ANTHEM BLUE CROSS

MEDI-CAL MANAGED CARE PROGRAM

ECM / CS PROVIDER AGREEMENT

WITH
NEVADA COUNTY BEHAVIORAL HEALTH

ANTHEM BLUE CROSS
MEDI-CAL MANAGED CARE PROGRAM
ECM / CS ANCILLARY PROVIDER AGREEMENT

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EXHIBITS

This Enhanced Care Management (ECM) / Community Supports (CS) Provider Agreement (hereinafter "Agreement") is made and entered into by and between the Medicaid Division of Blue Cross of California doing business as Anthem Blue Cross and its affiliates (hereinafter "Anthem") and Nevada County Behavioral Health (hereinafter "Provider"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 "Affiliate" means an entity owned or controlled either directly or through a parent or subsidiary entity by Anthem, or under common control with Anthem.

1.2 "Anthem Rate" means the lesser of Provider's Charges for Covered Services, or the total payment amount that Provider and Anthem have agreed upon as set forth in Exhibit A and made a part of this Agreement. The Anthem Rate is payment-in-full to Provider for Covered Services when Anthem is financially responsible to pay Provider for those Covered Services.

1.3 “Anthem Medi-Cal Managed Care Plan” is the healthcare service plan maintained and operated by Anthem pursuant to state contracts with the California Department of Health Care Services. Enrollees of an Anthem Medi-Cal Managed Care Plan are Medi-Cal beneficiaries.

1.4 "Charges" means the amount that Provider routinely bills and accepts as payment for products, services and supplies.

1.5 "Claim" means either the uniform bill claim form, electronic claim form in the format prescribed by Anthem or an invoice in a format prescribed by Anthem and submitted by Provider for payment by Anthem for Health Services provided to a Covered Individual.

1.6 "Clean Claim” means a claim that can be processed without obtaining additional information from Provider or from a third party. A Clean Claim does not include a claim being reviewed for Medical Necessity, or include a claim where the claim or Provider is under investigation for fraud, waste or abuse. [42 CFR 447.45(b)]

1.7 "Cost Share" means, with respect to Covered Services, the amount that a Covered Individual is required to pay under the terms of his or her Health Benefit Plan. Such payment may be referred to as a copayment, deductible, or other Covered Individual payment responsibility, and may either be a fixed amount or a percentage of the applicable payment owed for the Covered Services.

1.8 "Covered Individual" means for Medi-Cal beneficiaries, an “Eligible Beneficiary” as defined in the contract between Anthem and a state/federal Medicaid Program, who is enrolled in an Anthem Medi-Cal Managed Care Plan or Affiliate at the time Covered Services are provided. For purposes related to this Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to this Agreement, the term "Covered Individual" may be used interchangeably with the terms Medi-Cal, Medicaid, Covered Person, Member, Enrollee, or Subscriber, and the meaning of each is synonymous with any such other.

1.9 "Covered Services" means Medically Necessary Health Services provided by Provider to a Covered Individual as determined exclusively by Anthem in accordance with guidelines, standards, policies or regulations promulgated by the California Department of Healthcare Services or Anthem. To be a Covered Service, the services must be provided by Provider on a date when the person was both eligible with, and enrolled in, an Anthem Medi-Cal Managed Care Plan or Affiliate.

1.10 “Delegated Entity” or “Delegated Provider” means a risk bearing organization as defined in Health and Safety Code section 1375.4, that when applicable, is financially responsible for Covered Services provided by Provider and the entity to whom Provider shall seek payment from for those delegated Covered Services.

1.11 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. [see, 42 CFR 438.114]

1.12 "Health Benefit Plan" means either the document(s) describing the benefits and services covered under a Medi-Cal Managed Care Plan administered by Anthem pursuant to a contract with the California Department of Health Care Services whereby Anthem has agreed to provide managed care services to Medi-Cal beneficiaries enrolled in the Anthem Medi-Cal Managed Care Plan. Items, services or supplies not described in a Health Benefit Plan are not Covered Services.

1.13 "Health Services" means those services or supplies that Provider is licensed or certified, equipped and staffed to provide and are routinely provided to Provider’s individual patients.

1.14 "Medically Necessary" or "Medical Necessity" means, except as otherwise defined by the applicable Health Benefit Plan, procedures, supplies, equipment or services that are determined to be: (a) appropriate for the symptoms, diagnosis or treatment of the medical condition; (b) provided for the diagnosis or direct care and treatment of the medical condition; (c) within standards of good medical practice within the organized medical community; (d) not primarily for the convenience of the Covered Individual's physician or another provider, and (e) the most appropriate procedures, supplies, equipment or service which can safely be provided. The most appropriate procedures, supplies, equipment or service or supply must satisfy all of the following criteria: (i) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Covered Individual with the particular medical condition being treated than other alternatives; (ii) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and (iii) for inpatient facility admissions, the inpatient stay is necessary due to the kind of services the Covered Individual is receiving or the severity of the medical condition, and safe and adequate care cannot be received by the Covered Individual as an outpatient or in a less intensified medical setting.

1.15 "Network Participating Provider" means a provider, including physician, hospital, and ancillary healthcare provider, who has entered into a contract with Anthem to provide Health Services to Covered Individuals and participate in one or more of Anthem’s provider networks.

1.16 “Overpayment” means any funds that Provider receives or retains for providing services or supplies to Covered Individuals to which the Provider, after applicable reconciliation, is not entitled to keep.

1.17 “Provider Operations Manual” means the Anthem Medi-Cal Provider Operations Manual. The Provider Operations Manual is incorporated herein by this reference and applies to all Anthem Medi-Cal Managed Care Plans.

1.18 "Surcharge" means a fee which is charged to a Covered Individual by Provider for Health Service(s) but has not been approved by the applicable state regulatory authority, and is neither disclosed nor provided for in the Covered Individual's Health Benefit Plan.

1.19 Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered as referenced in Exhibit B.

1.20 Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), CS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan as referenced in Exhibit B.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Covered Individual Identification. Anthem shall provide a means of identifying a Covered Individual by issuing a paper, plastic, or other identification document to the Covered Individual, or by a telephonic, paper or electronic communication to the Provider. The identification will provide sufficient information so that Provider may contact Anthem to determine a Covered Individual's participation in a Health Benefit Plan. The identification alone will be insufficient to establish a Covered Individual's eligibility at the time a Health Service is provided. As such, Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself does not qualify the holder thereof as a Covered Individual, nor does the lack thereof mean that the person is not a Covered Individual.

2.1.1 Provider agrees that it will confirm that the person presenting the identification document is in fact the Covered Individual. Provider agrees that Anthem shall not be responsible for any fraudulent, deceptive or misuse of a Covered Individual’s identification document.

2.1.2 Anthem will provide verification of a Covered Individual's eligibility when Provider requests such verification. Provider acknowledges and agrees that any eligibility information provided by Anthem will not be deemed, interpreted, or considered as approval or authorization of the Medical Necessity of any Health Services provided, nor that any services provided are Covered Services.

2.2 Provider Services. Provider agrees to provide Covered Individuals with those Health Services and/or supplies set forth in Exhibit B, attached hereto and incorporated by reference herein, within the county location(s) listed in Exhibit C.

2.2.1 Provider agrees to adhere to the ECM / CS Scope of Work (SOW) as reference in Exhibit E attached hereto and incorporated by reference herein.

2.3 Provider Non-discrimination.

2.3.1 Provider agrees that its primary consideration shall be the quality of health care services rendered to Covered Individuals. As such, Provider agrees that it will provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or use any policy or practice that has the effect of discriminating against any Covered Individual because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, health status or need for health care services, the filing of any compliant or grievance, status as a litigant, status as a Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Covered Individuals that the Provider does not customarily provide to others.

2.3.2 As required by Anthem's Medi-Cal contracts with the State of California, Provider, its agents and employees, shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (over 40), marital status, and use of family and medical care leave pursuant to state or federal law. Provider shall insure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, its agents and employees, shall ensure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, its agents and employees, shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated there under (Title 2, California Code of Regulations, Section 11099 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full.

2.4 Standard of Care. Provider shall provide Health Services to Covered Individuals at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements. Should a Covered Individual suffer any complication or preventable adverse event as a direct result of the treatment and care provided by Provider, Provider agrees that Anthem does not have to pay Provider for the Medically Necessary treatment or care required to treat the complication or preventable adverse event that resulted from Provider's negligence.

2.5 Cost Effective Care. Provider shall provide Covered Services in the most cost effective setting and manner.

2.6 Publication and Use of Provider Information. For the term of this Agreement, Provider agrees that Anthem may use, publish, disclose, and display information and disclaimers, as applicable, relating to Provider. Anthem will make good faith efforts to share data with Provider prior to initial disclosure or publication of any information related to a procedure or service for its transparency initiative(s) impacting Provider, such as but not limited to, Anthem Care Comparison.

2.6.1 To the extent permitted by the requirements of the Knox-Keene Act, including Health and Safety Code Section 1395.5, for the term of this Agreement, Provider agrees to provide, and authorize Anthem to publish, its name, tax identification number or other provider identification number, and other information reasonably required by an employer, individual or government entity in Anthem marketing and informational materials. Anthem agrees that Provider may identify itself as a Network Participating Provider in the Network(s) in which Provider participates without prior approval from Anthem, provided Provider strictly follows the publishing guidelines for use of Anthem's name, symbols, trademarks, or service marks, as set forth in the provider manual(s), and that such participation in the Network is then in effect. Provider's ability to identify its participation as a Network Participating Provider without Anthem's consent excludes the issuance of any press release. Anthem shall have the right of prior approval of any other use of Anthem's symbols, trademarks, or service marks presently existing or later established. Except as provided in this section, each party reserves the right to control the use of its name and all symbols, trademarks, or service marks presently existing or later established. With the exception of limited downloading and copying rights which may be expressly posted by Anthem on its web sites, and which may be amended in Anthem's sole discretion, no rights are granted to Provider to reproduce, store, transmit or modify the content of such web sites in any

manner, to link to the home page, to deeplink to any content, or frame any portion of the web sites without Anthem's written permission.

