AMENDMENT NO. 2 TO THE
HOSPITAL SERVICES AGREEMENT (NON-CAPITATED)
BETWEEN
VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba GOLD COAST HEALTH PLAN)
AND
COUNTY OF VENTURA

This Amendment No. 2 (this "Amendment") to the Hospital Services Agreement (Non-Capitated) (the "Agreement") is made by Ventura County Medi-Cal Managed Care Commission, a public entity doing business as Gold Coast Health Plan ("Health Plan") and County of Ventura ("Provider"). This Amendment is effective as of January 1, 2026 (the "Amendment Effective Date").

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

RECITALS

WHEREAS, the Parties entered into the Agreement effective as of July 1, 2023;

WHEREAS, Dual Eligible Special Needs Plans ("D-SNPs") are Medicare Advantage ("MA") plans that provide specialized care and wrap-around services for dual eligible beneficiaries (i.e., those beneficiaries who are eligible for both Medicare and Medicaid);

WHEREAS, as part of California Advancing and Innovating Medi-Cal ("CalAIM"), the Department of Health Care Services ("DHCS") promotes enrollment in health plans for dual eligible members through a D-SNP model;

WHEREAS, DHCS acknowledges that having Medicare and Medi-Cal benefits managed by the same organization promotes better care coordination and care experience for members; and

WHEREAS, Health Plan will be a D-SNP plan beginning on January 1, 2026 and will offer Medicare and Medicaid products.

WHEREAS, the Parties seek to amend the Agreement to include provisions and requirements associated with Health Plan's D-SNP line of business.

NOW, THEREFORE, the parties hereto expressly agree to amend the Agreement as follows:

1. Capitalized terms used but not defined in this Amendment have the meanings ascribed to them in the Agreement. The above Recitals are true and correct and incorporated herein and made a part hereof.

2. The Agreement is amended as follows:

2.1 **Attachment C – Excluded Services** is modified to change its title to "**Attachment C-1 – Excluded Services**."

2.2 The Parties agree to negotiate in good faith to create a Medicare scope of services for Health Plan's D-SNP product to be added to the Agreement as "**Attachment C-2 – Medicare Dual Special Needs Plan Scope of Services Hospital**" no later than June 30, 2025.

2.3 **Attachment D-1 – Compensation Schedule** is modified to change its title to "**Attachment D-1 – Medi-Cal Compensation Schedule**."

2.4 **Attachment D-2 – Bariatric and GI Services ICD-10 Procedure Codes for Bariatric and Outpatient GI Services** is modified to change its title to "**Attachment D-1.A – Bariatric and GI Services ICD-10 Procedure Codes for Bariatric and Outpatient GI Services**."

2.5 "**Attachment D-2 – Medicare Dual Eligible Special Needs Plan Compensation Schedule**" is added to this Agreement as set forth below.

2.6 "**Attachment E – Medi-Cal Managed Care Program Provisions**" is modified to change its name to "**Attachment E-1 – Medi-Cal Managed Care Program Provisions**."

2.7 Attachment E is further modified to add "**Attachment E-2 – Medicare Program Regulatory Provisions**," "**Attachment E-3 – State Medicaid Agency Contract Provisions**," and "**Attachment E-4 Knox-Keene Regulatory Provisions**" to the Agreement as set forth below.

2.8 "**Attachment H – Schedule of Products**," which describes the products Health Plan offers and for which Provider furnishes Covered Services, is added to the Agreement as set forth below.

2.9 **Section 4.3 "Termination without Cause"** shall be deleted and replaced with the following:

"**Section 4.3 Termination without Cause.** Either party may terminate this Agreement or Provider's participation in either the Medi-Cal Program or Medicare Program products described in Attachment H - Schedule of Products (including the applicable exhibits and attachments hereto) without cause and for convenience upon at least ninety (90) days' notice to the other party in accordance with Section 7.26."

2.10 **Section 4.4 "Termination with Cause"** shall be deleted and replaced with the following:

"**Section 4.4 Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of

termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement or Provider's participation in either the Medi-Cal Program or Medicare Program products described in Attachment H - Schedule of Products (including the applicable exhibits and attachments hereto), as applicable to such uncured breach."

