The international deception or misrepresentation made by persons, including, but not limited to, PROVIDER, with the knowledge that such deception could result in some unauthorized benefit to themselves or some other person or entity. It also means practices that are inconsistent with sound fiscal and business practices or medical standards and result in an unnecessary cost to the Medi-Cal program or other Benefit Plans, or in payment for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. Fraud, Waste, and Abuse includes any act that constitutes fraud under applicable federal or state law including 42 CFR § 455.2 and Welfare & Institutions Code section 14043.1(i), and the overutilization or inappropriate utilization of services and misuse of resources.

1.21 Governmental Agencies - The Department of Managed Health Care ("DMHC"), DHCS, CMS, United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), California Attorney General - Division of Medi-Cal Fraud and Elder Abuse ("DMFEA"), and any other agency which has jurisdiction over PROVIDER, PARTNERSHIP or Medi-Cal (Medicaid).

1.22 Health Equity – The reduction or elimination of health disparities, health inequalities, or other disparities in health that adversely affect vulnerable populations.

1.23 Hospital – Any acute general care or psychiatric hospital licensed by the DHCS.

1.24 Identification Card - The card that is prepared by PARTNERSHIP, which bears the name and symbol of PARTNERSHIP and contains: a) Member name and identification number, b) Member's PCP, and other identifying data. The Identification Card is not proof of Member eligibility with PARTNERSHIP or proof of Medi-Cal eligibility.

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

1.26 Medically Necessary or Medical Necessity - Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code Section 14059.5(a) and 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a treatment or service is also Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in 42 USC Section 1396d(r)(5), as required by W&I Code Sections 14059.5(b) (1) and 14132(v), and as described in DHCS APL 19-010. Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain

age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. These services will be in accordance with accepted standards of medical practice and not primarily for the convenience of the Member or the participating healthcare provider.

1.27 Medical Home – A model of organization of primary care that delivers the core functions of primary health care which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

1.28 Medi-Cal Managed Care Program or Medi-Cal Program - The program that PARTNERSHIP operates under its Medi-Cal Agreement with DHCS.

1.29 Medi-Cal Manual - The Allied Health or Vision Care Services Provider Manuals of the DHCS, issued by the DHCS Fiscal Intermediary.

1.30 Medicare - The federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

1.31 Minor Consent Services – Covered Services of a sensitive nature that minor Members do not need parental consent to access, including, but not limited to, the following situations: a) sexual assault, including rape; b) drug or alcohol abuse for minors twelve (12) years or older; c) pregnancy; d) family planning; e) sexually transmitted diseases for minors twelve (12) years or older; f) diagnosis or treatment of infectious, contagious, or communicable diseases in minors twelve (12) years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and g) outpatient mental health care for minors twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or child abuse.

1.32 Non-Medical Transportation ("NMT") - The transportation of a Member by passenger car, taxicab or any other form of public or private conveyance to obtain covered Medi-Cal services. NMT does not include transportation services that are otherwise provided under NEMT. Refer to additional transportation requirements set forth in Attachment C-1 thru C-3.

1.33 Non-Emergency Medical Transportation (NEMT) - 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. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and per Title 22, CCR, Sections 51231.1 and 51231.2 is rendered by licensed providers. NEMT services do not include transportation of beneficiaries by

passenger car, taxicabs or other forms of public or private conveyances Refer to additional transportation requirements set forth in Attachment C-1 thru C-3.

1.34 Member or Medi-Cal Member - An Eligible Beneficiary who is enrolled in PARTNERSHIP.

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

1.36 Non-Physician Medical Practitioner - A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.

1.37 Provider Manual - The Manual of Operations Policies and Procedures for PARTNERSHIP Medi-Cal Managed Care Program.

1.38 Physician - Either an Attending Physician or a PCP, who has entered into an Agreement with PARTNERSHIP and who is licensed to provide medical care by the Medical Board of California and is a State Medi-Cal Program Provider.

1.39 Population Advisory Group - PROVIDER's process for: a) identifying Member health needs and health disparities; b) evaluating health education, cultural & linguistic, delivery system transformation and quality improvement activities and other available resources to address identified health concerns; and 3) implementing targeted strategies for health education, cultural & linguistic, and quality improvement programs and services.

1.40 Primary Care Case Management - The responsibility for primary and preventive care, and for the referral, consultation, ordering of therapy, admission to hospitals, provision of Medi-Cal covered health education and preventive services, follow-up care, coordinated hospital discharge planning that includes necessary post-discharge care, and maintenance of a medical record with documentation of referred and follow-up services.

1.41 Primary Care Provider (PCP) - The PCP is responsible for supervising, coordinating, and providing initial and Primary Care to Members; initiating referrals; and for maintaining the continuity of care for the Members; and serving as the Medical Home for Members. A PCP is a(n) general practitioner, family practitioner, internist, Obstetrician-Gynecologist, pediatrician, or Non-Physician Medical Practitioner. For SPD Members, a PCP may also be a Specialist or clinic. A resident or intern will not be a Primary Care Provider.

1.42 Primary Care Services - Those services defined in the Medi-Cal Agreement to be provided to Members by a PCP. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs.

1.43 Primary Hospital - Any hospital affiliated with PCP that has entered into an agreement with PARTNERSHIP.

1.44 Program Data - Data that includes but is not limited to: grievance data, appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month.

1.45 Provider Data - Information concerning PROVIDER, including, but not limited to, information about the contractual relationship between PROVIDER, Subcontractors, and Downstream Subcontractors; information regarding the facilities where Services are rendered; and information about the area(s) of specialization of PROVIDER, Subcontractors, and Downstream Subcontractors, as applicable.

1.46 Referral Authorization Form or RAF - The form or number evidencing authorization referral by PCP or Medical Director, or designee, to render specific non-emergency Covered Services to Medi-Cal Members.

1.47 Referral Physician - Any qualified physician, duly licensed in California that has been enrolled in the State Medi-Cal Program and executed an agreement with PARTNERSHIP, to whom a PCP may refer any Member for consultation or treatment.

1.48 Treatment Authorization Request or TAR - The form approved by PLAN for the provision of non-emergency Covered Services.

1.49 Urgent Care Services – Those Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

1.50 Quality Improvement and Health Equity Committee ("QIHEC") - A committee facilitated by PARTNERSHIP's Medical Director, or the Medical Director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.

1.51 Quality Improvement and Health Equity Transformation Program ("QIHETP") - The systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the Medi-Cal Agreement.

1.52 Senior and Persons with Disabilities (SPD) Member – A Member who falls under a specific SPD aid code as defined by DHCS.

1.53 Subcontractor - An individual or entity that has a subcontractor agreement with PARTNERSHIP that relates directly or indirectly to the performance of PARTNERSHIP's obligations under the Medi-Cal Agreement.

1.54 Template Data - Data reports submitted to DHCS by PARTNERSHIP, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

1.55 Utilization Management Program - The program(s) approved by PARTNERSHIP, which are designed to review and monitor the utilization of Covered Services, including the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Such program(s) are set forth in PARTNERSHIP's Provider Manual.

1.56 Working Days - Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays website.

SECTION 2
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

2.1 PROVIDER of Covered Services is responsible for:

2.1.1 Standards of Care – Provide Covered Services for those complaints and disorders of Medi-Cal Members that are within the PROVIDER's professional competence and licensure, as applicable, with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.

2.1.2 Licensure – Warrant that PROVIDER has, and will continue to have as long as this Agreement remains in effect, a valid unrestricted license, certification or registration in the State of California, as applicable to the Covered Services rendered. Warrant that PROVIDER has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by PARTNERSHIP. Warrant that the PROVIDER has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in any federal health programs including both Medicare and Medi-Cal Programs in accordance with the standards of participation contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations. Warrant that PROVIDER will maintain good standing in the Medi-Cal Program and affirm that PROVIDER does not appear on any Medi-Cal suspended provider list or any other list that would exclude or suspend PROVIDER from participating in any other state or federal health care program. Warrant that PROVIDER is qualified in accordance with current applicable legal, profession, and technical standards and has a valid National Provider Identification number.

(a) PROVIDER will notify PARTNERSHIP immediately if PROVIDER is referred for suspension or termination, or actually identified as suspended, excluded, or terminated from participation in the Medicare or Medi-Cal/Medicaid Programs.

2.1.3 Adequate Network or Staff - PROVIDER must maintain adequate networks and staff to ensure that it has sufficient capacity to provide and coordinate care for Covered Services in accordance with 22 CCR section 53853, Welfare & Institutions Code section 14197, 28 CCR section 1300.67.2.2, and all requirements in the Medi-Cal Agreement.

2.1.4 Covered Services – Provide the Medically Necessary Covered Services that are within his/her professional competence and in accordance with Section 2 of this Agreement.