2.7 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may each identify Provider as an Anthem Medi-Cal Managed Care Plan Network Participating Provider.

2.8 Submission of Provider Claims.

2.8.1 Provider shall submit all Claims for Covered Services within three hundred sixty-five (365) days from the date Covered Services are rendered to a Covered Individual using the national standard specifications and code sets as referenced in Exhibit A. In the event Provider is unable to submit claims using the national standard (UB04 or CMS 1500) specifications and DHCS-defined code sets, Provider shall submit an invoice to Anthem with a minimum set of data elements necessary for Anthem to convert the invoice to an encounter for submission to DHCS. If Anthem is the secondary payor, the three hundred sixty-five (365) day period will not begin until Provider receives notification of the primary payor's financial responsibility.

2.8.2 Provider agrees to bill Anthem at least monthly for any Covered Individual receiving extended Health Services from Provider. An extended Health Service is any on-going treatment in excess of 30 days.

2.8.3 Depending on the specific services provided to Covered Individuals under this ancillary provider agreement, Provider shall submit Claims on the applicable Universal Billing Form 04 (UB-04) promulgated by the National Uniform Billing Committee ("NUBC") or the CMS 1500 claim form, or any successor forms promulgated by either the NUBC or CMS. Claims shall be submitted in a format that is consistent with industry standards and acceptable to Anthem. Claims will be submitted electronically, or if electronic submission is not available, utilizing paper forms. Additionally, Provider Claims shall meet all billing requirements set forth in Anthem’s Provider Operations Manual. This manual provides additional guidance regarding Claim submission, including clarification on billing procedures for special circumstances such as when Anthem is the secondary payor. Provider agrees to comply with the billing procedures included in Anthem’s Provider Operations Manual.

2.8.4 Preventable Adverse Events ("PAEs"). When applicable, Provider shall include accurate and current CMS present-on-admission ("POA") indicators on all inpatient Claims submitted to Anthem for payment. Anthem will use such POA indicators and other applicable and CMS codes and conventions to identify PAEs and adjust inpatient payments to Provider under this Agreement consistent with instructions provided by CMS, and CMS’s practices and DRG groupers (hereinafter collectively, "CMS PAE Policies").

2.8.5 Provider agrees that Anthem may obtain and review all Provider information, medical records, or documents regarding any Claim. When requested by Anthem, Provider shall furnish records, documents or other information necessary to verify the Health Services provided, the Charges for such Health Services, or to determine Anthem’s financial liability for the Health Services listed on a Claim or invoice. When Anthem requests the additional information, medical records or documents, Provider shall provide the requested material and information within ninety (90) days, or before the expiration of the three hundred sixty-five (365) day period referenced above, whichever is longer. All materials and information will be provided to Anthem at no cost to Anthem or the Covered Individual. Once Anthem determines its payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Covered Individual's Health Benefit Plan.

2.9 Timely Payment of Clean Claims.

2.9.1 Anthem will adjudicate Clean Claims submitted by Provider within thirty (30) working days of the date Anthem receives the claim. For purposes of determining compliance with the stated time frames, the date of receipt is the date that Anthem receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

2.9.2 Payment shall be made in accordance with above stated timeframe unless the Claim, or portion thereof, is contested. If all or part of a Claim is contested, Anthem will notify Provider in writing within thirty (30) working days of receipt of the Claim. Anthem may contest a Claim where Anthem has not received all information necessary to determine its liability for the Claim, or has not been granted reasonable access to information or material concerning Provider services. Information that may be necessary to determine Anthem's liability includes reports or investigations concerning fraud, waste and abuse, necessary consents, releases, and assignments, a claim on appeal, relevant medical records, or other information necessary to determine Medical Necessity for the health care services provided.

2.9.3 The times frames set forth above shall in no way prevent or limit Anthem's right to recover any partial or complete payments made to Provider for Covered Services when Anthem determines that it has for any reason overpaid a Claim.

2.10 Payment in Full and Hold Harmless.

2.10.1 Provider agrees that the Anthem Rates set forth in Exhibit A and made a part of this Agreement shall apply to Health Services provided to Covered Individuals when Anthem is financially responsible for payment of the Covered Services.

2.10.2 Provider agrees that it will only seek payment for Covered Services from Anthem, or when applicable, from a Delegated Entity that has agreed to be financially responsible for the payment of the Covered Services provided by Provider. When Anthem has delegated financial responsibility for services provided by Provider to a Delegated Entity, Provider shall look only to the Delegated Entity for payment of those services.

2.10.3 Provider agrees that in no event, including nonpayment or insolvency by Anthem or a Delegated Entity, will Provider or any person acting on Provider's behalf, bill, charge, seek payment from, or have any recourse against a Covered Individual, or a person acting on the Covered Individual's behalf, for Covered Services provided pursuant to this Agreement. Provider agrees that it will not hold, or attempt to hold, a Covered Individual liable for the payment of Covered Services should Anthem, its Delegated Provider, or the State of California not pay Provider for Covered Services. Provider agrees not to balance bill a Covered Individual. If Anthem receives notice of any such conduct, it will take appropriate action.

This section does not prohibit Provider from collecting payment from the Covered Individual for:

2.10.3.1 Applicable Cost Shares;

2.10.3.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

(a) The waiver notifies the Covered Individual that the Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

(b) The waiver notifies the Covered Individual of the Health Service being provided and the date(s) of service;

(c) The waiver notifies the Covered Individual of the approximate cost of the Health Service; and

(d) The waiver is signed by the Covered Individual prior to receipt of the Health Service.

2.10.3.3 Any reduction in or denial of payment as a result of the Covered Individual's failure to comply with his/her utilization management program.

2.11 Provider Requirements for Services Provided to CCS Eligible Individuals.

2.11.1 Provider agrees that for Covered Individuals whose health condition is eligible for California Children's Services ("CCS"), Provider will submit a referral for CCS coverage within the time limits specified by CCS and Anthem. Provider agrees to provide Anthem with the names of all Covered Individuals whose condition may make the Covered Individual eligible to receive CCS covered services. Provider will not seek payment from Anthem, and Anthem will not pay Provider, for Health Services denied by CCS because the referral was not timely submitted by Provider to CCS.

2.11.2 If Provider is certified by CCS to provide CCS covered services to eligible Covered Individuals, Provider agrees that such services shall be provided by, or provided by order of, a CCS paneled provider. Provider will not seek payment from Anthem, and Anthem will not pay Provider, for Health Services denied by CCS because the care or treatment was not provided by a paneled provider.

2.11.3 If Provider is not certified by CCS to provide CCS covered services to eligible Covered Individuals, Provider shall transfer the care and treatment of a CCS eligible Covered Individual to the nearest CCS certified Provider within the time limits set by CCS or Anthem. When possible, the transfer shall be to a CCS paneled Network Participating Provider. Provider will not seek payment from Anthem, and Anthem will not pay Provider, for CCS covered Health Services provided to the Covered Individual if Provider fails to transfer a Covered Individual to a CCS certified Provider.

2.11.4 Provider agrees that under no situation or circumstances will Provider bill, or seek payment from, Covered Individuals for CCS covered services that were not paid.

2.12 Appeals/Adjustment Requests. If Provider believes a Claim for Covered Services has been improperly adjudicated or paid by Anthem, Provider shall submit a provider dispute request appealing Anthem's adjudication or payment of the Claim within one (1) year from the date of payment or explanation of payment. The provider dispute request shall be submitted in accordance with Anthem's payment appeal or adjustment process contained in Anthem's Provider Operations Manual. Provider acknowledges and agrees that a provider dispute request submitted more than one year after payment or explanation of payment, will be denied and no additional compensation will be paid to Provider on the Claim, and Provider will not be permitted to bill Anthem, or the Covered Individual for those services for which payment was denied.

2.13 Returning or Adjusting Overpayments.

2.13.1 Provider agrees to report and return all Overpayments it has received for services provided under this Agreement. Such Overpayments shall be reported and returned within 60 days after the date on which the Overpayment was first identified. [See, 42 U.S.C. 1320a-7k(d)].

2.13.2 Anthem may recover any Overpayment made to Provider where Anthem determined that all or part of any payment was an Overpayment under this Agreement. Where Anthem determines an Overpayment occurred, Anthem will notify Provider of the Overpayment and request a refund from Provider, in accordance with applicable laws and regulations. If Provider does not contest Anthem's notice of the Overpayment, Anthem will deduct from and set off against, the Overpayment amount from any amounts due and payable from Anthem to Provider for Covered Services provided at any time under this Agreement, in accordance with applicable laws and regulations. The Provider Operations Manual states the procedures concerning Overpayment recoveries.

2.13.3 Notwithstanding any other provision of this Agreement, a lien held by Provider under California Civil Code 3045.1, *et seq*. (or any similar law) shall not increase the maximum payment amount that Provider receives for providing Covered Services. Provider may only claim and collect under any such lien an amount which, when added to all amounts Provider has received from all other sources for such Covered Services, will not exceed the maximum compensation payable under this Agreement. Anthem may, under third party liability, third party recovery, or similar provisions of benefit agreements, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Anthem. Anthem's right to such a refund will not, in any case, alter the maximum compensation Provider is entitled to receive under this Agreement for Covered Services.