2.11 **Section 7.25 "Attachments"** is is deleted in its entirety and replaced with the following:

> "**7.25 Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:
>
> Attachment A – Provider Identification Elements
> Attachment B – Definitions
> Attachment C-1 – Excluded Services
> Attachment C-2 – Medicare Dual Special Needs Plan Scope of Services Hospital
> Attachment D-1 – Medi-Cal Compensation Schedule
> Attachment D-1.A – Bariatric and GI Services ICD-10 Procedure Codes for Bariatric and Outpatient GI Services
> Attachment D-2 – Medicare Dual Eligible Special Needs Plan Compensation Schedule
> Attachment E-1 – Medi-Cal Managed Care Program Provisions
> Attachment E-2 – Medicare Program Regulatory Provisions
> Attachment E-3 – State Medicaid Agency Contract Provisions
> Attachment E-4 – Knox-Keene Regulatory Provisions
> Attachment F – Acknowledgment of Receipt of Provider Manual
> Attachment G – Disclosure Form
> Attachment H – Schedule of Products"

3. All other terms and conditions of the Agreement remain in full force and effect. In the event of any conflict between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment control.

4. This Amendment may be executed in one or more counterparts, each of which is to be deemed an original, and all of which together constitute one and the same instrument. The facsimile, email, or other electronically made and/or delivered signature of a party is to be deemed to constitute an original signature for all purposes, and facsimile or electronic copies of this Amendment are to be deemed to constitute duplicate originals.

[*signature on following page*]

PROVIDER:	**HEALTH PLAN:**
COUNTY OF VENTURA	**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION dba Gold Coast Health Plan**
Executed by:	*Executed by:*
Signature	Signature
Printed Name	Printed Name
Title	Title
Date	Date
Address for Notices: Ventura County Health Care Agency 5851 Thille St.Suite 100 Ventura, CA 93003	Address for Notices: Gold Coast Health Plan 711 E. Daily Drive, Suite 106 Camarillo, CA 93010-6082

ATTACHMENT D-2

MEDICARE DUAL ELIGIBLE SPECIAL NEEDS PLAN COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the reimbursement terms set forth in this Attachment.

ARTICLE I - DEFINITIONS

1.1 Definitions. For purposes of this Attachment, the following capitalized terms shall have the meaning ascribed to them as follows:

1.1.1. Observation Covered Services: "Observation Covered Services" means the clinically appropriate and ongoing, short-term services, treatment, assessment, and reassessment furnished by Provider on Provider's premises, including the use of a bed, supplies, and periodic monitoring by nursing or other staff, that are reasonable and necessary to evaluate a Member's condition and determine whether a Member requires further treatment in a hospital setting or whether a Member should be discharged, subject to the following conditions:

a. Observation Covered Services end when all Medically Necessary services and medical interventions related to observation care are completed, including nursing follow-up care, performed after the physician's observation discharge orders are written. Observation Covered Services do not include the time a patient might spend waiting for transportation. Health Plan determines what constitutes Observation Covered Services using nationally recognized clinical criteria sets.

b. Health Plan does not recognize and authorize general standing orders for Observation Covered Services following all outpatient surgery. Health Plan determines what constitutes Observation Covered Services using Milliman Care Guidelines (MCG). For the avoidance of doubt, non-Covered Services cannot be considered Observation Covered Services under the Agreement.

1.1.2 Medicare Allowable: the amount that Medicare would pay for a Covered Service that is payable pursuant to applicable laws, Governmental Agency program requirements and this Agreement. For purposes of this Attachment D-2, the Medicare Allowable means the Medicare Program allowable payment rates (adjusted for locality or geography and any additional Medicare adjustments) as of the date of service. The Medicare Allowable includes deductions for cost-sharing amounts, including co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

The Medicare Allowable is based on the prevailing MS-DRG rate for inpatient Covered Services and the Outpatient Prospective Payment System ("OPPS") rate for outpatient Covered Services. Additionally, Medicare sequestration will apply.

1.1.3 Medicare Covered Service: those health care services within the normal scope of practice and licensure of Provider as described in Attachment C-2.

ARTICLE II - COMPENSATION TERMS

2.1 **Payment Terms.**

2.1.1. Inpatient Hospital Services

a. One hundred percent (100%) of the Medicare Allowable.

b. All Medicare Covered Hospital Services with a non-codable Medicare DRG or with no applicable Medicare Allowable will be reimbursed at forty percent (40%) of Hospital's billed charges, not to exceed $3,500 per day.

c. Observation Covered Services shall be paid at the hourly rate of $150, not to exceed $2,500. A two midnight stay shall be considered as Inpatient. A one midnight stay, if denied as an Inpatient, shall be reimbursed as Observation at $2,500.