2.1.5 Accessibility and Hours of Service – Providing Covered Services to Medi-Cal Members on a readily available and accessible basis in accordance with Applicable Requirements, including, but not limited to, 42 CFR section 438.206, Welfare & Institutions Code section 14197, 28 CCR section 1300.67.2.2, the Medi-Cal Agreement, and PARTNERSHIP's timely access policies and procedures as set forth in PARTNERSHIP's Provider Manual. Covered Services shall be provided during normal business hours at PROVIDER's usual place of business. PROVIDER shall ensure that Covered Services are provided in a timely manner appropriate for the nature of the Member's condition, consistent with good professional practice. Failure of PROVIDER to follow PARTNERSHIP timely access policies and procedures, reporting requirements, subcontractual requirements, state or federal law, or DHCS's requirements, may result, at PARTNERSHIP's option, in a corrective action plan or any sanctions.

2.1.6 Referrals – Unless otherwise agreed to by PARTNERSHIP except for Emergency Services and Urgent Care Services, provide Covered Services to Medi-Cal Members, only upon receipt of an appropriate referral to provide such Services from Medi-Cal Member's PCP PARTNERSHIP, or such other treatment authorization as described in PARTNERSHIP Provider Manual.

2.1.7 Case Management – Cooperate with Medi-Cal Member's PCP and PARTNERSHIP in the monitoring, coordination, and case management of the Medi-Cal Member's healthcare services. PROVIDER will promptly furnish a complete written report of the services rendered to a Medi-Cal Member to the Medi-Cal Member's PCP and, upon receipt of an appropriate consent, to PARTNERSHIP, on such form as may be prescribed in PARTNERSHIP Provider Manual.

a. PROVIDER agrees to abide by the Case Management Protocols which are included in PARTNERSHIP Provider Manual.

b. PROVIDER agrees to abide by PARTNERSHIP Provider Manual policies and procedures, which may be amended from time to time with ninety (90) business days' notice to PROVIDER.

c. PROVIDER to whom the PCP has delegated the authority to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.

d. PROVIDER acknowledges that PARTNERSHIP's Medical Director will assist in the management of catastrophic cases. PROVIDER will fully cooperate with PARTNERSHIP's Medical Director by providing information that may be required in the care of catastrophic cases, including but not limited to, prompt notification of known or suspected catastrophic cases.

2.1.8 Officers, Owners and Stockholders – Provide, as applicable, the ownership disclosure statement(s) included as Attachment A, the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by the Medi-Cal Agreement and/or legal requirements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. PROVIDER shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.

2.1.9 Credentialing – Provide PARTNERSHIP with a completed credentialing form, will use best efforts to notify PARTNERSHIP in advance of any change in such information, and will successfully complete a facility site review in accordance with DHCS APL 22-017, 22 CCR section 53856, and the Medi-Cal Agreement, Exhibit A, Attachment III, Provision 5.2.14 (*Site Review*), if deemed necessary by PARTNERSHIP in accordance with the Medi-Cal Agreement.

2.1.10 Actions Against PROVIDER – PROVIDER will adhere to the requirements as set forth in PARTNERSHIP Provider Manual and notify PARTNERSHIP by phone immediately and by certified mail within five (5) days of PROVIDER's learning of any action taken which results in restrictions for a medical disciplinary cause or reason as defined in Division 3 Chapter 3 Article 3 Title 22, CCR, commencing

with Sections 51000 et seq. regardless of the duration of the suspension, restriction or excluded from participating in the Medicare and Medi-Cal Programs.

2.1.11 Data Requirements - PROVIDER will comply with the following requirements:

2.1.11.1 Financial and Accounting Records – Maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith.

2.1.11.2 Reports - Submit reports as required by PARTNERSHIP or DHCS.

2.1.11.3 Social Determinants of Health (SDOH) – PROVIDER will identify, collect and provide PARTNERSHIP with data relating to Medi-Cal Members' SDOH, including but not limited to data for DHCS's 25 Priority SDOH Codes.

2.1.11.4 Compliance with Member Handbook – PROVIDER acknowledges that PROVIDER is not authorized to make nor will PROVIDER make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.

2.1.11.5 Promotional Materials – PROVIDER will consent to be identified as a PROVIDER in written materials published by PARTNERSHIP, including without limitation, marketing materials prepared and distributed by PARTNERSHIP and, display promotional materials provided by PARTNERSHIP within his/her office.

2.1.11.6 Facilities, Equipment and Personnel – Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement. All such facilities and equipment shall, to the extent required, be licensed or registered in accordance with applicable requirements. The operating personnel for such equipment shall be licensed or certified as required by applicable requirements. PROVIDER agrees to provide at least 60 days' notice to PARTNERSHIP prior to the opening of any new location, any significant changes in the capacity or services and 90 days prior to the closing of any location.

2.1.11.7 Trainings – PROVIDER shall participate in and complete all necessary trainings regarding the Medi-Cal Program conducted by PARTNERSHIP in accordance with the Medi-Cal Agreement, Exhibit

A, Attachment III, Provision 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (Provider Relations), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in and Exhibit A, Attachment III, Provision 5.1.1, Subsection C.3) (*Members' Right to Advance Directives*), and any other requirements set forth in the Medi-Cal Agreements.

2.1.11.8 Encounter Data, Provider Data, Program Data, Template Data Reporting - PROVIDER agrees to provide to PARTNERSHIP, either directly or through a designated subcontractor of PARTNERSHIP, complete, accurate, reasonable, and timely Encounter Data, Provider Data, Program Data, and Template Data, and any other reports or data as needed by PARTNERSHIP, in order for PARTNERSHIP to meet its data reporting requirements to DHCS. PROVIDER agrees to comply with the requirements set forth in Exhibit A, Attachment III, Provision 2.1.2 (Encounter Data Reporting), Provision 2.1.4 (Network Provider Data Reporting), Provision 2.1.5 (Program Data Reporting), and Provision 2.1.6 (Template Data Reporting) of the Medi-Cal Agreement.

2.1.12 Compliance with PARTNERSHIP Policies and Procedures - PROVIDER will comply with the policies and procedures approved by PARTNERSHIP for the provision of Covered Services under the Medi-Cal Managed Care Program. PROVIDER agrees to comply with all policies and procedures set forth in PARTNERSHIP Provider Manual. The Provider Manual is available through PARTNERSHIP website at www.Partnershiphp.org. PARTNERSHIP may modify Provider Manual from time to time as allowed under this Agreement. In the event the provisions of the Provider Manual are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail. In addition to the Provider Manual, additional requirements shall apply to transportation providers as set forth in Attachments C-1 thru C-3.

2.1.13 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 PARTNERSHIP's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with PARTNERSHIP by providing any information necessary to assess compliance. PARTNERSHIP shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. PROVIDER has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in PARTNERSHIP Provider Manual. PROVIDER shall provide or arrange for interpreter services for Members at all service locations at both medical and non-medical points of contact, at no

additional cost to PARTNERSHIP and at no cost to Members.

2.1.13.1 PROVIDER shall ensure that its cultural and Health Equity linguistic services programs align with PARTNERSHIP's Population Needs Assessment.

2.1.13.2 PROVIDER shall ensure cultural competency, Health Equity, sensitivity, and diversity training is provided to its PROVIDER's workforce, including employees and staff at key points of contact with Members, on an annual basis, in accordance with Medi-Cal Agreement, Exhibit A, Attachment III, Provision 5.2.11, Subsection C (Diversity, Equity and Inclusion Training).

2.1.14 Member Emergency Preparedness Plan - For purposes of this Section, "Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disaster.

2.1.14.1 PROVIDER shall annually submit evidence of adherence to CMS Emergency Preparedness Final Rule 81 FR 63859 to PARTNERSHIP;

2.1.14.2 PROVIDER shall advise PARTNERSHIP as part of the Emergency Plan; and

2.1.14.3 PROVIDER shall notify PARTNERSHIP within 24 hours of an Emergency if PROVIDER closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

2.1.15 Electronic Visit Verification – If applicable, PROVIDER shall comply with federal requirements for Electronic Visit Verification set forth in 42 USC section 1396b(l) and with state requirements for Electronic Visit Verification set forth in W&I Code section 14043.51 and all applicable DHCS APLs. If applicable PROVIDER shall implement a state-approved Electronic Visit Verification solution, as required, for personal care services provided in a Member's home by January 1, 2022 and for home health care services provided in a Member's home by January 1, 2023.

2.1.16 PROVIDER will verify Medi-Cal Member eligibility with PARTNERSHIP prior to rendering Covered Services. Referral from a PCP is not a guarantee of Medi-Cal Member eligibility with PARTNERSHIP or eligibility in the State Medi-Cal Program.

a. Member eligibility is available via telephone or electronic media. PARTNERSHIP makes best efforts to update Medi-Cal eligibility daily from DHCS eligibility tapes.

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

2.2 PARTNERSHIP is responsible for:

2.2.1 Member Assignment – Ensuring assignment of Medi-Cal Members to a PCP and Primary Hospital.

a. The Medi-Cal Member can select from the PCP contracting with PARTNERSHIP.

b. If the Medi-Cal Member does not select a PCP, PARTNERSHIP will assign Members to a PCP in a systematic manner as PARTNERSHIP deems appropriate and/or in accordance with Medi-Cal protocols.

c. The Medi-Cal Member will be assigned to a Primary Hospital for inpatient and outpatient hospital services and at which the Attending Physician has medical staff privileges.