2.14 Coordination of Benefits/Subrogation. Provider agrees to cooperate with Anthem regarding subrogation and coordination of benefits as set forth in the Provider Operations Manual. Provider shall make reasonable inquiry of Covered Individuals to learn whether the Covered Individual has health insurance or health benefit coverage other than from Anthem, or is entitled to payment by a third party under any other insurance or plan of any type. Provider shall promptly notify Anthem after receipt of information regarding a Covered Individual who may have a claim involving subrogation or coordination of benefits.

Provider acknowledges and agrees that the process for coordination of benefits to individuals whose coverage is based on their eligibility in a government healthcare program shall be as follows:

2.14.1 In all cases where Health Services are provided to a Covered Individual enrolled in an Anthem Medi-Cal Managed Care Plan, Anthem shall be the payor of last resort. As such, whenever benefits are to be coordinated with some other payor for Health Services provided to a Medi-Cal Managed Care Plan enrollee, Anthem shall be the secondary payor for all treatment and care provided to the Covered Individual.

2.14.2 In all cases where Health Services are provided to a Covered Individual who is enrolled in both the Medicare and Medi-Cal programs and Medicare is primary, Anthem's payment as the secondary payor shall be limited to the Medicare beneficiary's co-pay, deductible or co-insurance amount.

2.15 Fraud, Waste and Abuse.

2.15.1 Provider shall report to Anthem's compliance officer any incident of suspected fraud, waste or abuse, as defined in title 42 Code of Federal Regulation section 455.2. Where Provider has a reason to believe that an incident of fraud, waste or abuse has occurred by Provider, or by Provider's employee, agent, subcontractor, or other individual. Provider shall report that belief to Anthem within ten (10) working days of first suspecting any incident of fraud, waste or abuse.

2.15.2 Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against suspected incidents of fraud, waste or abuse arising from the delivery of Health Services provided to any patient covered under an Anthem Medi-Cal Managed Care Plan. Upon the request of Anthem, or any state or federal agency, Provider shall discuss with the state or federal agency appropriate actions prior to and during the course of any investigation into fraud, waste or abuse.

2.15.3 This contract shall immediately terminate for cause if at any time during the lifetime of this agreement Provider is excluded from participating in a Federal health care program under 42 U.S.C. sections 1320a-7 or 1320a-7a.

2.16 Provider Subcontractors. Anthem agrees that Provider may fulfill its contractual duties and obligations under this Agreement through subcontractors or delegates (Subcontractors and delegates are collectively referred to as "subcontractors"), subject to the conditions stated below:

2.16.1 Provider shall provide Anthem with a minimum of thirty (30) days prior written notice before entering into any subcontractor agreement for Health Services when the Health Services being sub-contracted away from Provider are Health Services currently provided by Provider and are Provider's obligation under this Agreement.

2.16.2 Provider acknowledges and agrees that it shall be solely responsible for paying subcontractor(s) for all Health Services provided by its subcontractor(s), and to indemnify and hold harmless Anthem, Covered Individuals and the Department of Health Care Services for any mistake, failure, or breach of this Agreement committed by subcontractor(s).

2.16.3 Provider agrees that it will require all subcontractors to abide by the terms and conditions of this Agreement when providing Health Services to Covered Individuals.

2.16.4 Provider agrees that it will require as a condition of any subcontract for Health Services, that the subcontractor make available for inspection and duplication the subcontract and the subcontractor's books and records regarding Health Services provided to Covered Individuals. The subcontract agreement shall allow inspection and duplication by the Department of Managed Health Care, the Department of Health Care Services, MRMIB, the Center for Medicare and Medicaid Services, the Department of Justice, or Anthem consistent with the requirements of section 3.3 of this Agreement.

2.17 Compliance with Provider Operations Manual and Policies, Programs and Procedures. Provider acknowledges that the Provider Operations Manual is an integral part of the obligations contemplated by this agreement. As such, Provider agrees to abide by, and comply with, the Provider Operations Manual, and other policies, programs and procedures established and implemented by Anthem (collectively "Policies"). Anthem may modify the Provider Operations Manual and Policies by providing notice to Provider at least ninety (90) calendar days in advance of the effective date of material modifications thereto.

2.18 In Network Referrals and Transfers. Provider shall, when medically appropriate, refer and transfer Covered Individuals to Network Participating Providers. Provider acknowledges that as a condition to coverage and payment for services provided to a Covered Individual, the services must be authorized by Anthem, or by the Network Participating Provider responsible for the Covered Individual's care. Provider agrees to obtain telephone authorization from the Network Participating Provider for any unscheduled Health Services. If prior authorization cannot be obtained, Provider agrees to notify the Network Participating Provider no later than the next working day.

2.19 Programs and Provider Panels. Provider acknowledges that Anthem may have, develop, or contract to develop, various networks or programs that have a variety of provider panels, program components and other requirements. Provider agrees that Anthem may discontinue, or modify

such networks or programs without notifying Provider or obtaining Provider's acquiescence to the discontinuance or modification of such networks or programs.

2.20 Provider's Inability to Carry Out Duties. Provider shall promptly send written notice, in accordance with the Notice section of this Agreement, to Anthem of:

2.20.1 Any change in Provider's business address;

2.20.2 Any legal, governmental, or other action involving Provider which could materially impair the ability of Provider to carry out its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.20.3 Any change in accreditation, Provider affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.21 Provider Accreditation. Provider agrees that all times while the parties are contracted pursuant to this Agreement, it will maintain in good standing all licenses required by law, as well as its certification to participate in the Medicare and Medicaid programs. If applicable, Provider further agrees that it shall meet or exceed the standards required by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Healthcare Facilities Accreditation Program (HFAP), or Medicare Program certification. Copies of such licenses, certifications and standards are attached as referenced in Exhibit D and made a part of this Agreement. Provider agrees to provide copies of all such, licenses, certifications and standards to Anthem each year that they are issued, and upon Anthem's written request.

2.22 Marketing and Promotion. Provider agrees to make reasonable efforts to assist Anthem in its marketing of Health Benefit Plans. To the extent permitted by 42 C.F.R. section 438.104 and the Knox-Keene Act, including Health and Safety Code Section 1395.5, Provider shall ensure that it maintains Anthem signs and health promotion, membership, and marketing materials as reasonably requested by Anthem, consistent with the signage visibility and marketing support granted to third party payers other than Anthem.

2.23 Language Assistance Program. Anthem maintains a language assistance program that ensures limited English proficient ("LEP") Covered Individuals have access to language assistance when accessing health care services. When language assistance is needed by a Covered Individual, Provider agrees to coordinate, cooperate and comply with Anthem's language assistance program as set forth in Anthem's Provider Operations Manual. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.

2.24 Utilization Management. Provider acknowledges that Anthem has an established utilization management program that will determine whether Health Services provided to Covered Individuals are Medically Necessary. Provider agrees that Anthem is responsible for the authorization of Covered Services provided to Covered Individuals and agrees to cooperate with Anthem's utilization management process.

2.24.1 Provider shall request a pre-service authorization at least three (3) working days prior to any scheduled medical service or supply so as to avoid retrospective denial of payment for such services or supplies.

2.24.2 Provider further agrees to participate, when applicable, in the concurrent utilization management process and promptly notify Anthem in instances where it is anticipated that a Covered Individual's care and treatment exceeds the care and treatment already authorized as Medically Necessary.

2.24.3 Provider agrees to be bound by Anthem's utilization management determinations subject to the dispute resolution process contained in section 7.1.1.

2.25 Notice of Provider Ownership. As required by the Department of Health Care Services' contract with Anthem, Provider agrees to provide the following information to Anthem and permit Anthem to disclose the information to the Department of Health Care Services.

2.25.1 The names of all officers and owners of Provider.

2.25.2 The names of all stockholders owning more than ten percent (10%) of the stock issued by Provider.

2.25.3 The names of all creditors holding more than five percent (5%) of the debt of Provider.

The information required by this section is included in Exhibit F and made a part of this Agreement. Provider agrees to provide Anthem with written notice of any changes to the information listed in subsections 2.25.1 through 2.25.3 within days of the effective date of the change.

2.26 Federal, State and Contract Requirements. As a Medi-Cal managed care organization, Anthem is subject to Federal requirements mandated by the Social Security Act, state requirements contained in the Knox-Keene Act and the Welfare and Institutions Code, and obligations contained in its state contract with Department of Health Care Services. Any contractual provision required to be in this Agreement under any of the cited laws or contract shall bind Anthem and Provider, whether or not the contractual provision is expressly provided in this Agreement. Provider certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in any of such programs by any Federal agency or by any department, agency or political subdivision of the State. For purposes of this paragraph, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations. Provider shall be required to submit a Disclosure of Ownership and Control Interest Statement form included in Exhibit F during the initial contracting, recontracting and/or recredentialing process or upon request by Anthem. The Provider further agrees to notify Anthem within thirty-five (35) days of any changes to the required disclosures.

2.27 Provider agrees to submit all reports required by Anthem necessary to comply with Medi-Cal Managed Care Program requirements. Provider agrees to submit to Anthem complete, accurate, reasonable, and timely provider data and encounter data necessary for Anthem to comply with the Department of Health Care Services' data reporting requirements.

2.28 Provider shall comply with applicable monitoring provisions of the contract between Anthem and Department of Health Care Services and any monitoring request by the Department of Health Care Services. Further, Provider agrees that Anthem shall revoke the delegation of activities or obligations, or specify other remedies in instances where Department of Health Care Services or Anthem determine that Provider has not performed satisfactorily.

2.29 Provider is entitled to all protections afforded to it under the Health Care Provider's Bill of Rights, including but not limited to Health & Safety Code §1375.7.

2.30 Anthem agrees to provide cultural competency, sensitivity and diversity training for Provider and Provider Subcontractors.