The hourly rate applies for hours 1 through 24. In the event an authorized admission occurs on the same calendar day as the patient receives Observation Covered Services, then the Medicare DRG rate applies for the entire stay, including observation. Otherwise, if the patient is not admitted and only receives Observation Covered Services, the rates set forth in Section 2.1.1.c. above shall apply.

2.1.2. Outpatient Hospital Services

a. One hundred percent (100%) of the Medicare Allowable.

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ATTACHMENT E-2
MEDICARE PROGRAM REGULATORY PROVISIONS

This Medicare Program Attachment sets forth the applicable Dual Eligible Special Needs Plan ("D-SNP") requirements, covering the provision of health care services, that the Centers for Medicare and Medicaid Services ("CMS") requires health plans to include in contracts and/or agreements between health plans and health care providers and their Downstream Subcontractors. This Attachment is hereby incorporated into the Agreement, and will be automatically modified to conform to subsequent changes or amendments by CMS to any D-SNP requirements set forth herein.

All terms and conditions of the Agreement not specifically modified by this Attachment remain unchanged and will control. In the event of any inconsistency between this Attachment and the Agreement, the terms and conditions of this Attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this Attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this Attachment and the applicable statute(s).

1. **Compliance with CMS Agreement**. Provider shall perform Covered Services and other obligations under the Agreement and this Attachment in a manner that is consistent and compliant with the CMS Agreement. Provider shall comply with applicable federal laws, regulations and CMS instructions. Without limiting the above, Provider shall comply with federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et. seq.) and the Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)); and HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

1.1 Health Plan shall monitor the Provider's performance under the Agreement on an ongoing basis. (42 CFR § 422.504(h); 42 CFR § 422.504(i)(3)(iii); 42 CFR § 422.504(i)(4)(iii); 42 CFR § 422.504(i)(4)(v); 42 CFR § 422.504(i)(1)).

Provider agrees to provide services in a manner consistent with professionally recognized standards of health care and benefits covered by Medicare. (42 CFR § 422.504(a)(3)(iii)).

2. **Compliance with Health Plan Requirements**. Consistent with its obligations under the Agreement, Provider represents and warrants that, in performing under this Attachment, Provider shall comply with all applicable Health Plan Requirements. (Medicare Managed Care Manual, Chapter 11, § 100.4).

3. **Data and Information**. Provider shall cooperate and assist with Health Plan's requests for information and shall promptly submit Encounter Data, medical records, and such other information as requested by Health Plan to allow Health Plan to respond in a timely manner to any data validation audits or requests for information by CMS, and to monitor and audit the obligation of Provider to provide reliable, complete, truthful, and accurate data and other information in accordance with applicable requirements and Health Plan requirements. Provider is required to submit timely, complete and accurate risk adjustment data as required by CMS. Failure to submit these data may result in sanctions including but not limited to a financial penalty at Health Plan's

sole discretion.(42 CFR §§ 422.310(d)(3)-(4); 422.504(a)(8), 422.504(d)-(e), 422.504(i)(2)-(4), and 422.504(l)(1)-(3)).

4. **Right to Audit**. Health Plan, HHS, the Controller General, or their designees have the right to audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of Provider, their related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract. For records subject to review, CMS will provide notification to Health Plan that a direct request for information has been initiated. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR § 422.504(d), 2 CFR § 422.504(i)(2)(i) – (iv)).

5. **Cost Sharing**. Provider shall not hold an enrollee liable for payment of any fees that are the obligation of Health Plan. For those enrollees eligible for both Medicare and Medicaid, such enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Health Plan shall inform Provider of those enrollees eligible for both Medicare and Medicaid and the rules for such enrollees. Specifically, Health Services for Medicare Parts A and B must be provided at zero cost to Health Plan's D-SNP Members. (42 CFR § 422.504(g)(1)(iii)). Health Plan shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual was not enrolled in such plan. Provider shall accept the Health Plan's payment as payment in full or bill the appropriate State source. (42 CFR § 422.504(i)(3)(i); 42 CFR § 422.504(g)). Provider also agrees to and shall ensure that all Downstream Entity Subcontracts contain language specifically stating that Health Plan's D-SNP Members will not be held liable for Medicare Part A and B cost sharing. (42 CFR § 422.504(g)(1)(iii)).