2.2.2 Listing – PARTNERSHIP will enter the name of PROVIDER onto a list from which Medi-Cal Members may choose to receive healthcare services. Such a list will contain the following information concerning PROVIDER:

a. PROVIDER's or site's name and any group affiliation, NPI number, address, telephone number, and, if applicable, web site URL for each service location;
b. For a medical group/foundation or IPAs, the medical group/foundation or IPA name, NPI number, address, telephone number, and, if applicable, web site URL shall appear for each Physician;
c. The hours and days when each service location is open;
d. The services and benefits available at each location, including accessibility symbols approved by DHCS and whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities;
e. California license number and type of license, if applicable;
f. The area of specialty, including board certification, or other accreditation, if any;
g. PROVIDER's cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered either by PROVIDER or a skilled medical interpreter at the PROVIDER's facility, and if PROVIDER has completed cultural competence training;

h. The telephone number to call after normal business hours;
i. Identification of whether PROVIDER is available to all or new Members; and
j. Any other information necessary for PARTNERSHIP to comply with 42 CFR 438.10(h), Health and Safety Code 1367.27, and other Applicable Requirements.

2.2.3 Payment for Authorized Service Only – PARTNERSHIP will reimburse PROVIDER for Covered Services provided to Members that are Medically Necessary and, if required, authorized by PARTNERSHIP Medical Director (or his/her designee). Payment will be made based on required authorization and claim billing requirements as identified in PARTNERSHIP Provider Manual pursuant to Section 2.20.5. However, prior authorization requirements are not applied to Emergency Services, Family Planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, initial mental health and substance use disorder (SUD) assessments, and Minor Consent Services

SECTION 3
SCOPE OF SERVICES

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

3.1.1 NEMT Services when Medically Necessary and in accordance with Title 22, CCR, Section 51323 and PARTNERSHIP's Provider Manual and policies and procedures.

3.1.2 Other necessary durable medical equipment rental, and medical supplies, or other services (i.e. Substance Use Treatment services) determined by PCP to be Medically Necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member.

3.1.3 A Treatment Authorization Request approved by PARTNERSHIP's Medical Director shall be obtained for Covered Services per PARTNERSHIP's policies and procedures and as outlined in PARTNERSHIP's Provider Manual. All services and goods required or provided hereunder will be consistent with sound professional principles, community standards of care, and medical necessity.

3.1.4 Nothing expressed or implied herein shall require the PROVIDER to provide to or order on behalf of the Medi-Cal Member, Covered Services which, in the professional opinion of the PCP or PROVIDER, are not Medically Necessary for the treatment of the Medi-Cal Member's disease or disability.

3.2 Prescription Drugs – PROVIDER will coordinate with DHCS contractor administering the Medi-Cal Rx program and work directly with the Medi-Cal Rx program to resolve issues with the Member's pharmacy prescription benefits for pharmacy services. PROVIDER shall follow associated drug utilization or disease management guidelines and protocols and, if required, submit a TAR with supporting documentation for any Physician Administered Drugs requiring prior authorization.

3.3 Non-Discrimination

3.3.1 Medi-Cal Members – PROVIDER will provide services to Medi-Cal Members in the same manner as such services are provided to other patients of PROVIDER, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Program. Subject to the foregoing, PROVIDER will not subject Medi-Cal Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, ethnic group identification, age, sex, gender, gender identity, gender expression, political affiliation, health status, or physical or mental disability, medical condition (including cancer), genetic information, pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, identification with any other persons or groups defined in Penal Code section 422.56, status as a Member of PARTNERSHIP, filing a complaint as a Member of PARTNERSHIP, or any other protected category, in accordance with Title I and II of the Age Discrimination Act of 1975, Section 504 of the Rehabilitation Act, of 1973, 45 C.F.R. Part 80 and 84, Title 28 CFR Part 36, Title IX of the Educational Amendments of 1973, California Government Code Sections 7405 and 11135, California Confidentiality of Medical Information Act at Civil Code Section 51 et seq., the Unruh Civil Rights Act, W&I Code section 14029.91, Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), Section 1557 of the Affordable Care Act, and the rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination will include but is not limited to: denying any Medi-Cal Member any Covered Service or availability of a facility; providing to a Medi-Cal Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Medi-Cal Members under this Agreement except where medically indicated; subjecting a Medi-Cal Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Medi-Cal Member in any way in the enjoyment of any advantage or privilege

enjoyed by others receiving many Covered Services, treating a Medi-Cal Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, sexual orientation, identification with any other persons or groups defined in Penal Code section 422.56, or any other protected category of the Members to be served; utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and potential Members..

3.3.1.1 For the purpose of this Section, genetic information includes the carrying of a gene, which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes include, but are not limited to, Tay-Sachs trait, sickle-cell trait, Thalassemia trait, and X-linked hemophilia.

3.3.2 General Compliance. Pursuant to the requirements of the Medi-Cal Agreement, the PROVIDER will not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, gender identity, gender expression, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of PARTNERSHIP, or filing a complaint as a Member of PARTNERSHIP, and denial of family care leave. 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. PROVIDER will ensure the evaluation and treatment of PROVIDER's employees and applicants for employment are free from discrimination and harassment. PROVIDER will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et. seq.). The applicable regulations of the Fair Employment and

Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4, Chapter 5 are incorporated into this Agreement by reference and made a part hereof as set forth in full. PROVIDER will give notice of his obligations under this Section to labor organizations with which PROVIDER has a collective bargaining or other agreement.

3.3.2.1 PROVIDER shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC Section 4212). 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.

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

3.3.2.3 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.

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

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

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

3.3.2.7 PROVIDER will include the provisions of this Section 3.3 in every subcontract unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. PROVIDER will take such action with respect to any subcontract as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event PROVIDER becomes involved in, or is threatened with litigation by a 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.

3.4 QIHETP and Utilization Management Program – PROVIDER agrees to cooperate and to participate with PARTNERSHIP in QIHETP and Utilization Management Program including but not limited to activities to improve the quality of care and services and member experience, credentialing and re-credentialing, peer review and any other activities required by PARTNERSHIP, the Governmental Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. In addition, the PROVIDER will participate in the development of corrective action plans for any areas that fall below PARTNERSHIP standards ensuring medical records are readily available to the PARTNERSHIP staff as requested. PROVIDER will cooperate with collection and evaluation of data for quality performance and agrees that PARTNERSHIP may use data for quality improvement activities. PROVIDER shall comply with all final determinations rendered by PARTNERSHIP's QIHEC.

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

b. In the interest of program integrity or the welfare of Medi-Cal Members, PARTNERSHIP may introduce additional utilization controls or quality improvement programs as may be necessary.

3.5 Mental Health Parity - PROVIDER agrees to comply with all applicable mental health parity requirements set forth in 42 CFR section 438.900 et seq.

SECTION 4
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

4.1 Exclusions - Members in need of services, which are not Covered Services, as described in Division 3, Subdivision 1, Chapter 3, Article 4, Title 22, California Code of Regulations, will not be reimbursed by PARTNERSHIP. PROVIDER will not bill and expect reimbursement by PARTNERSHIP for the following excluded services provided to Medi-Cal Members described below.

4.2 Services Neither Covered nor Compensated - PROVIDER understands that PROVIDER will not be obligated to provide Medi-Cal Members with, and PARTNERSHIP will not be obligated to reimburse PROVIDER for, the following Excluded Services pursuant to this Agreement (services for which PARTNERSHIP does not receive capitation payment

from the DHCS.)

(a) Dental Services, except those Covered Services specified in Exhibit A, Attachment III, Provision 4.3.18 (*Dental*) in the Medi-Cal Agreement;.

(b) Home and Community Based Services (HCBS) waiver program services.

(c) Specialty Mental Health Services as specified in Exhibit A, Attachment III, Provision 4.3.13 (*Mental Health Services*) in the Medi-Cal Agreement;

(d) Alcohol and Substance Use Disorder treatment services, outpatient heroin and other opioid detoxification, with the except of medications for addiction treatment as specified in Exhibit A, Attachment III, Provision 4.3.14 (*Alcohol and SUD Treatment Services*) in the Medi-Cal Agreement;

(e) Laboratory services provided under the State serum alphafeto protein testing program administered by the Genetic Disease Branch of DHCS;

(f) Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Provision 5.3.7 (*Services for All Members*) in the Medi-Cal Agreement;

(g) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;

(h) Direct Observed Therapy for tuberculosis;

(i) Prayer or spiritual healing as specified in 22 CCR Section 51312;

(j) Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code Section 56340. However, PARTNERSHIP is still responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III, Provision 4.3.17 (*School-Based Services*) in the Medi-Cal Agreement;

(k) State Sponsored Services:

(l) Childhood lead poisoning case management services provided by the local health department;

(m) Non-medical services provided by to individuals with developmental disabilities, including but not limited to respite, out-of-home placement, and supportive living;

(n) End of life services as stated in Health and Safety Code Section 443 et seq. and APL 16-006;

(o) Prescribed and covered outpatient drugs, medical supplies and enteral nutritional produces when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 20-020; and

(p) Other services as may be determined by the DHCS and PARTNERSHIP, and as noticed to PROVIDER. In the event of such a change, a thirty (30) day notice will be given to PROVIDER.