2.31 If Provider is responsible for the coordination of care for Covered Individuals, Anthem agrees to share with Provider any utilization data that Department of Health Care Services has provided to Anthem and Provider agrees to receive the utilization data provided and use it as Provider is able for the purpose of Covered Individual care coordination.

2.32 PROVIDER agrees to cooperate with Anthem's administration of its internal quality of care review and provider grievance resolution procedures.

2.33 Parties acknowledge PROVIDER is a HIPAA Covered Entity, and that with respect to Covered Services as outlined in Exhibit B, PROVIDER provides such services as a HIPAA Covered Entity, and is responsible for any data collected in that capacity. PROVIDER acknowledges it is solely responsible for its compliance with HIPAA.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary Information. All information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. Neither party shall disclose any information proprietary to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services to a Covered Individual; (4) upon the express written consent of the parties; or (5) as required by law or regulation, except that either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information.

3.2 Confidentiality of Personally Identifiable Information. Both parties agree to abide by state and federal laws and regulations regarding confidentiality of the Covered Individual's personally identifiable information.

3.3 Access to Provider Records.

3.3.1 Provider agrees that Anthem or its authorized representative may review, audit, and duplicate data and other records maintained by Provider regarding services Provider provides to Covered Individuals, and the cost thereof to the extent permitted by state and federal law including but not limited to the Agreement between Anthem and the Department of Health Care Services. Records include but are not limited to: medical and clinical records, encounter data, and records relating to billing, payment and assignment. Provider shall make such records and information available to Anthem or its authorized representative at all reasonable times at Provider's place of business upon Anthem's request. Such books and records shall be made available to Anthem in a form maintained in accordance with the general standards applicable to such books or record keeping.

3.3.2 Provider further agrees that the Directors or their designated representatives from the California Department of Managed Health Care, the California Department of Health Care Services, the Department of Health and Human Services ("DHHS"), the Centers for Medicaid and Medicare Services ("CMS"), Inspector General and the Department of Justice may inspect, audit and copy all financial, medical or other records maintained by Provider as may be necessary to ensure Anthem's compliance with the requirements of the Knox-Keene Act, the Medi-Cal program, or Anthem's contract with DHCS. [42 CFR 438.6(g)] Access to Provider's records and data for any government inspection shall be consistent to the access provided to Anthem under section 3.3.1. Should any governmental regulatory entity request certified documents, information, or data as part of that entity's inspection or audit, Provider agrees to have an authorized officer certify the accuracy of the documents, information or data produced by Provider. Furthermore, Provider agrees to make available all of its premises, facilities, equipment, books, records,

contracts, computer and other electronic systems pertaining to the services Provider provides to Covered Individuals furnished under the terms of this Agreement.

3.3.3 Provider agrees that it will maintain its books, records and other papers for at least ten (10) years from the final date of the Medi-Cal Managed Care Program Agreement between Anthem and the Department of Health Care Services or from the date of completion of any audit, whichever is later. In addition, such obligation will not terminate upon the termination of this Agreement. Anthem agrees to reimburse Provider quarterly for reasonable expenses related to its review or audit not to exceed the lesser of ten (10) cents per page or a total of twenty-five dollars ($25.00) related to the duplication and preparation of requested records. Anthem maintains the right to audit such records to determine the appropriateness of payments made. Anthem's audit policy is described in its Provider Operations Manual.

If Department of Health Care Services, CMS or DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, Department of Health Care Services, CMS or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, Department of Health Care Services has the right to suspend or terminate the Provider from participation in the Medi-Cal Managed Care Program; seek recovery of payments made to the Provider; impose other sanctions under the Medi-Cal State Plan contract between Department of Health Care Services and CMS, and direct Anthem to terminate this Agreement due to fraud.

3.3.4 Anthem agrees and acknowledges that Provider's participation with the obligations contained in this section shall not be a waiver of Provider's right to maintain as confidential all proceedings of its Quality Assurance Committee, Professional Review Committee, or any other similar committee whose deliberations and findings are protected by California Evidence Code Section 1156 through 1157.7. These confidentiality provisions shall remain in effect notwithstanding any subsequent termination of this Agreement.

3.4 Transfer of Medical Records. Provider shall share a Covered Individual's medical records, and forward medical records and clinical information in a timely manner to other health care providers treating a Covered Individual, at no cost to Anthem, the Covered Individual, or other treating healthcare providers.

3.5 Upon request by the Department of Health Care Services, Provider shall timely gather, preserve and provide to the Department, in the form and manner specified by the Department of Health Care Services, any information specified by the Department, subject to any lawful privileges, in Provider's or its subcontractors' possession, relating to threatened or pending litigation by or against the Department of Health Care Services. (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 the Department of Health Care Services. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify the Department of Health Care Services of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Agreement or subcontracts entered into under this Agreement. The Department of Health Care Services shall reimburse reasonable costs incurred by Provider in complying with these requests, subject to limitations established by the Department of Health Care Services.

ARTICLE IV
INSURANCE

4.1 Anthem Insurance. Anthem shall self-insure or maintain insurance as shall be necessary to insure Anthem and its employees, acting within the scope of their duties.

4.2 Provider Insurance.

4.2.1 Provider, at its sole expense, agrees to self-insure or maintain professional liability and comprehensive general liability in amounts acceptable to Anthem as set forth in the Anthem Provider Operations Manual.

4.2.2 Upon Request by Anthem, Provider agrees to provide Anthem with copies of insurance policies or evidence of the ability to respond to any and all damages, as provided in section 4.2.1.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Anthem and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Anthem be construed to be providers of Health Services or responsible for the provision of such Health Services. Provider shall be solely responsible to the Covered Individual for treatment and medical care with respect to the provision of Health Services. Provider may freely communicate with Covered Individuals regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

5.2 Blue Cross Blue Shield Association (BCBSA). Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Anthem, that Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans ("Association"), permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the state where Anthem is located, and that Anthem is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any Association person, entity or organization, and that no Association person, entity or organization other than Anthem shall be held accountable or liable to Provider for any of Anthem's obligations to Provider created under this Agreement. Provider has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Provider to use the Brands. Any references to the Brands made by Provider in its own materials are subject to review and approval by Anthem. This section shall not create any additional obligations on the part of Anthem, other than those obligations already created under other provisions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. Anthem and Provider shall each indemnify, defend and hold harmless the other party, and its directors, officers, employees, agents and subsidiaries, from and against any and all losses, claims, damages, liabilities, costs and expenses (including, without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's failure to perform its obligations under this Agreement, and/or the indemnifying party's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification

providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Anthem be liable to Provider for any extra-contractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

6.3 Period of Limitations. Unless otherwise provided for in this Agreement, neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim. The deadline for initiating an action shall not be tolled by the appeal process, meet and confer process, provider dispute resolution process or any other administrative process. To the extent a dispute is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between Anthem and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures and any applicable state law exhaustion requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures set forth below.

7.1.1 Medical Necessity/Experimental or Investigational Disputes. Any dispute concerning whether a service provided or to be provided by Provider to a Covered Individual is not a Covered Service because such service is not Medically Necessary, or is experimental or investigational shall be resolved by an independent review organization (IRO). If the issue has already been reviewed by an IRO at the Covered Individual's request, then Anthem and Provider agree to be bound by the findings of such IRO. If not, then the Provider shall choose the IRO from a list provided by Anthem containing two or more such organizations. Anthem and Provider agree to be bound by the findings of such IRO with respect to such dispute. Anthem and Provider further agree to equally split the costs charged by the IRO for conducting each case review. This process shall be the exclusive means for resolving medical necessity / experimental or investigational disputes.

7.1.2 With respect to disputes other than those addressed in subsection 7.1.1, to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Anthem Provider Operations Manual may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees within twenty (20) calendar days following the date on

which the receiving party receives the demand letter, the parties' shall meet and confer in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, within ninety (90) calendar dates following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services (JAMS) shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of section 7.1 above that remains unresolved at the conclusion of the applicable process outlined in section 7.1 above shall be resolved by binding arbitration in the manner set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above. An arbitration demand shall not aggregate more than one hundred (100) disputed claims involving Covered Individuals arising out of this Agreement.

7.2.1 Selection and Replacement of Arbitrator(s). If the total amount in dispute as set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.2 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.3 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities to pursue, on a class basis, any dispute; provided however, that if an arbitrator or court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

ARTICLE VIII
TERM AND TERMINATION

8.1 Department of Health Care Services Contract Approval. Provider acknowledges that this Agreement, and any subsequent amendment to this Agreement, shall become effective only upon the written approval by the Department of Health Care Services, or by operation of law as follows: (i) for the initial Agreement, where the Department of Health Care Services has acknowledged receipt of the Agreement and neither approves or disapproves the Agreement within sixty (60) days of its receipt; (ii) for any amendment to the Agreement governing compensation, services, or term,

where the Department of Health Care Services has acknowledged receipt of the amendment and neither approves or disapproves the amendment within thirty (30) days of its receipt.

8.2 Initial Term of Agreement. The initial term of this Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect for a term of one (1) year ("Initial Term"), automatically renewing for consecutive one (1) year terms unless otherwise terminated as provided herein.

8.3 Termination Without Cause. At any time, either party may terminate or renegotiate this Agreement without cause with such termination to be effective on or after the expiration date of the Initial Term, by giving at least one hundred and twenty (120) days prior written notice of termination to the other party.

8.4 Future Negotiations. Notwithstanding any provision to the contrary contained in this Agreement, if the parties enter into discussions or negotiations concerning a new Provider Agreement which is to take effect subsequent to the termination or expiration of this Agreement and the parties are unable to reach agreement on the terms of the new Provider Agreement prior to the effective date of termination or expiration, the Provider shall accept as payment in full the Anthem Rate in effect under this Agreement on the day immediately prior to the termination or expiration until such time as a new Provider Agreement is effective, or until ninety (90) days after the date upon which either the Provider or Anthem gives written notice to the other terminating negotiations (such time period to be referred to as the "Interim Period").