6. **Benefit Continuation**. Provider agrees, and will require its Downstream Entities to agree, to provide for the continuation of MA Member health care benefits, for all such Members, for the duration of the contract period for which CMS payments have been made, and for such MA Members who are hospitalized on the date the CMS Contract terminates, or in the event of an insolvency of Health Plan, through the date of the MA Member's discharge. (42 CFR § 504(g)(2)).

7. Excluded Providers. Enrollees shall not be financially liable for services, items, or drugs furnished, ordered, or prescribed to the enrollee by any entity or provider on the preclusion list as described in 42 CFR § 422.222. Notwithstanding any other provisions of this Agreement, Health Plan shall not make any payment or pay any claim, nor does Health Plan have any obligation to make any payment or pay any claim to Provider for individuals and entities included on the preclusion list, defined in 42 CFR § 422.2. (42 CFR § 422.504(i)(2)(v)).

8. **Delegation.** Health Plan may delegate activities or functions to Provider. If Health Plan delegates the selection of the providers, contractors, or subcontractors to Provider, Health Plan shall retain the right to approve, suspend or terminate any such arrangements. Should Health Plan delegate any activities or functions, such activities shall be specified in the delegation agreement between the parties. The delegation agreement shall also specify for the revocation of delegated activities or reporting requirements as well as other remedies where Provider's performance has

been unsatisfactory; that performance of the Provider shall be monitored by Health Plan on an ongoing basis; and that Health Plan may review the credentials of those affiliated with Provider and may review, approve and audit Provider's credentialing process. (42 CFR § 422.504(i)(4)(i)-(iv); 42 CFR § 422.504(i)(5)).

9. **Prompt Payment**. Health Plan and Provider agree that Health Plan will pay for Clean Claims for services that are covered by Medicare within thirty (30) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is a Clean Claim. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR § 422.520(b)).

10. **On-Site Evaluations**. Provider agrees to permit (and shall cause Downstream Entities to permit) CMS, DHHS, the Comptroller General, and Health Plan or their designees to conduct on-site evaluations of Provider and Downstream Entity personnel, physical premises, facilities, and equipment to assess and audit Provider's performance under the Agreement. Provider shall also comply with the agencies' recommendations based on such onsite evaluation, if any. (42 CFR § 422.504(e)).

11. **Confidentiality of Medical Records and Enrollment Information**. Provider shall comply (and shall cause its Downstream Entities to comply) with all applicable requirements regarding health care privacy and security, including without limitation the confidentiality and security provisions stated in the regulations at 42 CFR §§ 422.118, 422.504(a)(13), and 423.136, as amended, for any medical records or other health and enrollment information that Provider or its Downstream Entities maintain with respect to Health Plan's MA Members. Additionally, with respect to such Members, Provider and Downstream Entities must establish procedures that are consistent with Health Plan Requirements to do the following:

11.1 Compliance. Provider shall abide by all federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Provider must safeguard the privacy of any information that identifies a particular Member and have procedures that specify:

11.1.1 For what purposes the information will be used within the organization; and

11.1.2 To whom and for what purposes it will disclose the information outside the organization.

11.2 Release of Records. Ensure that medical information is released only in accordance with applicable federal or State law, or pursuant to court orders or subpoenas consistent with law. Provider must:

11.2.1 Maintain the records and information in an accurate and timely manner.

11.2.3 Ensure timely access by Members to the records and information that pertain to them.

11.3 This Section 10 ("Confidentiality of Medical Records and Enrollment Information") shall survive termination of the Agreement, regardless of the cause giving rise to termination. Provider shall ensure that all Downstream Entity Subcontracts contain this provision.

12. **Subcontracting**. Provider agrees that it will not contract with any person or entity to furnish functions, activities or services (including Provider Services) under the Agreement unless (i) such entity is specifically obligated, through a written agreement executed between such entity and Provider (or such entity and a Downstream Entity), to comply with all of the provisions contained in this Medicare Attachment and (ii) such written agreement specifically permits Health Plan to approve, suspend, or terminate the agreement. Provider agrees to promptly provide Health Plan with a copy of any such written agreement, upon request. (42 CFR § 422.504(i)(3)(ii)).