4.3 Restricted Services/Special Reimbursement.

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

a. Prior authorization for restricted and/or limited service will be provided only through the Medical Director of PARTNERSHIP or his/her designee.

b. The Medi-Cal Manual specifies certain restrictions and limitations with respect to abortion and sterilization and those services are subject to the limitations specified therein.

4.3.2 PCP referral or prior authorization from PARTNERSHIP is not required for reimbursement by PARTNERSHIP to PROVIDER for the following services:

a. The provision and reimbursement of limited services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.

b. Family Planning Services are excluded from PCP capitated services and may be obtained by patient self-referral in accordance with 42 CFR Section 441.20. Family Planning services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.

4.3.3 PCP referral is not required for beneficiaries designated as Direct Members.

4.3.4 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program.

SECTION 5
PAYMENTS AND CLAIMS PROCESSING

5.1 Payment – PARTNERSHIP will reimburse PROVIDER for Covered Services provided which have been authorized by PARTNERSHIP in accordance with PARTNERSHIP policies and procedures and upon submission of a complete CMS-1500 or UB-04 claim form, along with evidence of prior authorization, if required, and submission of complete

data through electronic transfer, or, on exception, via a hard copy, as described in Section 5.3 herein. Reimbursement will be made within forty-five (45) Working Days of receipt by PARTNERSHIP of a Clean Claim. The following conditions must be met in addition to the above requirements for reimbursement of services:

5.1.1 The Medi-Cal Member is eligible for Medi-Cal benefits with PARTNERSHIP at the time the Covered Service is rendered by PROVIDER, and

5.1.2 The service is a Covered Service under the Medi-Cal Program according to the Medi-Cal Agreement, PARTNERSHIP Provider Manual and policies and procedures, and State and federal regulations in effect at that time.

5.1.3 All claims for reimbursement of Covered Services must be submitted to PARTNERSHIP within three hundred and sixty-five (365) days from the date of Services. Claims received on the 366th day form the date of service will be denied. PARTNERSHIP will make no exceptions or pro-rated payments beyond the 12 month billing limit. For claims for capitated Services, the CMS-1500 forms or the submission by electronic transfer will be made by PROVIDER the 15th day of the month following the month of service during the term of this Agreement.

5.1.4 A summary report will accompany each check identifying Medi-Cal Members who are eligible to receive Covered Services from PROVIDER and the appropriate amount of reimbursement dispersed per Medi-Cal Member.

5.2 Effect of Suspension or Exclusion - PROVIDER shall not be eligible for compensation from PARTNERSHIP for services rendered after PROVIDER has been suspended or excluded from the Medi-Cal Program. PROVIDER may not seek any payment from Members for services rendered during the time of the exclusion or suspension from the Medi-Cal Program. In the event PROVIDER's payment suspension is lifted, PARTNERSHIP will compensate PROVIDER for services rendered during the suspension at that time.

5.3 Entire Payment – PROVIDER will accept from PARTNERSHIP compensation as payment in full and discharge of PARTNERSHIP's financial liability. Covered Services provided to Medi-Cal Members by PROVIDER will be reimbursed as set forth in this Agreement and in accordance with PARTNERSHIP's Provider Manual and policies and procedures. PROVIDER will look only to PARTNERSHIP for such compensation. PARTNERSHIP has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes retroactive or prospective reduction of reimbursement rates if rates from the State to PARTNERSHIP are reduced by DHCS.

5.3.1 Rate Adjustment – In the event DHCS increases the published Medi-Cal base rate by more than five percent (5%), PARTNERSHIP has the right to adjust its rates based on Medi-Cal rates as set forth in this Agreement. PROVIDER agrees that

PARTNERSHIP may reduce its rates according to the actuarial equivalent of the increased base rates. PARTNERSHIP shall provide PROVIDER with written notice of the new rates and the parties shall meet and confer in good faith to reach agreement on such new rates.

5.3.2 Fee-For-Service (FFS) – PARTNERSHIP will reimburse the PROVIDER at the rates set forth in Attachment C for all properly documented and authorized, to the extent required, Medi-Cal Covered Services provided to Medi-Cal Members.

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

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

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

5.5.2 PROVIDER will report to PARTNERSHIP the discovery of third party tort action for a Medi-Cal Member within ten (10) business days of discovery.

5.6 Subcontracts

5.6.1 All subcontracts between PROVIDER and PROVIDER's subcontractors will be in writing, and will be entered into in accordance with the requirements of Exhibit A, Attachment III, Provisions 3.1.1 and 3.1.6 of the the Medi-Cal Agreement, and all Applicable Requirements, including but not limited to, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W&I Code Section 14200 et seq.; and Title 22, CCR, Section 53000 et seq.

5.6.2 As applicable, PROVIDER shall ensure that all subcontractors will be credentialed and recredentialed in accordance with PARTNERSHIP's policies and procedures, including checking for subcontractor's status with the Medi-Cal and Medicare programs to ensure subcontractor is not excluded or suspended from such programs.

5.6.3 All subcontracts and their amendments will become effective only upon written approval by PARTNERSHIP and Governmental Agencies, as required, and will fully disclose the method and amount of compensation or other consideration to be received by the subcontractor from the PROVIDER. PROVIDER will notify Governmental Agencies, as required, and PARTNERSHIP when any subcontract is amended or terminates. PROVIDER will maintain and make available to PARTNERSHIP and Governmental Agencies, upon request, copies of all PROVIDER's subcontracts related to ordering, referring, rendering, or providing Covered Services.

5.6.4 PROVIDER agrees to assist PARTNERSHIP in the transfer of care of Members in the event of a subcontract termination for any reason.

5.6.5 All agreements between PROVIDER and any subcontractor will require subcontractor to comply with the following:

a. Records and Records Inspection – Make 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, evaluation, examination or copying, in accordance with the Access Requirements and State's Right to Monitor, as set forth in Medi-Cal Agreement, Exhibit E, Provision 1.22 (*Inspection and Audit of Records and Facilities)* by PARTNERSHIP and the Governmental Agencies for a term of at least ten (10) years from the final date of the Medi-Cal Agreement period or from the date of completion of any audit, whichever is later; submit to PROVIDER and PARTNERSHIP all reports required by PROVIDER, PARTNERSHIP, or Governmental Agencies; and timely gather, preserve, and provide to relevant Governmental Agencies any records in subcontractor's possession, in accordance with in accordance with Exhibit E, Section 1.27 (*Litigation Support*) of the Medi-Cal Agreement.

b. Surcharges – The subcontractor will not collect a Surcharge for Covered Services from a Medi-Cal Member or other person acting on their behalf. If a Surcharge erroneously occurs, subcontractor will refund the amount of such Surcharge to the Medi-Cal Member within fifteen (15) days of the occurrence and will notify PARTNERSHIP of the action taken. Upon notice of any Surcharge, PARTNERSHIP will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Medi-Cal Member and deducting the amount of the Surcharge and the expense incurred by PARTNERSHIP in correcting the payment from the next payment due to PROVIDER.

c. Notification – Notify DHCS and PARTNERSHIP in the event the agreement with subcontractor is amended or terminated. Notice will be given in the manner specified in Section 9.4 Notices.

d. Assignment – Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS and PARTNERSHIP.

e. Additional Requirements – Be bound by the provisions of Section 3.3, Non-Discrimination; Section 8.7, Survival of Obligations after Termination; Section 7.5, PROVIDER_Indemnification; and any other provisions of this Agreement that are applicable to subcontractors.

f. Domestic Partners – Any subcontracting of subcontracting health facility, licensed in accordance with California Health & Safety Code Section 1250 will ensure that Medi-Cal Members are permitted to be visited by the Medi-Cal Member's domestic partner, the children of the Medi-Cal Member's domestic partner, and the domestic partner of the Medi-Cal Member's parent or child.

5.7 Overpayments - PROVIDER will report and return all overpayments PROVIDER identifies to PARTNERSHIP within 60 days of becoming aware of an overpayment from PARTNERSHIP and notify PARTNERSHIP in writing of the reason for overpayment in accordance with Exhibit A, Attachment III, Provision 1.3.6 (*Treatment of Overpayment Recoveries*) of the Medi-Cal Agreement. If PARTNERSHIP identifies the overpayment, PROVIDER will reimburse PARTNERSHIP within 30 Working Days of receipt of a written or electronic notice from PARTNERSHIP of an overpayment, unless PROVIDER contests such overpayment within 30 Working Days in writing and identifies the portion of the overpayment being contested and the specific reasons for contesting the overpayment. Pursuant to 42 CFR Section 438.608(d) PARTNERSHIP is required to annually report PROVIDER overpayments to DHCS. Overpayment is any payment made to PROVIDER by PARTNERSHIP to which the PROVIDER is not entitled under Title XIX of the Social Security Act.