During the Interim Period, the non-price terms, including but not limited to any hold harmless provisions of this Agreement shall be applicable, and any limitations contained in the Agreement by which Provider charge increases are capped when calculating payment under a percentage of charge methodology shall also be extended into the Interim Period, as follows: all of the charge capping percentages, measurement periods, notification requirements and methodologies in effect on the day immediately prior to termination or expiration of the Agreement shall be extended into, and through the end of, the Interim Period.

8.5 Breach of Agreement. Except for circumstances giving rise to the Termination With Cause section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.6 Termination With Cause.

8.6.1 This Agreement may be terminated automatically and immediately by Anthem if:

8.6.1.1 Provider commits any act or conduct for which its license(s), permit(s), or governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services is suspended, revoked, lost or voluntarily surrendered in whole or in part; or

8.6.1.2 Provider commits any act or conduct which results in a governmental, regulatory or accrediting entity placing Provider on probation;

8.6.1.3 Provider commits a fraud or makes any material misstatement or omission on any document related to this Agreement which it submits to Anthem or to a third party; or

8.6.1.4 Provider files for bankruptcy, makes an assignment for the benefit of its creditors without Anthem's written consent, or if a receiver is appointed over Provider's business or assets; or

8.6.1.5 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.6.1.6 Provider fails to maintain Anthem's credentialing or certification standards; or

8.6.1.7 Anthem reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being or safety of patients may be jeopardized; or

8.6.1.8 Provider has been abusive to a Covered Individual; or

8.6.2 This Agreement may be terminated automatically and immediately by Provider if:

8.6.2.1 Anthem commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.6.2.2 Anthem commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or

8.6.2.3 Anthem files for bankruptcy, or if a receiver is appointed; or

8.6.2.4 Anthem's insurance coverage as required by this Agreement lapses for any reason.

8.7 Transactions Prior to Termination. Termination shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the date of such termination.

8.8 Continuance of Care-Termination. If this Agreement is terminated, Provider shall continue to provide and be compensated for Covered Services under the terms of this Agreement to Covered Individuals who are Provider inpatients on the date of the termination until those Covered Individuals are discharged or can be safely transferred to another Network Participating Provider. If this Agreement is terminated for reasons other than the grounds set forth in the "Termination With Cause" provision, Provider, at Anthem's sole discretion, shall continue to provide and be compensated for Covered Services under the terms of this Agreement to Covered Individuals who at the time of termination are receiving services from Provider for one of the following conditions (as defined in Health and Safety Code Section 1373.96): (1) an acute condition; (2) a serious chronic condition; (3) a pregnancy; (4) a terminal illness; (5) care of a newborn child between birth and age thirty-six (36) months; or (6) performance of a surgery or other procedure that has been authorized by Plan (or the relevant delegated medical group/IPA) as part of a documented course of treatment and has been recommended and documented by Provider to occur within one hundred eighty (180) days of the termination date of this Agreement. For cases involving an acute condition, a terminal illness or a pregnancy, such services will continue through the duration of the acute condition, the terminal illness or the pregnancy, respectively. For cases involving a serious chronic condition, such services will continue until the course of treatment has been completed and arrangements have been made for a safe transfer to another participating Provider as determined by Plan in consultation with Provider, consistent with good professional practice, such period not to exceed twelve (12) months from the termination of this Agreement. For cases involving care of a newborn child, as specified above, such services will continue for a period not to exceed twelve (12) months from the termination of this Agreement.

After the effective date of termination, this Agreement shall remain in effect for the resolution of all matters unresolved as of that date.

In the event this Agreement is terminated, Provider agrees to assist Anthem in the transfer of Member medical care including making available to the Department and Anthem copies of medical records, patient files, and any other pertinent information held by Provider necessary for efficient case management of Members, as determined by the Director of the Department of Health Care Services. If applicable, Provider agrees to require its subcontractors to comply with this Section 8.8. The parties acknowledge that the cost of reproduction required by this provision will not be billed to members, but will be borne by the Provider.

8.9 Department of Health Care Services Notification. Provider agrees to timely notify the Department of Health Care Services of the termination of this Agreement.

8.10 Survival. In the event of termination of the Agreement, the following provisions shall survive:

8.10.1 Payment in Full and Hold Harmless (Section 2.10)

8.10.2 Adjustments for Incorrect Payments (Section 2.12)

8.10.3 Confidentiality/Records (Article III)

8.10.4 Indemnification and Limitation of Liability (Article VI)

8.10.5 Dispute Resolution and Arbitration (Article VII)

8.10.6 Continuance of Care-Termination (Section 8.8)

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Notwithstanding any other provision herein to the contrary, Anthem agrees to give Provider at least ninety (90) calendar days prior notice of any change by Anthem to a material term of this Agreement (except for any change necessary to comply with prospective changes required by the Department of Health Care Services, state or federal law or regulations or any accreditation requirements of a private sector accreditation organization and a shorter timeframe is required for compliance.) If Provider desires to negotiate the change (except for any change necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization), Provider shall notify Anthem no later than thirty (30) days after receipt of Anthem's notice. If the parties are unable to agree to such change or if Provider elects not to engage in any negotiations (and the change is not necessary to comply with state or federal law or regulations nor any accreditation requirements of a private sector accreditation organization), Provider may terminate this Agreement, notwithstanding the provisions of Article VIII of this Agreement, by providing Anthem, no later than forty-five (45) business days after receipt of Anthem's notice of the material change, with written notice of such intent to terminate this Agreement. Any such termination would not be effective until ninety (90) calendar days after Anthem's receipt of Provider's notice of intent to terminate.

Anthem agrees to inform Provider of prospective requirements added by the Department of Health Care Services to the contract between Anthem and the Department of Health Care Services before the requirement would be effective and Provider agrees to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by the Department of Health Care Services and to the extent possible.

9.2 Assignment. Neither Provider nor Anthem shall assign this Agreement or their respective rights, duties or obligations under this Agreement without the express written consent of the non-assigning

party. Provider and Anthem agree that consent to an assignment shall not be unreasonably withheld. Any attempted assignment in violation of this provision shall be void as to the non-assigning party. Notwithstanding the foregoing, Provider agrees that any assignment or delegation of Provider's rights, duties or obligations under this Agreement or any Provider subcontract agreement shall be null and void unless prior written approval is obtained from the Department of Health Care Services.

Provider acknowledges and agrees that this section shall not apply to any of Anthem's duties or obligation that Anthem has capitated and delegated to a Delegated Entity.

9.3 Scope/Change in Status. Anthem and Provider agree that this Agreement applies to Health Services rendered at the locations as set forth on the Provider Locations Attachment of this Agreement. Anthem may limit this Agreement to Provider's locations, operations or business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the following events:

9.3.1 Provider otherwise changes its locations, business or operations, or business or corporate form or status; or

9.3.2 Provider is acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, expansion; or

9.3.3 Provider acquires or controls any other medical Provider, service or beds through any manner, Including but not limited to asset only purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.4 Provider (a) sells, transfers or conveys its business or any substantial portion of its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; or (b) enters into a management contract with another entity.

9.3.5 If Anthem consents in writing not to limit the Agreement to the original corporate entity, then Provider warrants and covenants that this Agreement will be assumed by the new entity unless the new entity already has an agreement with Anthem, in which case Anthem will determine which Agreement will prevail. Provider shall provide Anthem one hundred twenty (120) days prior written notice of any change in this section 9.3.

9.4 Definitions. Unless otherwise specifically noted, the definitions set forth in this Agreement will have the same meaning when used in any attachment, the Provider Operations Manual and Policies.

9.5 Entire Agreement. This Agreement (including items incorporated herein by reference) constitutes the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, floods, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.

9.7 Compliance with Medi-Cal Managed Care Program, Federal and State Laws. Anthem and Provider agree to comply with all requirements of the law relating to their obligations under this Agreement, all applicable requirements of the Medi-Cal Managed Care Program, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations, and as to Provider, its agents and employees, they shall be and remain licensed and certified (including Medicare certification in unqualified, unrestricted status) in

accordance with all state and federal laws and regulations (including those applicable to utilization review and Claims payment) relating to the provision of Provider services to Covered Individuals. Provider shall supply evidence of such licensure, compliance and certifications to Anthem upon request. From time to time legislative bodies, boards, departments or agencies may enact, issue or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all such laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by such laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this section and any other provision in this Agreement, this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither it nor any of its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at http://www.epls.gov/ or its successor) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://www.oig.hhs. gov/fraud/exclusions.asp or its successor), or as otherwise designated by the Federal government. If Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to (1) immediately notify Anthem of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with, (1) the laws of the State of California unless such state laws are preempted by federal law, and (2), the laws and applicable regulations governing the Medi-Cal Managed Care contract between the Department of Health Care Services and Anthem.

9.9 Intent of the Parties. It is the intent of the parties that this fee-for-service Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent Anthem utilizes a designee, which in such event shall give rights only within the scope of such designation, and to the extent specified in the Payment in Full and Hold Harmless section of this Agreement.

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider from participating in or contracting with any provider, preferred provider organization, health maintenance organization, or health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Anthem does not warrant or guarantee that Provider will be utilized by any particular number of Covered Individuals.