13. **Grievance and Appeals**. Provider shall cooperate, and will require its Downstream Entities, as applicable, to cooperate with Health Plan's grievance and appeals procedures which shall be consistent with 42 CFR § 422 Subpart M, and shall comply with CMS and DHCS requirements as applicable for processing grievances and appeals with respect to Provider's participation in Health Plan's MA program. The obligations of Provider shall be at the sole cost and expense of Provider and nothing contained in this Agreement shall cause Health Plan to be liable or responsible for any such obligation or the costs or expenses associated therewith.

14. **Marketing Requirements**. Provider shall not engage (and shall cause its Downstream Entities not to engage) in marketing of Health Plan's MA program, except in the manner and to the extent expressly requested by Health Plan. Provider and Downstream Entities shall remain neutral when assisting with enrollment decisions. If Provider or a Downstream Entity is asked to assist Health Plan with marketing of Health Plan's MA program, Provider shall, and will require its Downstream Entities to, comply with all applicable requirements, including without limitation, applicable statutes and regulations as well as CMS regulations and the Medicare Communications and Marketing Guidelines. (42 CFR §§ 422.2262 and 422.2268; Medicare Communications and Marketing Guidelines at § 60.3).

15. **Compliance and Anti-Fraud**.

15.1 Compliance. Provider shall comply with federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.) and the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); the HIPPA administrative simplification rules at 45 CFR parts 160, 162 and 164; and all laws applicable to recipients of federal funds. (42 CFR § 422.504(h)(1)).

15.2 Compliance Program. Provider shall institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable requirements and Health Plan requirements and the incidence of fraud, waste, and abuse relating to the operation of Health Plan's MA Program in compliance with 42 CFR § 422.503(b)(4)(vi).

15.3 Reporting Potential Fraud, Waste, or Abuse or Non-Compliance. Provider shall promptly report to Health Plan any instances where Provider, after reasonable and timely inquiry, suspects (i) potential fraud, waste, and abuse or noncompliance with applicable requirements by Provider, a Downstream Entity, or others, including MA Members, or (ii) overpayments by CMS. (42 C.F.R. §§ 422.503(b)(4)(vi)(D)).

15.4 Federal Funds. Provider acknowledges that payments for Health Services received from Health Plan are, in whole or part, from federal funds. As a result, Provider and Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act of 1973 as implemented by 45 CFR Part 84. (Medicare Managed Care Manual, Chapter 11, § 120).

16. **Cultural and Linguistic Requirements**.

16.1 Provider shall provide all Health Services in a culturally competent manner and promote equitable access to all enrollees including, at minimum, the following persons: people with limited English proficiency or reading skills; people of ethnic, cultural, racial, or religious minorities; people with disabilities; people who identify as lesbian, gay, bisexual, or other diverse sexual orientations; people who identify as transgender, non-binary, and other diverse gender identities, or people who were born intersex; people living in rural areas and other areas with high levels of deprivation; people otherwise adversely affected by persistent poverty or inequality.

16.2 Provider shall ensure that all Downstream Entity Subcontracts contain a provision addressing cultural competency. Provider and all Downstream Entities shall provide interpreter services for all Members at all provider sites. (42 CFR § 422.112(a)(8)).

17. **Credentialing**. Provider shall also participate and require all Downstream Entities to participate in Health Plan's credentialing and recredentialing requirements. (42 CFR § 422.504(i)(4)(iv)).

18. **No Enrollment Limitation.** Provider agrees that providers, including, but not limited to PCPs, are prohibited from closing or otherwise limiting their acceptance of MA Members as patients unless the same limitations apply to all commercially insured members. (42 CFR § 422.110(a)).

19. **Refusal to Contract or Pay**. Health Plan agrees that there will be no refusal to contract or pay an otherwise eligible health care provider for the provision of Health services solely because such provider has in good faith:

19.1 Communicated with or advocated on behalf of one or more of his/her prospective, current, or former patients regarding the provisions, terms, or requirements of Health Plan's MA program as they relate to the needs of such provider's patients; or

19.2 Communicated with one or more of his/her prospective, current, or former patients with respect to the method by which such provider is compensated by Health Plan for Health Services provided to the patient. (42 CFR § 422.206).

20. **Indemnification**. Provider agrees that Provider is not required to indemnify Health Plan against any civil liabilities for expenses or damages abased on Health Plan's denial of medically necessary care. (42 CFR § 422.212).