5.8 Recoupments. PROVIDER acknowledges and agrees that, in the event that PARTNERSHIP determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Agreement, PARTNERSHIP shall have the right to recover such amounts from PROVIDER by recoupment or offset from current or future amounts due from PARTNERSHIP to PROVIDER. This right to recoupment or offset shall extend to any amounts due from PROVIDER to PARTNERSHIP including, but not limited to, amounts due because of:

5.8.1 Payments made under this Agreement that are subsequently determined to have been paid at a rate that exceeds the payment required under this Agreement.

5.8.2 Payments made for services provided to a Member that is subsequently determined to have not been eligible on the date of service.

5.8.3 Unpaid Conlan reimbursement owed by PROVIDER to Member. Refers to *Conlan v. Shewry, 2006.*

5.9 Other Insurance Coverage - Medi-Cal is the payor of last resort recognizing other Health coverage as primary. PROVIDER must bill other health coverage ("OHC") primary carrier before billing PARTNERSHIP for reimbursement of Covered Services and, with the exception of authorized Medi-Cal share of cost payments, will at no time seek compensation from Medi-Cal Members or the DHCS. PROVIDER may look to the Member for non-Covered Services upon Member's written consent for such non-covered services.

5.10 Coordination of Benefits - Prior to delivery Covered Services to Members, PROVIDER shall review the Medi-Cal eligibility record for the presence of OHC. If the requested service is covered by OHC, PROVIDER must instruct the Member to seek the service from the OHC carrier. Regardless of the presence of OHC, PROVIDER shall not refuse to render Covered Services to a Member. PROVIDER has the right to collect all sums as a result of Coordination of Benefits efforts for Covered Services provided to Medi-Cal Member with OHC.

a. The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and Applicable Requirements , the Medi-Cal Manual, and PARTNERSHIP Provider Manual.

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

c. PROVIDER shall report to PARTNERSHIP the discovery of third party insurance coverage for a Medi-Cal Member within 10 days of discovery.

d. PROVIDER will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the PROVIDER, but will be reported to PARTNERSHIP on the encounter form or encounter tape.

SECTION 6
RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

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

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

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

6.1.3 PROVIDER will ensure that medical records are legible.

6.1.4 Members shall have access to their medical records, and where legally appropriate, may receive copies of, amend, or correct their medical records. PROVIDER shall provide any notice to, or obtain any consent from, Members or, as appropriate, persons authorized to consent on behalf of Members, as may be required by any applicable federal or State laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the California Medical Information Act ("CMIA"), regarding the receipt, use and disclosure of Protected Health Information and Medical Information, as those terms are defined in HIPAA and CMIA respectively.

6.2 Records and Records Inspection Rights.

6.2.1 Access to Records – PROVIDER will permit PARTNERSHIP and any agency having jurisdiction over PARTNERSHIP, including and without limitation the Governmental Agencies, to inspect, audit, examine, copy, and evaluate the premises, facilities, equipment, books, records, contracts, computer, and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of this Agreement, for a term of at least ten (10) years from final date of the Medi-Cal Agreement period or from the date of completion of any audit, whichever is later, in accordance with the Access Requirements and State's Right to Monitor, as set forth in Medi-Cal Agreement, Exhibit E, Provision 1.22 (*Inspection and Audit of Records and Facilities*) and at all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California.

a. PARTNERSHIP will pay for the cost of copying records, $0.10 per page, not to exceed $20.00 per medical record or claim billing records.

b. PROVIDER shall permit PARTNERSHIP, Governmental Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review PROVIDER's work performed or being performed hereunder, PROVIDER's locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy records and any other books, accounts and materials relevant to the provisions of services under this Agreement. PROVIDER will provide all reasonable facilities, cooperation and assistance during such inspection and reviews, including for the safety and convenience of the authorized representatives in the performance of their duties.

6.2.2 Maintenance of Records – PROVIDER will maintain records within the State, unless otherwise approved by PARTNERSHIP and required Governmental Agency in advance, in accordance with the good business practices and generally accepted accounting principles applicable to such book and record keeping and in accordance with applicable law.

a. Records will include all books, charts, documents, papers, management information systems, procedures, Encounter Data, working papers, reports submitted to PARTNERSHIP, financial and administrative records, all medical records, medical charts, laboratory results, prescription files, subcontracts, authorizations, and other documentation pertaining to medical and non-medical services rendered to Medi-Cal Members, to the cost thereof, and to the manner and amount of payments, including payments received from Members or others on their behalf. Records include notes, documents, reports and other information related to provider disputes and determinations. Records also include all Medi-Cal 35-file paid claims data and any other records that are customarily maintained by PROVIDER for purposes of verifying claims information and reviewing appropriate utilization of Covered Services, including but not limited to the quantity and quality of Covered Services.

b. PROVIDER will retain all records for a period of at least ten (10) years from the final date of the Medi-Cal Agreement period or from the date of completion of any audit, whichever is later.

c. If there is any litigation, claim, negotiation, audit, review, examination, evaluation, or other action pending at the end of such period, then PROVIDER shall retain said records until such action is completed.

d. PROVIDER's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.

e. PROVIDER will not charge the Medi-Cal Member for the copying and forwarding of their medical records to another provider.

6.3 Disclosure to Government Officials - PROVIDER shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, PROVIDER shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Health Plan Employer Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, auditors, vendors, consultants, subcontractors, and specialists and such other officials entitled by law or under the Medi-Cal Agreements (collectively, "Government Officials") as may be necessary for compliance by PARTNERSHIP with the provisions of all state and federal laws and contractual requirements governing PARTNERSHIP, including, but not limited to, the Social Security Act and the regulations promulgated thereunder, Knox-Keene Health Care Service Plan Act of 1975 and the regulations promulgated thereunder, and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at PROVIDER's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. PROVIDER shall use all reasonable efforts to immediately notify DHCS and PARTNERSHIP of any subpoenas, document production requests, or requests for records received by PROVIDER related to this Agreement.

6.4 Records Related to Recovery for Litigation - Upon request by PARTNERSHIP, PROVIDER shall timely gather, preserve and provide to PARTNERSHIP, in the form and manner specified by PARTNERSHIP or any Governmental Agency, any information specified by PARTNERSHIP, subject to any lawful privileges, in PROVIDER'S possession, relating to threatened or pending litigation by or against PARTNERSHIP or 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 PARTNERSHIP or DHCS. PARTNERSHIP acknowledges that time may be of the essence in responding to such request. PROVIDER shall use all

reasonable efforts to immediately notify PARTNERSHIP of any subpoenas, document production requests, or requests for records, received by PROVIDER related to this Agreement.

6.5 Patient Confidentiality

a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Applicable Requirements, including, but not limited to, Title 42 CFR, Section 431.300 et seq., W&I Code Section 14100.2, and regulations adopted thereunder.

b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members will be protected by the PROVIDER and his/her staff.

c. PROVIDER may release medical records in accordance with Applicable Requirements pertaining to the release of this type of information.

d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by PROVIDER, PROVIDER: (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to PARTNERSHIP all requests for disclosure of such information, except medical records made in accordance with Applicable Requirements, (3) will not disclose except as otherwise specifically permitted by the Medi-Cal Agreement, any such information to any party other than DHCS, without DHCS's prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder, and (4) will, at the expiration or termination of the Agreement, return all such information to PARTNERSHIP or maintain such information according to written procedures sent to PARTNERSHIP by the DHCS for this purpose. PROVIDER shall provide a signed Declaration of Confidentiality in the format set forth in the Provider Manual, prior to the Effective Date of this Agreement.

e. PROVIDER and any subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, private information, and any other confidential information to any unauthorized persons or entities;

f. With respect to Minor Consent Services, PROVIDER and any subcontractors are prohibited from disclosing any information relating to such services without the express consent of the minor Member.

g. Notwithstanding any other provision of the Agreement, PROVIDER will comply with all confidentiality requirements relating to the receipt of Sensitive Services, including, but not limited, those set forth in the California Confidentiality of Medical Information Act.

SECTION 7
INSURANCE AND INDEMNIFICATION

7.1 Insurance – Throughout the term of this Agreement and any extension thereto, PROVIDER will maintain appropriate insurance programs or policies as set forth in Attachments C-1 through C-3.

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

7.2 Other Insurance Coverage - In addition to Section 7.1.1 above, PROVIDER will also maintain, at its sole expense, a policy or program of general liability insurance (or other risk protection) with minimum coverage including and no less than One Hundred Thousand Dollars ($100,000) per person for the protection of the interest and property of PROVIDER's property together with a Combined Single Limit Body Injury Liability and Property Damage Insurance of not less than One Hundred Thousand Dollars ($100,000) for its members and employees, PARTNERSHIP Members, PARTNERSHIP and third parties, namely, personal injury on or about the premises of the PROVIDER, and general liability.

7.3 Workers' Compensation - PROVIDER's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to PARTNERSHIP upon request.

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

7.5 PROVIDER Indemnification - PROVIDER will indemnify, defend, and hold harmless Medi-Cal Members, the State of California, PARTNERSHIP and their respective officers, agents, and employees from the following:

a. PROVIDER claims. Any and all claims and losses accruing or resulting to PROVIDER or any of its subcontractors or any person, firm, corporation or other entity furnishing or supplying work, services, materials or supplies in connection with the performance of this Agreement.

b. Third Party claims. Any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by PROVIDER, its agents, employees and subcontractors, in the performance of this Agreement.

c. Sanctions – Any and all sanctions or administrative penalties imposed upon PARTNERSHIP by a Governmental Agency as a result of PROVIDER's non-compliance with the terms and conditions of this Agreement.