9.11 Notices. All notices required or permitted to be given under this Agreement shall be in writing and shall be delivered to the party to whom notice is to be given either (i) by personal delivery (notice shall be deemed given on the date of delivery), (ii) by United Parcel Post (UPS) or other next day delivery service (notice shall be deemed given on the date of actual receipt), (iii) by first-class mail, postage prepaid certified or registered return receipt requested (notice shall be deemed given on the date of actual delivery) and (iv) by cablegram or telegram with confirmation of transmission (notice shall be deemed given on the date on the confirmation) (v) facsimile transmission with confirmation (notice shall be deemed given on the date on the confirmation) and (vi) electronic mail (notice shall be deemed given on the date of transmittal).

To ANTHEM Provider Engagement & Contracting Processing
Anthem State Sponsored Programs
21515 Burbank Blvd, 2nd Floor
Woodland Hills, California 91367

MS:CA9302-L02B

With copies to: Legal Department- State Sponsored Business
21515 Burbank Blvd, 3rd Floor
Woodland Hills, CA 91367
Attn: SSB Counsel
Fax#: (855) 852-8811

To PROVIDER at:

All notices required or permitted to be given under this Agreement to the Department shall be in writing, deposited in the United States Postal Service as first class registered mail, postage prepaid to:

Regular Mail:
DEPARTMENT OF HEALTH CARE SERVICES
Medi-Cal Managed Care Division
MS# 4409
P.O. Box 997413
Sacramento, CA 95899-7413
Attn: Contracting Officer for Anthem Blue Cross

Federal Express:
DEPARTMENT OF HEALTH CARE SERVICES
Medi-Cal Managed Care Division
MS# 4409
1501 Capitol Avenue, 4th Floor
Sacramento, CA 94814

[Note: for GMC counties use MS# 4409]

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Interpretation. No provision of this Agreement shall be interpreted for or against any party because that party or his/her/its legal representative drafted the provision(s).

(REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK)

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES

THE EFFECTIVE DATE OF THIS AGREEMENT IS: _____

ANTHEM	**NEVADA COUNTY BEHAVIORAL HEALTH**
Signature	**Signature, Authorized Representative**
Name	**Name**
Title	**Title**
Date	**Date**
	Tax ID

EXHIBIT A

PROVIDER REIMBURSEMENT

Medi-Cal

Reimbursement for authorized Health Services shall be at one hundred percent (100%) of the attached ANTHEM Medi-CAL Proprietary Fee Schedule (Fee Schedule) per county.

Provider shall accept the above reimbursement for services or the Provider's billed amount, whichever is less as payment in full for those Covered Services provided to Members. Anthem may update or adjust the Fee Schedule from time to time upon ninety (90) days prior written notice to Provider.

EXHIBIT B

COVERED SERVICES

PROVIDER shall indicate which CS will be rendered and which ECM population of focus will be served. Provider shall render services and be compensated in the counties (service area) listed in Exhibit C. Anthem may add counties in Exhibit C, to Provider's service area upon thirty (30) days written notice to Provider.

Insert check mark indicating which CS services provider will render under this agreement:

☐ Housing Transition Navigation Services

☐ Housing Deposits

☐ Housing Tenancy and Sustaining Services

☐ Short-Term Post-Hospitalization Housing

☐ Recuperative Care (Medical Respite)

☐ Respite Services

☐ Day Habilitation Programs

☐ Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)

☐ Community Transition Services/Nursing Facility Transition to a Home

☐ Personal Care and Homemaker Services

☐ Environmental Accessibility Adaptations (Home Modifications)

☐ Medically Supportive Food/Meals/Medically Tailored Meals

☐ Sobering Centers

☐ Asthma Remediation

Insert check mark indicating which of the ECM populations of focus provider will render services to under this agreement:

☐ High utilizers(Adults)

☒ Individuals experiencing homelessness, including chronic homelessness

☐ Adults & Children/Youth transitioning from incarceration

☒ Adults with Serious Mental Illness or Substance Use Disorder

☐ Adults at risk for institutionalization, eligible for long-term care

☐ Nursing facility residents who desire to return to living in the community

☐ Children or youth

EXHIBIT C

PROVIDER COUNTY SERVICE AREA

Provider can service Members within the following counties as check marked below:

Bay Area	Gold Country	Central Valley	Northern	Eastern Sierra	Los Angeles
☐ Alameda	☐ Amador	☐ Fresno	☐ Colusa	☐ Alpine	☐ Los Angeles
☐ Contra Costa	☐ Butte	☐ Kings	☐ Glenn	☐ Inyo	
☐ Sacramento	☐ Calaveras	☐ Madera	☐ Sutter	☐ Mono	
☐ San Benito	☐ El Dorado	☐ Tulare	☐ Tehama		
☐ San Francisco	☐ Mariposa				
☐ Santa Clara	☒ Nevada				
	☐ Placer				
	☐ Plumas				
	☐ Sierra				
	☐ Tuolumne				
	☐ Yuba				

EXHIBIT D

COPIES OF LICENSES AND CERTIFICATES

PROVIDER to attach copies of the following documents:

1. DOO (located within Exhibit F)
2. W-9
3. Proof of Insurance as applicable
    - Professional liability Insurance Face Sheet
    - General Liability Face Sheet
    - Commercial Auto Policy Declaration
4. Background Check
5. Practice Profile Roster
6. Business Associate Agreement as applicable

EXHIBIT E

SCOPE OF WORK

Enhanced Care Management

I. DEFINITIONS

Key terms are defined as follows:

1. **Authorized Representative (AR):** An individual or organization that the Member designates to act on her behalf with respect to the implementation of ECM services.
2. **CalAIM:** a multi-year initiative by CA-DHCS to improve the quality of life and health outcomes high-risk populations by implementing broad delivery system reforms. Enhanced Care Management (ECM) is a key CalAIM initiative.
3. **California Department of Health Care Services: (DHCS)-** A Department within the California Health and Human Services Agency that administers Medi-Cal, a program that provides healthcare services to low-income people.
4. **ECM Participant ("Participant"):** means an Anthem Medi-Cal Member who has been assigned by Anthem to receive ECM services from Provider.
5. **ECM Provider:** A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
6. **ECM Provider Guide:** Anthem's detailed expectations ECM providers including required policies and procedures, as well as best practice recommendations. The ECM Provider Guide is an essential companion to this Scope of Work.
7. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high- need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
8. **Lead Care Manager:** A Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with Anthem, as described in the DHCS-MCP ECM and CS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
9. **Managed Care Plan (MCP):** An organization contracted by DHCS to administer a standard set of healthcare benefits for a population of Medi-Cal participants. Anthem Blue Cross is a Medi-Cal MCP.
10. **Population of Focus:** One of seven defined populations that are eligible for ECM, including: Experiencing Homelessness, High Utilizers, Serious Mental Illness (SMI) or Substance Use Disorder (SUD), Transitioning from incarceration, Individuals at Risk for Institutionalization who are Eligible for Long-Term Care Services, and Nursing Facility Residents, and High-Risk Children or Youth. For a complete description see (DHCS CalAIM Proposal)
11. **Service Planning Area (SPA)**: A Los Angeles County Department of Public Health designated geographic regions. Los Angeles County is divided into 8 SPAs.

12. **Subcontract:** a written agreement entered into by the Provider with any of the following: A Provider of health care services who agrees to furnish ECM services. Or any other organization or person(s) who agree(s) to perform any administrative function or service for the Provider specifically related to fulfilling the Provider's obligations to DHCS and Anthem under the terms of this Agreement. "Subcontractor" means an individual or entity who has a Subcontract with Provider that relates directly or indirectly to the performance of the Provider's obligations under this Agreement with Anthem.

II. Service Overview

1. Certified Population(s) focus: ECM provider is certified and has agreed to render services to the population (s) of focus as referenced in Exhibit B.

2. Population segment
    1. Inclusion Criteria (if applicable): Individuals experiencing homelessness will include only those who have co-occurring SUD/SMI. Adults with SMI or SUD will only include those who are experiencing homelessness.
    2. Exclusion Criteria (if applicable): n/a

[Please identify any limitations or qualifications to accepting eligibility lists for any member who meets the population and ECM level of care criteria; e.g. only serve clients fleeing domestic violence]

3. Service Capacity
    1. See Capacity Report

II. ECM Provider Requirements Provider Experience and Qualifications

1. ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve;
2. ECM Provider shall have experience and expertise with the services it will provide;
3. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS-MCP ECM and CS Contract and associated guidance;
4. ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary;
5. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways;
6. ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including CS Providers, to coordinate care as appropriate to each Member;
7. ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

8. Contracted ECM Providers who are also contracted CS Providers should provide separate and distinct ECM and CS services to authorized members

III. Medicaid Enrollment/Vetting for ECM Providers

1. If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    a. If APL 19-004 does not apply to an ECM Provider, the ECM Provider must comply with Anthem's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.
2. Refer to the Anthem ECM Provider Guide, pg. 9, Section 2.3 for more details.

IV. Identifying Members for ECM

1. ECM Provider is encouraged to identify Members who would benefit from ECM and send a request to Anthem, to determine if the Member is eligible for ECM, consistent with Anthem's process for such request.
2. Refer to the Anthem ECM Provider Guide, pg 15-16, Section 3.1 for more details.

V. Member Assignment to an ECM Provider

1. MCP shall communicate new Member assignments to ECM Provider as soon as possible, but in any event no later than ten business days after ECM authorization.
2. With the exception noted below, ECM Provider shall immediately accept all members assigned by Anthem for ECM, provided that the member is attributed to a population of focus which the Provider is certified to serve. Provider shall not be allowed to serve a subset of preferred members to the exclusion of other eligible members in the population of focus (e.g., empaneled members, Provider referrals). The purpose of this policy is ensure sufficient capacity for all eligible members in a County. Provider may request to revisit this policy in the future.
    a. Exception: ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.
        1. ECM Provider shall immediately alert Anthem if it does not have the capacity to accept a Member assignment.
3. Upon initiation of ECM, ECM Provider shall ensure each Member assigned has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports (CS), and other services that address social determinants of health (SDOH) needs, regardless of setting.
4. ECM Provider shall advise the Member on the process for changing ECM Providers, which is permitted at any time.
    a. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.
    b. ECM Provider shall notify Anthem if the Member wishes to change ECM Providers.
    c. MCP must implement any requested ECM Provider change within thirty days (20 business days).
5. ECM Provider shall advise the Member on the process for changing Lead Care Manager, which is permitted at any time.
    a. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.

b. MCP must implement any requested ECM Provider change within thirty days (20 business days).