21. **Discrimination Prohibited**. Provider shall not (and shall cause Downstream Entities to not) deny, limit, or condition the furnishing of benefits to MA Members on the basis of any factor that is related to health status, including, but not limited to the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; or (g) disability. Provider agrees (and shall cause Downstream Entities to agree) to comply with Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and applicable requirements, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under the MA program. (42 CFR § 422.110(a)).

22. **D-SNP Requirements**.

22.1 Quality Improvement Program. Provider agrees (and shall cause Downstream Entities to agree) to actively participate in and cooperate with Health Plan's Quality Improvement Program for the D-SNP. Provider shall submit timely and accurate data to Health Plan necessary for quality improvement reporting to CMS, as requested by Health Plan. (42 CFR §§ 422.202(b), 422.504(a)(5)).

22.2 Individual Care Plans. Provider shall ensure the timely completion of an Individual Care Plan ("ICP") for each D-SNP Member in accordance with Health Plan requirements. (42 CFR § 422.101(f)(1)(ii)).

22.3 Admission Notifications. Provider agrees (and shall cause Downstream Entities to agree) to provide required notifications in accordance with Health Plan Requirements of a D-SNP Member's admission to a hospital or skilled nursing facility. (42 CFR § 422.107(d)).

23. **Termination**. Health Plan or Provider must provide one hundred and twenty (120) days' written notice to the other should either Party terminate the Agreement without cause. (42 CFR § 422.202(d)(4)).

24. **Access Requirements**. Provider shall comply with CMS requirements Health Plan's standards for appointment wait times and hours of operation. (42 CFR § 422.112(a)(1)).

25. **Continuation of Benefits**. Continuation of health care benefits shall be provided for all enrollees during the duration of the contract period between Health Plan and CMS for which CMS payments have been made, and for enrollees who are hospitalized on the date Health Plan's

contract with CMS terminates, or in the event of insolvency, through discharge. In order to meet this requirement, Health Plan may use contractual arrangements, insurance acceptable to CMS, financial reserves acceptable to CMS, or any other arrangement acceptable to CMS. (42 CFR § 422.504(g)(2)-(3)).

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ATTACHMENT E-3
STATE MEDICAID AGENCY CONTRACT REQUIREMENTS

This State Medicaid Agency Contract ("SMAC") Attachment sets forth the applicable Dual Eligible Special Needs Plan ("D-SNP") requirements, covering the provision of health care services, that are required be included in contracts and/or agreements between health plans and health care providers and their downstream subcontractors. This Attachment is hereby incorporated into the Agreement.

All terms and conditions of the Agreement not specifically modified by this Attachment remain unchanged and will control. In the event of any inconsistency between this Attachment and the Agreement, the terms and conditions of this Attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this Attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this Attachment and the applicable statute(s).

1. Contractor shall use a secure email data exchange through a Health Information Organization, or an electronic process approved by the Department of Health Care Services ("DHCS"), to inform Health Plan in a timely manner of any hospital or skilled nursing facility ("SNF") admissions for all Members, if applicable.

    1.1 Contractor shall make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the Contractor's inpatient services, if applicable.

    1.2 Contracted SNFs shall use a secure email, a data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform Health Plan of any SNF admission, discharge, or transfer for all Members. For SNF admissions, SNFs shall make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, SNFs shall make this notification in advance, if at all possible, or at the time of the Member's discharge or transfer from the SNF.

2. Contractor shall cooperate with Health Plan's training on the Medi-Cal Automated Eligibility Verification System ("AEVS") interface and the interpretation of eligibility.

3. Contractor shall not impose cost-sharing requirements on D-SNP Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Social Security Act, and 42 CFR § 422.504(g)(1)(iii).

4. Contractor agrees to accept Health Plan's Medicare reimbursement as payments in full for services rendered to Dual Eligible Enrollees, or to bill Medi-Cal or Health Plan as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal.

5. Contractor shall comply with Welfare and Institutions Code section 14019.4 with respect actions upon obtaining proof of eligibility.

ATTACHMENT E-4
KNOX-KEENE REGULATORY PROVISIONS

The below provisions apply exclusively to Covered Services provided and activities engaged in pursuant to the agreement between health care services plan ("Health Plan") and Provider (the "Agreement") pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (the "Act") contract requirements and the rules set forth in California Health and Safety Code §1340 et seq. and/or Title 28, California Code of Regulations. Authorities are cited in parentheses for ease of reference to relevant regulatory requirements.

1. In the event that Health Plan fails to pay for health care services, the enrollee shall not be liable to Provider for any sums owed by the plan. No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan. (Health & Safety Code § 1379.)

2. Provider shall:

2.1 Permit confidential treatment by the Department of Managed Health Care ("DMHC") of payment rendered or to be rendered to the Provider without concealment or misunderstanding of other terms and provisions of the contract. (28 CCR § 1300.67.8(a).)

2.2 Maintain such records and provide such information to the Health Plan or to the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Act and the rules thereunder, that such records will be retained by the Provider for at least two years, and that such obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise. (28 CCR § 1300.67.8(b).)

2.3 Allow the Health Plan to have access at reasonable times upon demand to the books, records and papers of the Provider relating to the health care services provided to subscribers and enrollees, to the cost thereof, to payments received by the Provider from subscribers and enrollees of the Health Plan (or from others on their behalf), and, unless the Provider is compensated on a fee-for-service basis, to the financial condition of the Provider. (28 CCR § 1300.67.8(c).)

2.4 Not surcharge for covered services and whenever the Health Plan receives notice of any such surcharge the Health Plan shall take appropriate action. (28 CCR §1300.67.8(d).)

3. Provider shall comply with and participate in Health Plan's unified Grievance and Appeals system which shall be in accordance with 28 CCR § 1300.68.

4. Provider shall comply with and participate in Health Plan's Quality Improvement Program which shall be in accordance with 28 CCR § 1300.70.

5. Provider shall comply with the requirements for timely access to non-emergency services, to the extent applicable, as set forth in 28 CCR § 1300.67.2.2.

6. Provider must disclose in Exhibit 1 to this Attachment all current subcontracts which it holds related to the services performed under the Agreement. Other than as specifically indicated in Exhibit 1, Provider shall not utilize the services of any subcontractors in providing the services

required hereunder without Health Plan's prior written approval. Provider shall request approval by submitting a written description of the services to be subcontracted along with the name of the subcontractor. If approved by Health Plan, Provider shall remain the prime contractor for the services and be responsible for the conduct and performance of each approved subcontractor. If approved by Health Plan, Provider shall furnish to Health Plan a copy of the executed subcontract. Any subcontract must include the plan licensing/State requirements described in this Addendum to the Agreement. All references to Provider in the Agreement in the context of providing services, where applicable, will also include Provider's approved subcontractors.

7. Prior to any material revision to any subcontract of Provider relating to the Agreement, Provider shall notify and obtain approval from Health Plan. (28 CCR § 1300.52.1.)

8. Pursuant to California Health & Safety Code Section 1381, all of Provider's records, books, and papers related to the Agreement shall be located in this State to the extent feasible. If outside the State, DMHC may, upon reasonable notice, require that such records, books and papers, or a specified portion, be made available for examination in this State, or that a true and accurate copy of such records, books and papers, or a specified portion, be furnished to DMHC. If outside of the State, all of Provider's records, books, and papers related to the Agreement shall be available to Health Plan electronically upon request. (California Health & Safety Code § 1381.)

9. In order to monitor the proper performance of Provider, Health Plan shall have the right to:

9.1 Request, in writing, internal audits and/or inspections by Provider. Provider shall provide a written report to Health Plan of the results and any findings within sixty (60) days of such written request by Health Plan. If such functions are delegated to a third party, Provider shall obtain prior approval by Health Plan and Provider shall directly supervise and be responsible for the engagement.

9.2 Conduct an annual inspection of Provider, and to further require corrective action if the results of such inspection indicate any deficiencies.

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EXHIBIT 1 – SUBCONTRACTORS

ATTACHMENT H
SCHEDULE OF PRODUCTS

Provider has been approved to provide Covered Services in accordance with the applicable terms and conditions of the Agreement to the following programs:

Medi-Cal Program: is a state- and federally-funded program pursuant to a contract between Health Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. Health Plan offers a Medi-Cal product, in which Provider participates.

Medicare Program: is a program sponsored by Health Plan pursuant to a contract with the federal Centers for Medicare and Medicaid Services under the Medicare Advantage program. The Medicare Program includes any the Dual Special Needs Program offered by Health Plan, which is designed to cover individuals with both Medicare and Medi-Cal coverage. Health Plan offers a Medicare D-SNP Products in which Provider participates.