7.6 PARTNERSHIP Indemnification – PARTNERSHIP will indemnify, defend, and hold harmless PROVIDER, and its agents, and employees from any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by PARTNERSHIP, its officers, agents or employees, in the performance of this Agreement.

SECTION 8
TERM, TERMINATION, AND AMENDMENT

8.1 Initial Term and Renewal – This Agreement will be effective on the date indicated and will automatically renew at the end of one year and annually thereafter unless terminated sooner as set forth below. Further, this Agreement is subject to DHCS approval and this Agreement will become effective only upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the Agreement, and has failed to approve or disapprove the proposed Agreement within sixty (60) calendar days of receipt.

8.2 Termination Without Cause – Either party upon ninety (90) days prior written notice to the other party may terminate this Agreement without cause.

8.3 Immediate Termination for Cause by PARTNERSHIP – PARTNERSHIP may terminate this Agreement immediately by written notice to PROVIDER upon the occurrence of any of the following events:

8.3.1 The suspension or revocation of PROVIDER's license to practice medicine in the State of California; the suspension or termination of PROVIDER's membership on the active medical staff of any hospital; or the suspension, revocation or reduction in PROVIDER's clinical privileges at any hospital; or suspension, exclusion and/or

disbarment from Medicare, Medi-Cal, or the Medicaid program in any state; or if PROVIDER's name is found on the following Medi-Cal Suspended and Ineligible Provider list posted at http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp or on the Restricted Provider Database; or loss of malpractice insurance; or failure to meet PARTNERSHIP's re-credentialing criteria.

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

8.3.3 If PARTNERSHIP determines, pursuant to procedures and standards adopted in its QIHETP, that PROVIDER has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of PARTNERSHIP Provider Manual.

8.3.4 If PARTNERSHIP or DHCS determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member.

8.3.5 If PARTNERSHIP or DHCS determines that PROVIDER has committed Fraud, Waste or Abuse; or

8.3.6 If PARTNERSHIP determines that PROVIDER has filed a petition for bankruptcy or reorganization, insolvency, as defined by law or PARTNERSHIP determines that PROVIDER is unable to meet financial obligations as described in this Agreement.

8.3.7 If PARTNERSHIP or Governmental Agency determines that PROVIDER has not performed satisfactorily; or

8.3.8 If PROVIDER breaches Section 9.10, Marketing Activity and Patient Solicitation. An immediate termination for cause made by PARTNERSHIP pursuant to this will not be subject to the cure provisions specified in Section 8.4 Termination for Cause with Cure Period.

8.4 Termination for Cause With Cure Period – In the event of a material breach by either party other than those material breaches set forth in Section 8.3, Immediate Termination for Cause by PARTNERSHIP above, the non-breaching party may terminate this Agreement upon thirty (30) Working Days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach within thirty (30) Working Days of the notification, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.

8.5 Continuation of Services Following Termination – Should this Agreement be terminated, PROVIDER will, at PARTNERSHIP's option, continue to provide Covered Services to Medi-Cal Members who are under the care of PROVIDER at the time of termination until the services being rendered to the Medi-Cal Members by PROVIDER are completed, unless PARTNERSHIP has made appropriate provision for the assumption of such services by another physician and/or provider. Upon termination of this Agreement, PROVIDER agrees to accept payment at 100% of prevailing Medi-Cal rate or the contract rate in place at the time of termination but only upon mutual written agreement between the parties and agrees to adhere to PARTNERSHIP policies and procedures.

8.6 Continuation of Services criteria:

a) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

b) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

c) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period.

d) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.

e) The care of a newborn child between birth and age 36 months.

f) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

8.7 Transition - PROVIDER will ensure an orderly transition of care for Medi-Cal Members, including but not limited to the transfer of Medi-Cal Member medical records. Payment by PARTNERSHIP 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.

8.8 Medi-Cal Member Notification Upon Termination – Notwithstanding Section 8.3, Immediate Termination for Cause by PARTNERSHIP, upon the receipt of notice of termination by either PARTNERSHIP or PROVIDER, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, PARTNERSHIP at its option, may immediately inform Medi-Cal Members of such termination notice.

8.9 Survival of Obligations After Termination – Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of PROVIDER will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 8.5, Continuation of Services Following Termination; 2) Section 6.2, Records and Records Inspection; 3) 5.7, Overpayments; and 5.8 Recoupments; 4) Section 7.5, PROVIDER Indemnification; and 5) 5.4 Medi-Cal Member Billing. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between PROVIDER and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. PROVIDER will assist PARTNERSHIP in the orderly transfer of Medi-Cal Members to the provider they choose or to whom they are referred. Furthermore, PROVIDER shall assist PARTNERSHIP 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.

8.10 Access to Medical Records Upon Termination – Upon termination of this Agreement and request by PARTNERSHIP, PROVIDER will allow the copying and transfer of medical records of each Medi-Cal Member to the physician and/or provider assuming the Medi-Cal Member's care at termination. Such copying of records will be at PARTNERSHIP's expense if termination was not for cause. PARTNERSHIP will continue to have access to records in accordance with the terms hereof.

8.11 Termination or Expiration of PARTNERSHIP's Medi-Cal Agreement – In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, PROVIDER will allow DHCS and PARTNERSHIP to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, PROVIDER will assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the PROVIDER's subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. Under no circumstances will a Medi-Cal Member be billed for this service.

SECTION 9
GENERAL PROVISIONS

9.1 Assignment. Assignment or delegation of this Agreement will be void unless prior written approval is obtained from DHCS.

9.2 Amendment – This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by DHCS and other Governmental Agency, if required, and shall become effective only as set forth in Medi-Cal Agreement.

9.2.1 PARTNERSHIP shall provide at least ninety (90) business days' notice of its intent to change a material term of this Agreement or a manual, policy, or procedure referenced in this Agreement, unless a change in state or federal law or regulations or any accreditation requirements of a private sector accreditation organization requires a shorter time frame for compliance, and PROVIDER shall have the right to negotiate and agree to the change.

9.2.2 PROVIDER shall have the right to exercise PROVIDER's intent to negotiate and agree to the change by providing a written response within thirty (30) business days of receipt of PARTNERSHIP's notice described in Section 9.2.1, and shall have the right to terminate the Agreement within ninety (90) business days of PROVIDER's receipt of the notice described in Section 9.2.1 if PROVIDER does not exercise the right to negotiate the change or no agreement is reached during negotiations. If PROVIDER does not exercise PROVIDER's right to negotiate the change or PROVIDER's right to terminate the Agreement, the material change becomes effective ninety (90) business days from the date of the notice described in Section 9.2.1.

9.2.3 In the event a change in law, regulation, the Medi-Cal Agreement, or any accreditation requirement from an accreditation organization, requires an amendment to this Agreement, PROVIDER's refusal to accept such amendment will constitute reasonable cause for PARTNERSHIP to terminate this Agreement pursuant to the termination provisions hereof.

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

9.4 Notices – Any notice required or permitted to be given pursuant to this Agreement will be in writing addressed to each party as set forth below. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. Either party will have the right to change the place to which notice is to be sent by giving forty eight (48) hours written notice to the other of any change of address.

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

California Department of Health Care Services
Medi-Cal Managed Care Division
MS. 4407, P.O. Box 997413
Sacramento, CA 95899-74133
Attention: Contracting Officer

9.4.2 PROVIDER will notify PARTNERSHIP as required by the terms of this Agreement, including, but not limited to, in the event of an amendment or the termination of the Agreement, at the following address:

Partnership HealthPlan of California
Provider Relations Department
4665 Business Center Drive
Fairfield, CA 94534

9.4.3 PARTNERSHIP will notify PROVIDER as required by the terms of this Agreement, including, but not limited to, in the event of an amendment or the termination of the Agreement, to the address indicated on the signature page of this Agreement.

9.5 Entire Agreement – This Agreement, together with the Attachments and PARTNERSHIP Provider Manual and policies and procedures, contains the entire agreement between PARTNERSHIP and PROVIDER relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

9.6 Headings – The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

9.7 Governing Law – This Agreement will be governed by and construed in accordance with all Applicable Requirements governing the Medi-Cal Agreement. Such laws and regulations include, but are not limited to, the Knox-Keene Health Care Service Plan Act of 1975 codified at Health and Safety Code Section 1340 *et seq.* (unless expressly excluded under the Medi-Cal Agreement); 28 CCR Section 1300.43 *et seq.*; W&I Code Sections 14000 and 14200 *et seq.*; and 22 CCR Sections 53800 and 53900 *et seq.* The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California and the United States of America, and the contractual

obligations of PARTNERSHIP. Further, this Agreement is subject to the requirements of the Social Security Act and the regulations promulgated thereunder. Any provision required in this Agreement by law, regulation, or the Medi-Cal Agreement will bind PARTNERSHIP and PROVIDER whether or not provided in this Agreement.

9.8 Affirmative Statement, Treatment Alternatives. PROVIDER may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

9.9 Reporting Fraud, Waste and Abuse – PROVIDER is responsible for reporting all cases of suspected Fraud, Waste and Abuse, where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members, by PARTNERSHIP-contracted physicians or providers, or by PROVIDER within 10 days to PARTNERSHIP, or PARTNERSHIP's Subcontractor or Downstream Subcontractor, if applicable, for investigation. PROVIDER shall allow PARTNERSHIP to share such information with DHCS in accordance with the provisions of the PARTNERSHIP Provider Manual and Exhibit A, Attachment III, Provision 1.3.2, Subsection D (*Contractor's Reporting Obligations*) and Provision 1.3.2, Subsection D.6) (*Confidentiality*) of the Medi-Cal Agreement.

9.10 Marketing Activity and Patient Solicitation – PROVIDER will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of PARTNERSHIP and DHCS.

9.10.1 PROVIDER will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.

9.10.2 During the period of this Agreement and for a one year period after termination of this Agreement, PROVIDER and PROVIDER's employees, agents or subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which PROVIDERS render contracted services to PARTNERSHIP Members.

9.10.3 In the event of breach of this Section 9.10, in addition to any other legal rights to which it may be entitled, PARTNERSHIP may at its sole discretion, immediately terminate this Agreement. This termination will not be subject to Section 8.4, Termination for Cause with Cure Period.

9.11 Nondisclosure and Confidentiality – PROVIDER will not disclose the payment provisions of this Agreement except as may be required by law.

9.12 Non-Exclusive Agreement – To the extent compatible with the provision of Covered Services to Medi-Cal Members for which PROVIDER accepts responsibility hereunder,

PROVIDER reserves the right to provide professional services to persons who are not Medi-Cal Members including Eligible Beneficiaries. Nothing contained herein will prevent PROVIDER from participating in any other prepaid health care program.

9.13 Counterparts – This Agreement may be executed in two (2) or more counterparts, each one (1) of, which will be deemed an original, but all of which will constitute one (1) and the same instrument.

9.14 HIPAA - PARTNERSHIP is required to comply with HIPAA and its implementing regulations, and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder, and the CMIA, regarding the receipt, use and disclosure of Protected Health Information and Medical Information, and other obligations imposed by Governmental Agencies, state laws applicable to the confidentiality of patients and medical information.

9.15 Compliance with Laws - PROVIDER shall comply with all laws and regulations applicable to its operations and to the provision of services hereunder. PARTNERSHIP will inform PROVIDER of prospective requirements added by State or federal law or DHCS that impact obligations undertaken through the Agreement before the requirement would be effective, PROVIDER agrees to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS or required by law.

9.16 Compliance with Agreement - If PARTNERSHIP determines that PROVIDER is in breach of this Agreement for failure to comply the terms of this Agreement, then PARTNERSHIP with good cause, upon written notice to the PROVIDER and in accordance with Section 9 of the Agreement may seek to impose an administrative and/or financial penalties against PROVIDER and/or seek to terminate the Agreement.

9.17 Corrective Action - PARTNERSHIP'S written notice will outline the specific reasons, in PARTERNSHIP'S determination, the PROVIDER is in non-compliance of this Agreement. Required actions for the PROVIDER to cure the breach will be set forth in the written notice. In the event the PROVIDER fails to cure those specific claims set forth by PARTNERSHIP within thirty (30) days of the receipt of the notice, PARTNERSHIP reserves the right to impose an administrative and/or financial penalties against PROVIDER and up to and including termination of the Agreement immediately upon notice to the PROVIDER. Notice of an administrative and/or financial penalty will include the following information:

a. Effective date
b. Detailed findings of non-compliance
c. Reference to the applicable statutory, regulatory, contractual, PARTNERSHIP policy and procedures, or other requirements that are the basis of the findings
d. Detailed information describing the penalties (s)

e. Timeframes by which the organization or individual shall be required to achieve compliance, as applicable
f. Indication that PARTNERSHIP may impose additional penalties if compliance is not achieved in the manner and time frame specified; and
g. Notice of a contracted provider's right to file a complaint (grievance) in accordance with PARTNERSHIP policy and procedure.

9.18 If, due to PROVIDER's non-compliance with this Agreement, administrative or monetary sanctions are imposed on PARTNERSHIP by a state or federal agency, PARTNERSHIP reserves the right to pass through any sanctions to PROVIDER, as solely determined by PARTNERSHIP.

9.19 No Waiver – No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Agreement shall impair such right or power or be construed to be a waiver thereof. A waiver by wither of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

SECTION 10
GRIEVANCES AND APPEALS

10.1 Appeals and Grievances.

10.1.1 PROVIDER complaints, concerns, or differences will be resolved as outlined in the following paragraphs and as set forth in PARTNERSHIP's Provider Manual. PROVIDER and PARTNERSHIP agree to and will be bound by the decisions of PARTNERSHIP's grievance and appeal mechanisms.

10.1.2 PROVIDER may file a formal provider grievance in writing through United States postal service or in-person at any of PARTNERSHIP's offices within 365 days of the occurrence of the determination or action or inaction that is subject of the grievance. PARTNERSHIP has forty-five (45) Working Dys from the date the grievance is received to resolve the grievance. If the resolution is not satisfactory to PROVIDER, PROVIDER may request a Provider Grievance Review Committee (PGRC) meeting. PROVIDER will be advised of decision within ten (10) Working Days after the meeting is held.

10.2 Arbitration – If the parties cannot settle grievances or disputes between them through PARTNERSHIP's internal provider dispute mechanism, the dispute will be submitted,

upon the motion of either party, to arbitration under the appropriate rules of the American Arbitration Association (AAA). All such arbitration proceedings will be administered by the AAA; however, the arbitrator will be bound by applicable state and federal law, and will issue a written opinion setting forth findings of fact and the legal reasons on which the decision is based. If possible, the arbitrator shall be an attorney or retired judge with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties agree that all arbitration proceeding will take place in Solano County, California that the appointed arbitrator will be encouraged to initiate hearing proceedings within thirty (30) days of the date of his/her appointment, and that the decision of the arbitrator will be final and binding as to each of them. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for such error. The arbitrator shall have the power to grant all legal and equitable remedies available under California law, including but not limited to, preliminary and permanent private injunctions, specific performance, reformation, cancellation, accounting and compensatory damages; provided, however, that the arbitrator(s) shall not be empowered to award punitive damages, penalties, forfeitures or attorney's fees. Each party shall be responsible for their own attorney fees. The party against whom the award is rendered will pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award, or take an appeal pursuant to the provisions of the California Civil Code.

10.2.1 Administration and Arbitration Fees. In all cases submitted to AAA, the parties agree to share equally the AAA administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees will be advanced by the initiating party subject to final apportionment by the arbitrator in the award.

10.2.2 Enforcement of Award. The parties agree that the arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce said award. Costs of filing may be recovered by the party, which initiates such action to have an award enforced.

10.2.3 Impartial Dispute Settlement. Should the parties, prior to submitting a dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, joint request for such services may be made to the AAA, or the parties may initiate such other procedures as they may mutually agree upon at such time.

10.2.4 Initiation of Procedure. Nothing contained herein is intended to create, nor will it be construed to create, any right of any Medi-Cal Member to independently initiate the arbitration procedure established in this Section. Further, nothing contained herein is intended to require arbitration of disputes regarding professional negligence between the Member and the PROVIDER.

10.2.5 Administrative Disputes. Notwithstanding anything to the contrary in this Agreement, any and all administrative disputes which are directly or indirectly related to an allegation of PCP malpractice may be excluded from the requirements of this Section.

10.2.6 Government Claims Act. Separate and apart from the provider dispute resolution process outlined in this Section, all disputes are subject to the provisions of the California Government Claims Act (Government Code Section 905 et seq.). Arbitration must be initiated within one (1) year of the earlier of the date the dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, it shall be deemed waived and forever barred.

10.3 Peer Review and Fair Hearing Process – If PROVIDER is determined to constitute a threat to the health, safety or welfare of Medi-Cal Members, PROVIDER will be referred to PARTNERSHIP Peer Review Committee. PROVIDER will be afforded an opportunity to address the Committee. PROVIDER will be notified in writing of the Peer Review Committee's recommendation and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict, or terminate the provider affiliation, to institute a monitoring procedure, or to implement continuing educational requirements.

10.4 Credentialing – PARTNERSHIP's Credentialing Committee will review all provider files to determine whether a provider meets PARTNERSHIP credentialing or re-credentialing requirements or, as applicable, provider licensure and compliance with the State Medi-Cal Program Standards of Participation. PROVIDER will be afforded an opportunity to address this Credentialing Committee if there is an adverse recommendation by the Credentialing Committee regarding PROVIDER's credentials. PROVIDER will be advised in writing of the Credentialing Committee's recommendation and notified of their rights to the Fair Hearing process. The Credentialing Committee can recommend denial of a provider's initial application or can deny the re-credentialing of a current provider.

10.5 PROVIDER will cooperate with PARTNERSHIP in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the Medi-Cal Member grievance procedure set forth in PARTNERSHIP Provider Manual. A description of PARTNERSHIP's Member grievance procedure shall be readily available at PROVIDER facilities and PROVIDER shall promptly provide Members with grievance forms upon request. PROVIDER shall cooperate with PARTNERSHIP in responding to Member grievances and requests for independent medical reviews.

SECTION 11
RELATIONSHIP OF PARTIES

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

11.2 Oversight Functions – Nothing contained in this Agreement will limit the right of PARTNERSHIP to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended. PROVIDER will comply with all monitoring provisions in the Medi-Cal Agreement and any monitoring requests by DHCS.

11.3 PROVIDER-Patient Relationship – This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her PROVIDER. PROVIDER will be responsible for maintaining the professional relationship with Medi-Cal Members and is solely responsible to such Medi-Cal Members for all medical services provided. PARTNERSHIP will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of PROVIDER. Patients must be informed of risks, benefits and consequences of the treatment options, including the option of no treatment and make decisions about ongoing and future medical treatments. PROVIDER must ensure that patients with disabilities have effective communication throughout the health system in making decisions regarding treatment options.

ATTACHMENT A
INFORMATION REGARDING OFFICERS, OWNERS, AND STOCKHOLDERS

List the names of the officers, owners, stockholders owning more than 5% of the stock issued by the physician, and major creditors holding more than 5% of the debt of the organization identified on the execution page of this Agreement. (This is a requirement of Title 22, CCR, Section 53250).

ATTACHMENT B
FACILITY LOCATIONS

List the facility site name(s), location(s) that apply to this Agreement. Add page if additional site information if applicable.

Tax Identification number: 0000

Provider Type: Ancillary, Public Health

Billing NPI: 0000

Facility or Provider Name: County of Nevada

Address: 500 Crown Point Circle
Grass Valley, California 95945

10075 Levon Ave, Truckee, California 96161

County: Nevada

Phone number: 530-265-1450

Fax number:

PHC # (internal use only): 0000

Contract# (internal use only):
County_of_Nevada_Provider_Request_to_Join_Network_005517

ATTACHMENT D

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)

ANCILLARY RATE SCHEDULE

COUNTY OF NEVADA

EFFECTIVE DATE:

The base rate of payment is based on the current State of California Medi-Cal fee-for-service rate in effect on the date services are rendered and claims will be paid at the rate set forth below. Refer to the Provider Manual for additional billing criteria at www.Partnershiphp.org.

Specialty	Reimbursement Rate
Public Health Clinic (TB and Immunizations)	100% of the Prevailing Medi-Cal Fee Schedule

ATTACHMENT X
TO THE HEALTH CARE SERVICES AGREEMENT

NETWORK PROVIDER
MEDI-CAL REQUIREMENTS

This Attachment X sets forth the applicable requirements that are mandated by the DHCS Medi-Cal Contract with Partnership Healthplan (the "Medi-Cal Contract"), State and Federal Laws and Regulations, and applicable APLs. This Attachment X is included in this Agreement to reflect compliance with laws and DHCS's requirements for "PROVIDER" as a contracted Network Provider. Any citations in this attachment are to the applicable sections of the Medi-Cal Contract or applicable law. This attachment will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this attachment and any other provision of the Agreement, this attachment will control with respect to Medi-Cal. Any capitalized term utilized in this attachment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this attachment. If a capitalized term used in this attachment is not defined in the Agreement or this attachment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

1. The parties acknowledge and agree that this Agreement specifies the services to be provided by PROVIDER. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.1); 22 CCR 53250(c)(1).)

2. The parties acknowledge and agree that the term of the Agreement, including the beginning and end dates as well as methods of extension, renegotiation, phaseout, and termination, are included in this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.2).)

3. The parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by PROVIDER from PARTNERSHIP. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.3).)

4. PROVIDER shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Agreement, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, All Plan Letters, and provisions of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.5).)

5. PROVIDER shall timely gather, preserve and provide to DHCS, CMS, Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in PROVIDER's possession, in accordance with the Medi-Cal Contract, Exhibit E, Section 1.27 (*Litigation Support*). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.10).)

6. PROVIDER must assist PARTNERSHIP as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Section 1.17 (*Phaseout Requirements*) of the Medi-Cal Contract, in the event of Medi-Cal Contract termination for any reason. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.11).)

7. The parties agree this Agreement may be terminated, or subject to other remedies, if DHCS or PARTNERSHIP determine that PROVIDER has not performed satisfactorily. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.12).)

8. PROVIDER will hold harmless both the State and Members in the event PARTNERSHIP or, if applicable, a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by PROVIDER pursuant to this Agreement. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.13).)

9. PROVIDER shall not bill a Member for Medi-Cal Covered Services. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.14).)

10. The parties confirm PROVIDER's right to all protections afforded to PROVIDER under the Health Care Providers' Bill of Rights, as set forth in Health and Safety Code Section 1375.7, including, but not limited to, PROVIDER's right to access PARTNERSHIP's dispute resolution mechanism and submit a grievance pursuant to Health and Safety Code Section 1367(h)(1). (Medi-Cal Contract, Exhibit A, Attachment III, Provision 3.1.6, Subsection A.20).)

11. PROVIDER agrees to receive training from PARTNERSHIP and receive notice from PARTNERSHIP of any changes to PARTNERSHIP's Grievance and Appeals policies and procedures. (Medi-Cal Contract, Exhibit A, Attachment III, Provision 4.6, Subsection I.)

12. PROVIDER, and PROVIDER's employees, officers and directors, shall comply with the conflict of interest requirements set forth in Exhibit H of the Medi-Cal Contract. (Medi-Cal Contract, Exhibit H, Provision A.)

13. PROVIDER agrees to all remedies specified by the Agreement and the Medi-Cal Contract, including, but not limited to, revocation of delegated functions, imposition of corrective actions, and imposition of financial sanctions, in instances where DHCS or PARTNERSHIP determine PROVIDER has not performed satisfactorily. PROVIDER acknowledges that PARTNERSHIP must, upon discovery of PROVIDER's noncompliance with the terms of the Agreement or any Medi-Cal requirements, report any significant instances (i.e., in terms of gravity, scope and/or frequency) of

noncompliance, imposition of corrective actions, or financial sanctions pertaining to the obligations under the Medi-Cal Contract to DHCS within three (3) Working Days of the discovery or imposition. (DHCS APL 23-006.)

14. This Agreement and all information received from PROVIDER in accordance with the requirements under the Medi-Cal Agreement shall become public record on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of PROVIDER, stockholders owning more than 5 percent of the stock issued by PROVIDER and major creditors holding more than 5 percent of the debt of PROVIDER will be attached to the Agreement at the time the Agreement is presented to DHCS. (Medi-Cal Agreement, Exhibit A, Attachment III, Provision 3.1.12; Welfare & Institutions Code 14452.)

15. PROVIDER shall notify PARTNERSHIP and DHCS within ten (10) calendar days of discovery that any third party may be liable for reimbursement to PARTNERSHIP and/or DHCS for Covered Services provided to a Plan Member, such as for treatment of work related injuries or injuries resulting from tortious conduct of third-parties. PROVIDER is precluded from receiving duplicate payments for Covered Services provided to Plan Members. If this occurs, PROVIDER may not retain the duplicate payment. Once the duplicate payment is identified, PROVIDER must reimburse PARTNERSHIP. If PROVIDER fails to refund the duplicate payment, PARTNERSHIP may offset payments made to PROVIDER to recoup the funds. (APL 21-007; Welfare & Institutions Code 14124.70 – 14124.791). Notice shall be provided to DHCS in accordance with Exhibit E, Provision 1.26, Subsection C of the Medi-Cal Agreement.:

16. PROVIDER shall report Provider-Preventable Condition ("PPC")-related encounters in a form and frequency as specified by PARTNERSHIP and/or DHCS. (Medi-Cal Agreement, Exhibit A, Attachment III, Provision 3.3.17;; 42 CFR 438.3(g).)

17. PROVIDER will immediately report to PARTNERSHIP the discovery of a security incident, breach or unauthorized access of Medi-Cal Member protected health information (as defined in 45 CFR 160.103) or personal information (as defined in California Civil Code Section 1798.29). (Medi-Cal Agreement, Exhibit G, Provision H.1.)

18. PROVIDER must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type. PROVIDER shall provide verification of enrollment as well as a copy of the executed Medi-Cal Provider Agreement (DHCS Form 6208) between PROVIDER and DHCS, if applicable. In the event PARTNERSHIP assisted PROVIDER with the enrollment process, PROVIDER consents to allow DHCS and PARTNERSHIP share information relating to the PROVIDER application and eligibility, including but not limited to issues related to program integrity. PROVIDER's enrollment documentation must be made available to DHCS, CMS or other authorized Governmental Agencies upon request. (APL 22-013; 42 CFR 438.602(b).)

19. PROVIDER represents and warrants that PROVIDER and its affiliates are not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive

Order No. 12549. Further, PROVIDER represents and warrants that PROVIDER is not excluded from participation in any health care program under section 1128 or 1128A of the Social Security Act. (42 CFR 438.610.)

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