6. Refer to the Anthem ECM Provider Guide, pg 22. Section 3.4.2 for more details.

VI. ECM Provider Staffing

1. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned Member consistent with this Provider Standard Terms and Conditions, the DHCS-MCP ECM CS Contract and any other related DHCS guidance.
2. The ECM provider is expected to follow any DHCS provided guidance on staffing.
3. Refer to the Anthem Provider Guide, pg. 9-12, Section 2.5.1 for additional staffing recommendations.

VII. ECM Provider Outreach and Member Engagement

1. ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with Anthem's Policies and Procedures.
2. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.
3. ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.
    a. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences:
        i. Mail
        ii. Email
        iii. Texts
        iv. Telephone calls
        v. Telehealth
4. ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and the Contract with Anthem.
5. Refer to the Anthem ECM Provider Guide, pg 30, Section 3.8.1 for more details.

VIII. Initiating Delivery of ECM

1. ECM Provider shall obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between Anthem and ECM, CS, and other Providers involved in the provision of Member care to the extent required by federal law.
2. Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.
3. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to Anthem.
4. ECM Provider shall notify Anthem to discontinue ECM under the following circumstances:
    a. The Member has met their care plan goals for ECM;
    b. The Member is ready to transition to a lower level of care;

c. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
d. ECM Provider has not had any contact with the Member despite multiple attempts.

5. When ECM is discontinued, or will be discontinued for the Member, Anthem is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).
6. Refer to the Anthem ECM Provider Guide, pg. 19, Section 3.3 for more details.

IX. ECM Requirements and Core Service Components of ECM

1. ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.
2. ECM Provider shall:
   a. Ensure each Member receiving ECM has a Lead Care Manager;
   b. Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;
   c. Alert Anthem to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources; and
   d. Follow Anthem instruction and participate in efforts to ensure ECM and other care management services are not duplicative.
3. ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as CS Providers, as appropriate, to coordinate Member care.
4. ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with Anthem's Policies and Procedures, as follows:
   a. Outreach and Engagement of Anthem Members into ECM.
   b. Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:
      i. Engaging with each Member authorized to receive ECM primarily through in-person contact; When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
      ii. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care and may be needed to inform the development of an individualized Care Management Plan.
      iii. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
      iv. Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental

v. health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community- based and social services, and housing;
vi. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and
vii. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight

c. Enhanced Coordination of Care, which shall include, but is not limited to:
i. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;
ii. Maintaining regular contact with all Providers, that are identified as being a part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;
iii. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
iv. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
v. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
vi. Ensuring regular contact with the Member and their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

d. Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:
vii. Working with Members to identify and build on successes and potential family and/or support networks;
viii. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and
ix. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

e. Comprehensive Transitional Care, which shall include, but is not limited to:
x. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
xi. For Members who are experiencing, or who are likely to experience a care transition:
1. Developing and regularly updating a transition of care plan for the Member;
2. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
3. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility,

4. residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
5. Coordinating medication review/reconciliation; and
6. Providing adherence support and referral to appropriate services.

f. Member and Family Supports, which shall include, but are not limited to:
   i. Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and Anthem, as applicable;
   ii. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;
   iii. Ensuring the Member's ECM Provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);
   iv. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;
   v. Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and
   vi. Ensuring that the Member has a copy of their Care Plan and information about how to request updates.

g. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
   vii. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by Anthem as CS; and
   viii. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

X. Subcontracting

1. ECM Provider may subcontract with other entities or individuals in order to fulfill the obligations of ECM. Provider shall maintain policies and procedures, approved by Anthem, to ensure that Subcontractors fully comply with all terms and conditions of this Agreement, applicable regulations and DHCS regardless of sub-contracting arrangements, Provider retains overall responsibility for all duties outlined in this agreement.
2. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-MCP ECM CS Contract.
3. If the ECM Provider subcontracts, the Provider shall be responsible for all required reporting and coordination.
4. ECM Provider will disclose its subcontracting relationship to Anthem, and demonstrate subcontractor readiness
5. Anthem reserves the right to allow or disallow a Provider's subcontractor

XI. Delegation

1. When determined as necessary and appropriate through the Anthem Provider evaluation process, Anthem may delegate certain responsibilities to other providers, community-based organizations, or internal teams until it is determined that the Provider is ready to take on said responsibility.

IX. Training

1. ECM Providers shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by Anthem, including in-person sessions, webinars, and/or calls, as necessary.
2. Refer to the Anthem ECM Provider Guide for more details.

X. Data Sharing to Support ECM

1. Anthem will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS and Anthem guidance for data sharing where applicable:
    a. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
    b. Encounter and/or claims data;
    c. Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members; and
    d. Reports of performance on quality measures and/or metrics, as requested.
2. Refer to the Anthem ECM Provider Guide, pg. 20, Section 3.3.3 for more details.

XI. Quality and Oversight

1. ECM Provider acknowledges that Anthem will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include site visits, audits and/or corrective actions.
2. ECM Provider shall respond to all Anthem requests for information and documentation to permit ongoing monitoring of ECM.
3. Program (e.g., ECM Director) and organization-level (e.g. CFO) leadership shall, at a minimum, attend bi-annual Performance Review meetings.
4. Provider shall comply with applicable monitoring provisions of the contract between Anthem and DHCS and any monitoring request by DHCS. Further, Provider agrees that Anthem shall revoke the delegation of activities or obligations, or specific other remedies in instances where DHCS or Anthem determine that Provider has not performed satisfactorily.
5. Refer to the Anthem ECM Provider Guide, pg. 34-36, Section 5 for more details

Community Supports

I. Definitions

1. Enhanced Care Management (ECM): External care coordination program that provides a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal members.

2. Community Supports: Flexible wrap-around services that Anthem will integrate into its population health strategy. These services are not included in the State Plan, but are medically appropriate, cost-effective substitutes for state plan services included within the contract. Examples of Community Supports include but are not limited to housing transition and sustaining services, recuperative care, respite, home and community-based wrap around services for members to transition or reside safely in their home or community, and sobering centers.

3. CS Provider: a contracted Provider of DHCS-approved CS. CS Providers are entities with experience and/or training providing one or more of the CS approved by DHCS.

II. Service Overview

1. Community Supports are voluntary, flexible wrap-around services or settings provided by the Anthem and integrated into its population health management programs. The services are provided as a substitute for utilization of other services or settings such as a hospital or skilled nursing facility admission, discharge delays, or emergency department use. CS will be integrated with care management for Members at medium to high levels of risk and fill gaps in state plan benefits to address medical or other needs that may arise from social determinants of health. See Exhibit B for in scope Community Supports.

III. CS Provider Requirements Provider Experience and Qualifications

1. Experience and training in the elected CS.
   a. The CS Provider shall have experience and/or training in the Provision of the CS being offered.
   b. The CS Provider shall have the capacity to provide the CS in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by Anthem.
2. If the CS Provider subcontracts with other entities to administer its functions of CS, the CS Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.
3. The CS provider will perform all services as outlined in the Anthem CS Program Guide and in the DHCS CS Policy Guide.
4. Contracted ECM Providers who are also contracted CS Providers should provide separate and distinct ECM and CS services to authorized members

IV. Medicaid Enrollment/Vetting for ECM Providers

1. CS Providers for whom a State-level enrollment pathway exists, shall enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.

2.

a. If APL 19-004 does not apply to an CS Provider, the CS Provider will comply with Anthem's process for vetting the CS Provider, which may extend to individuals employed by or delivering services on behalf of the CS Provider, to ensure it can meet the capabilities and standards required to be an CS Provider.

V. Initiating Delivery of Community Supports

1. CS Provider shall deliver contracted CS in accordance with DHCS service definitions and requirements.
2. CS Provider shall maintain staffing that allows for timely, high-quality service delivery of the CS that it is contracted to provide.
3. CS Provider shall:
   a. Accept and act upon member referrals from Anthem for authorized CS, unless the CS Provider is at its pre-determined capacity;
      i. Provider shall be permitted to decline a Member assignment if CS Provider is at its pre-determined capacity.
      ii. Provider shall immediately alert Anthem if it does not have the capacity to accept a Member assignment.
   b. Conduct outreach to the referred Member for authorized CS as soon as possible. Including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;
   c. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;
   d. Coordinate with other Providers in the Member's care team, including ECM Providers, other CS Providers and Anthem;
   e. Comply with cultural competency and linguistic requirements required by federal, State, and local laws, and in contract(s) with Anthem; and
   f. Comply with non-discrimination requirements set forth in State and Federal law and the Contract with Anthem.
4. When federal law requires authorization for data sharing, CS Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to Anthem.
   a. Member authorization for CS-related data sharing is not required for the CS Provider to initiate delivery of CS unless such authorization is required by federal law. CS Provider will be reimbursed only for services that are authorized by Anthem. In the event of a Member requesting services not yet authorized by Anthem, CS Provider shall send prior authorization request(s) to Anthem, unless a different agreement is in place (e.g., if Anthem has given the CS Provider authority to authorize CS directly).
5. If an CS is discontinued for any reason, CS Provider shall support transition planning for the Member into other programs or services that meet their needs.
6. CS Provider is encouraged to identify additional CS the Member may benefit from and send any additional request(s) for CS to Anthem for authorization.

VI. Payment for CS

1. CS Provider shall record, generate, and send a claim or invoice to Anthem for CS rendered.
   a. If CS Provider submits claims, CS Provider shall submit claims to Anthem using specifications based on national standards and codes set to be defined by DHCS.
   b. In the event CS Provider is unable to submit claims to Anthem for CS-related services using specifications based on national standards or DHCS defined standard specifications code sets, CS Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the CS services rendered, and CS Providers' information to support appropriate reimbursement by Anthem, that will allow

c. Anthem to convert CS invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

2. CS Provider shall not receive payment from Anthem for the provision of any CS not authorized by Anthem.
3. CS Provider must have a system in place to accept payment from Anthem for CS rendered.

a. Anthem will adjudicate Clean Claims submitted by Provider within thirty (30) working days of the date Anthem receives the claim. For purposes of determining compliance with the stated time frames, the date of receipt is the date that Anthem receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

VII. Data Sharing to Support CS

1. As part of the referral process, Anthem will ensure CS Provider has access to:
   a. Demographic and administrative information confirming the referred Member's eligibility for the requested service;
   b. Appropriate administrative, clinical, and social service information the CS Provider might need in order to effectively provide the requested service; and
   c. Billing information necessary to support the CS Provider's ability to submit invoices to Anthem.
2. Refer to the Anthem CS Provider Guide for more details.

VIII. Quality and Oversight

1. CS Provider acknowledges Anthem will conduct oversight of its delivery of CS to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both Anthem and the CS Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

EXHIBIT F

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of [5%] or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **Please attach a separate sheet if necessary.**

Answer all questions as of the current date. If additional space is needed, note on the form that the answer is being continued and attach a sheet referencing the relevant item number. Please return the original to us and retain a copy for your files. If a question is not applicable, respond N/A for that question. You should completely answer all applicable questions — No questions should be left blank.

You must provide dates of birth and Social Security numbers (SSNs) for validation purposes as outlined in 42 CFR 455.104 (b)(1)(ii).

Identifying information		
Provider entity name:	Provider DBA name (if different from provider entity name):	Entity NPI:
Entity TIN:	Medicaid ID:	Provider phone #:

Provider address — List all practice locations. Must include at least one street address. Attach a separate sheet if needed.	City	State	ZIP

Owner or control information

An **owner** is a person or business entity that owns [5%] or more of the assets, stock, or profits of the provider entity. This [5%] may be **direct** ownership or **indirect** ownership. (for example, an individual might own [50%] of a company that owns the actual **provider entity**. This means that the indirect ownership is [50%.]) In addition to ownership of stock, an owner also has a legal obligation like a mortgage or loan that is secured by the assets of the provider entity.

A **person with control** is someone who directs the provider entity — this includes directors, trustees and officers of corporations, and partners in a partnership. If the provider entity is a nonprofit entity, respond N/A in the column for percent of ownership.

A **managing employee** is someone who makes the day-to-day decisions for the provider entity. These individuals include office or billing managers for smaller providers; for larger provider entities, a managing employee may be the head of a major operating group such as the director of Accounting, director of same- day services or another executive/management position typically listed below the corporate officers on an organizational chart.

An **agent** is an individual who has the legal ability to bind the provider entity (for example, the provider entity may use an agent to obtain contracts on its behalf). Please provide the following information for owners, persons with control interests, managing employees and agents of the provider entity. Attach a separate sheet if needed.

List the name, title, address, date of birth (DOB), and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of [5%] or greater.

List the name, tax identification number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of [5%] or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Master list		
Last name:	First name:	Middle initial:
Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		City:
State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:
Last name:	First name:	Middle initial:
Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		City:
State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:
Last name:	First name:	Middle initial:
Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		City:
State:	ZIP:	DOB:

Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:
Specific questions:		
1. Is any person on the master list related to another person on the master list (spouse, parent, child or sibling)? Yes ☐ No ☐ *If no, go to the next question. If yes, please provide the following information:*		
If yes, please provide the following information about the related persons.	**Relationship**	
Full name of first related person		
Full name of second related person		
2. Does any person or entity in the master list have an ownership or control interest in any other provider entity? Yes ☐ No ☐ *If no, go to the next question. If yes, please provide the following information about the other provider entity in which the person on the master list has an interest.*		
Name of other provider entity:	Address:	City:
State:	ZIP:	TIN:
3. Has any person or entity on the **master list** ever been **excluded** from participation in federal healthcare programs (Medicaid, CHIP or TRICARE) in the past? Excluded means that a provider or entity has been told by the Department of Health and Human Services — Office of the Inspector General (HHS OIG) that they may no longer be a provider for any federally funded healthcare program. Yes ☐ No ☐ *If no, go to the next question. If yes, please provide the following information.*		
Full name of individual or entity:	Beginning date of exclusion or termination:	End date of exclusion or termination:
Reason for exclusion or termination:		
4. Since the inception of Medicaid, CHIP or TRICARE, were any of the individuals or entities on the **master list** convicted of a criminal offense related to that person's involvement in a related program? Yes ☐ No ☐ **If no, go to the next question. If yes, please provide the following requested information.**		
Name on court records:	SSN:	DOB:
Matter of the offense:	Date of the conviction:	Exclusion period of the offense if excluded by the HHS OIG:
5. Were any of the individuals or entities on the **master list** ever **debarred** from participation in federal government contracts? **Debarred** means an individual is not allowed to participate in contracts paid for by the federal government whether or not those contracts are in the healthcare area. Yes ☐ No ☐ **If no, go to the next question. If yes is checked, provide the following information.**		
Date of debarment:	Length of debarment:	
Reason for debarment:		
6. Was any person or entity on the master list ever terminated from a state's Medicaid or CHIP program for reasons having to do with program integrity (fraud or abuse)? Terminated means the provider lost the right to bill a state's Medicaid or CHIP programs for a cause related to fraud or abuse. Yes ☐ No ☐ **If no, go to the next question. If yes, please provide the following information.**		
Full name of provider:	State of practice when terminated:	

Reason for termination:	Date of termination:

7. Did any person or entity on the **master list** ever have civil monetary penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a provider by a governmental agency that manages a federal healthcare program. Yes ☐ No ☐ **If no, go to the next question. If yes, please provide the following information.**

Full name of the individual or entity:		State of practice when the CMP assessed:
Reason for CMP:	Amount of CMP:	Date of CMP:

8. Did anyone on the master list obtain ownership interest? Yes ☐ No ☐

a. As a result of a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal healthcare program, or was in fact excluded or terminated from participation in a federal healthcare program?

b. Due to circumstances of the original owner being a member (currently or formerly) of the current owner's immediate family or household at the time of the transfer of ownership?

9. **Immediate family** is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in- law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Member of household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit. This includes domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of the household. Yes ☐ No ☐ **If *no*, go to the next question. If *yes*, please provide the following information**

Full name of original owner:	SSN or TIN of original owner:
Place of transfer:	Date of transfer:

10. List any **subcontractor** in which this **provider entity** has a direct or indirect **ownership** interest of at least [5%]. A **subcontractor** is a person or company that this **provider entity** contracted with to do some of the **provider entity's** management functions (for example, a billing agent or medical services provider such as a medical lab).

Full name of subcontractor:		Address:	
City:	State:	ZIP:	TIN
Full name of subcontractor:		Address:	
City:	State:	ZIP:	TIN

a. For each **subcontractor(s)** listed above, please provide the following information for the individuals with an **ownership** or **control** interest in the **subcontractor(s)**. See the previous sections above for a definition of these terms. **Attach a separate sheet if necessary.**

Full name:	Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):

City:	State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:	

b. Is anybody on the list above related to any person on the **master list**? Yes ☐ No ☐ **If no, go to the next question. If yes, please provide the following information about the related persons.**

Full name of first related person:	Relationship:
Full name of second related person:	Relationship:

Business transactions

1. Has the **disclosing entity** had any financial transaction/significant business transactions with any **subcontractor** totaling more than [$25,000]? Yes ☐ No ☐ **If *no*, go to the next question** If *yes*, list the ownership of any **subcontractor** with whom this provider had one or more business transactions totaling more than[$25,000]during the previous [12-month period], any significant business transactions between this **provider** and any wholly owned **supplier**, or between the **provider** and any **subcontractor** during the past [five-year period.]

Full name:	Address:	
City:	State:	ZIP:

2. Does the **provider entity wholly own** a **supplier**? **Supplier** means an individual, agency or organization from which the **provider entity purchases goods and services** used in carrying out its responsibilities under Medicaid (for example, a commercial laundry, a manufacturer of hospital beds or a pharmacy). Yes☐ No ☐ **If *no*, go to the next question If *yes*, supply the following information about the supplier.**

Name:	Address:	
City:	State:	ZIP:
NPI:	TIN:	

Signature

The state or federal Medicaid agency may refuse to enter into, renew or terminate an agreement with a provider if it is determined that a provider did not fully, accurately and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. The signature below **must** be the written signature of an individual who can legally bind this **provider entity**.

In compliance with *42 CFR 455.104(c)*, a provider shall provide a *Disclosure of Ownership* (*DOO*) upon application for network participation and/or prior to execution of a provider agreement at the time of recredentialing/reenrollment. A provider must provide the *DOO* within 35 days after any change in ownership of the disclosing entity. In compliance with *42 CFR 455.105(b)*, a provider must submit full and complete ownership information within 35 days of the date on a request by the secretary or the Medicaid agency outlined above in *Section III. Business Transactions*.

Name of person (printed):	Signature of person:
Title:	Date:
Name of person completing form:	Phone number of person completing form: