

**VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION  
PROVIDER SERVICES AGREEMENT-SPECIALIST**

This Amended and Restated Provider Services Agreement (“the Agreement”) is made this 1<sup>st</sup> day of July, 2023 (the “Effective Date”) by and between VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a California public agency, hereinafter referred to as “Health Plan”, and COUNTY OF VENTURA, hereinafter referred to as “Provider”, a group of physicians each of whom is licensed to practice medicine in the State of California pursuant to California Business and Professions Code, Division II, Chapter 5, Section 200 et seq., each of whom is eligible to participate in and certified to provide services under the California Medi-Cal (Medicaid) program, and each of whom meets applicable requirements under Titles XVIII and XIX of the Social Security Act. Health Plan and Provider are each referred to as a “party” and collectively referred to as “parties”.

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

**Provider**

COUNTY OF VENTURA

**Health Plan:**

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

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*Executed by:*

\_\_\_\_\_  
*Executed by:*

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Signature

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Signature

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Printed Name

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Printed Name

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Title

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Title

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Date

\_\_\_\_\_  
Date

**Address for Notices:**

Ventura County Health Care Agency  
5851 Thille Street  
Ventura, CA 93003

**Address for Notices:**

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

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

**RECITALS**

- A. Health Plan is a County Organized Health System established pursuant to California Welfare and Institutions Code, Section 14087.54.
- B. Health Plan entered into agreements with the State of California, Department of Health Care Services ("DHCS") in accordance with the requirements of California Welfare and Institutions Code, Section 14200 et seq.; Title 22, California Code of Regulations ("CCR"), Section 53000 et seq.; and applicable federal and State laws and regulations, under which Health Plan has agreed to arrange for or provide health care services under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in Health Plan's Medi-Cal Managed Care Program. (collectively, the "Medi-Cal Agreement").
- C. Health Plan arranges for the provision of health care services to members assigned to Health Plan under the terms of the Medi-Cal Agreement by contracting with other health plans, Hospitals, physicians, and other health care providers.
- D. Provider is eligible to participate in and certified to provide health care services under the California Medi-Cal Managed Care Program and meets applicable requirements under Titles XVIII and XIX of the Social Security Act.
- E. Provider desires to provide certain health care services to Health Plan's eligible Members in connection with Health Plan's contractual obligations under the terms of the Medi-Cal Agreement.

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

**ARTICLE ONE - DEFINITIONS**

- 1.1 **Provider** means the County of Ventura, including, where the context requires, the health care professional(s) or entity(ies) identified in monthly rosters provided by Provider which contain the elements identified in Attachment A to this Agreement.
- 1.2 **Provider Operations Bulletin** is a bi-monthly bulletin sent to providers that includes Health Plan operational and regulatory updates.
- 1.3 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B, attached hereto and incorporated herein.

**ARTICLE TWO - PROVIDER OBLIGATIONS**

- 2.1 **Serving as a Panel Provider.** Provider shall serve on Health Plan's panel of providers. Provider agrees that its practice information may be used in Health Plan's provider

directories, promotional materials, advertising and other informational material made available to the public and Members. Provider's practice information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, clinic/group affiliation, Hospital affiliation, language capabilities, building access for people with disabilities, and ability to accept new patients. Provider shall promptly notify Health Plan of any changes in this practice information.

## 2.2 **Standards for Provision of Care.**

- a. **Provision of Covered Services.** Provider shall provide and cause its subcontractors to provide Covered Services to Members, within the scope of Provider's business and practice, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program. Only Covered Services are eligible for reimbursement by Health Plan.
- b. **Standard of Care.** Provider shall provide and cause its subcontractors to provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.
- c. **Facilities, Equipment, and Personnel.** Provider shall maintain and cause its subcontractors to maintain facilities, equipment, personnel and administrative services at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act. In addition, Provider shall permit Health Plan and its representatives reasonable access to such facilities for onsite inspections and credentialing purposes. Provider agrees to provide at least sixty (60) days' notice to Health Plan prior to the opening of any new location and ninety (90) days' notice to Health Plan prior to the closing of any location.
- d. **Prior Authorization.** If Provider determines that it is Medically Necessary to consult with other health professionals or for a Member to obtain Covered Services from any physician, Hospital, or other health care provider, Provider shall obtain the prior authorization of Health Plan in accordance with the Provider Manual. Provider shall comply with the referral procedures set forth in the Provider Manual and attachments thereto, which are in effect at the time of the referral, and shall not directly or indirectly engage in self-referral or any method of referral not specifically authorized by the Provider Manual. Upon and following such prior authorization, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care. In addition to any other right or remedy under this Agreement, Health Plan may, at Health Plan's option, deny payment for Covered Services rendered that were not prior authorized, if required, by Health Plan, or retain from any amount owed to Provider an amount equal to the amount of money paid by Health Plan to the party or provider rendering non-Plan authorized referral services to Members.

- e. **Referrals.** Unless otherwise agreed to by Health Plan, and except as described in the Provider Manual, Provider shall provide Covered Services to Members only upon receipt of an appropriate referral to provide services from the Member's Primary Care Physician, Health Plan, or such other service authorization as described in the Provider Manual.
- f. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, Hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers") and shall only refer Members to Participating Referral Providers.
- g. **Member Eligibility Verification.** Provider shall verify eligibility of Members prior to rendering services. Prior authorization from Health Plan or referral from a Primary Care Physician is not a guarantee of Member eligibility with Plan or eligibility in the Medi-Cal Managed Care Program.
- h. **Emergency Room Referral.** If Provider refers a Member to an emergency room, Provider shall notify Health Plan on the next business day.
- i. **Admissions.** Provider shall cooperate with and comply with Health Plan's Hospital admission and prior authorization procedures set forth in this Agreement and in the Provider Manual.
- j. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient Hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by Provider.
- k. **Availability of Services.** Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.
- l. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.
- m. **Consultation with Medical Director.** Provider may at any time seek consultation with Health Plan's Medical Director on any matter concerning the treatment of a Member.

### 2.3 Subcontract Arrangements.

- a. **Written Health Plan Approval.** Provider will not utilize the services of any subcontractors in providing the Covered Services required hereunder without Health Plan's prior written approval for each named subcontractor (which consent Health Plan may grant or withhold in Health Plan's sole and absolute discretion). Provider may satisfy the preceding requirement by (1) obtaining Health Plan's prior written approval of Provider's template subcontract agreements described in Section 2.3.e. (which shall contain the requirements imposed on subcontractors under the applicable provisions of Articles 3 and 7, Section 4.7, and Exhibit E), and (2) submitting a file copy of the cover page and signature page for each executed subcontract within thirty (30) days of execution, unless the terms of such executed agreements vary from those imposed on subcontractors under the applicable provisions of Articles 3 and 7, Section 4.7, or Exhibit E, in which case the subcontract must be submitted to Health Plan for prior written approval. Health Plan shall act to approve or deny such subcontracts at its sole discretion within thirty (30) calendar days, unless DHCS review is required, in which case approval shall be within the timeframe and at the discretion of DHCS. This subsection shall not apply to subcontracts executed by Provider prior to the Effective Date.
- b. **Binding to Agreement.** Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.
- c. **Immediate Removal.** Provider may require the immediate removal of any of Provider's subcontractors from assignment under this Agreement if Health Plan is not satisfied with the subcontractor's performance or if the subcontractor violates any terms or conditions under this Agreement.
- d. **Provider Responsibility.** Provider shall remain the prime contractor for the Covered Services and be responsible for the conduct and performance of each of its subcontractors as if Provider had performed all of the subcontracted Covered Services.
- e. **Subcontract Template.** Provider shall provide Health Plan with a specimen of its standard forms of subcontract (together with any general variations to be used in terms and provisions of such standard forms) made, or to be made, with parties with which Provider has, or will have, a contractual relationship to provide Covered Services. Upon DHCS request, Provider shall provide copies of all subcontracts to DHCS.
- f. **Hold Harmless.** Provider acknowledges and agrees that it shall be solely responsible for paying subcontractors for all Covered Services provided by its subcontractors, and to indemnify and hold harmless Health Plan, Members and DHCS for any mistake, failure, or breach of this Agreement committed by subcontractors.

2.4 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities and in Medical Transportation vehicles as practical, and (b) shall cooperate with and participate in all reasonable Health Plan marketing efforts. Provider shall not use Health Plan's name, trademarks, service marks, logos or other identifiers (collectively, "Trademarks"), or make any reference to Health Plan or its Trademarks in any advertising or promotional materials without the prior written permission of Health Plan, except for its internal business use, as required by law or to comply with the request of a Governmental Agency. Neither party shall use the other party's name.

2.5 **Nondiscrimination.**

- a. **Provision of Care.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.
- b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position. Provider shall comply with the Fair Employment and Housing Act and the applicable regulations promulgated thereunder.

2.6 **Recordkeeping.**

- a. **Maintaining Member Medical Record.** Provider shall maintain and require its subcontractors to maintain a medical record for each Member to whom Provider renders Covered Services. Provider or provider's subcontractor shall open each Member's medical record upon the Member's first encounter with Provider or provider's subcontractor. The Member's medical record shall contain all information required by State and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Such records shall be maintained in a current, detailed, organized, and comprehensive manner. Provider shall retain all such records for at least seven (7) years after rendering Covered Services and the records of a minor child shall be kept for a period of at least one (1) year after the minor has reached the age of eighteen (18) years, but in no event less than seven (7) years or such longer time period as may be required by law.
- b. **Confidentiality of Member Health Information.** Provider and its subcontractors shall comply with all applicable State and federal laws, Health Plan's policies and procedures, and government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member



names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This subsection shall not affect or limit Provider's obligation to make available medical records, Encounter Data and information concerning Member care to Health Plan, any Governmental Agency, or other providers of health care upon authorized referral.

- c. **HIPAA.** Provider and Health Plan each acknowledge that it is a "Covered Entity" as that term is defined in the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services ("DHHS"), as amended (the "HIPAA Privacy Rule"). As a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality. Provider shall adequately protect the confidentiality of individually identifiable health information and shall comply with the HIPAA Privacy Rule and with all State and federal laws governing the confidentiality of Members' individually identifiable health information. If Provider identifies any inappropriate uses of individually identifiable health information or breach of the HIPAA Privacy Rule with respect to Health Plan or Members, Provider must promptly notify Health Plan's privacy officer at [compliance@goldchp.org](mailto:compliance@goldchp.org).
- d. **National Provider Identification ("NPI").** Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (Title 45, Code of Federal Regulations ("CFR"), Section 162.402 et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System for itself or for any subpart of Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan.
- e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by State or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with Governmental Agencies (including the Medi-Cal Agreement), or third party payers, any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with the Utilization Review and Management Program, grievances, peer review, HEDIS studies, the Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan and/or as required to any Governmental Agency.
- f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of State

and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

- g. **Access to Accounting and Financial Books and Records.** Health Plan shall have the right to inspect the accounting and administrative books and records of Provider as permitted and required by law, at all reasonable times at Provider's place of business or at such other mutually agreeable location in California. Provider shall also permit the inspection of such books and records by Governmental Agencies as may be required by law and required by the Governmental Agency. When requested by Health Plan or a Governmental Agency, Provider shall produce copies of such records at no cost.
- h. **Survival.** The obligations as set forth in this Section shall survive any termination of this Agreement.

## 2.7 **Records and Audit.**

- a. **Audits and Inspections.** Provider agrees to make all of its premises, facilities, equipment, books, records, documents, contracts, computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of this Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying by the DHCS, the Centers for Medicare and Medicaid Services ("CMS"), the DHHS Inspector General, the Comptroller General, the federal and State Department of Justice ("DOJ"), and the California Department of Managed Health Care ("DMHC"), or their designees, and at all reasonable times at Provider's place of business or at such other mutually agreeable location in California.
- b. **Books and Documents.** Books and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, Encounter Data and any other documentation pertaining to medical and non-medical services rendered to Members. These books and documents will disclose the quantity of Covered Services provided under this Agreement, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Provider administered its daily business, and the cost thereof.
- c. **Records Retention.** Provider shall maintain complete and accurate records to validate and document its (i) compliance with this Agreement, (ii) performance of the services, and (iii) charges for services, all in accordance with general standards applicable to such book or record keeping consistently applied. Provider and its subcontractors shall retain such accounting and administrative books and records, including all Encounter Data, working papers, reports submitted to Health Plan, financial records, and other documentation pertaining to services rendered to Members for a minimum of ten (10) years from the final date of the Agreement term or from the date of completion of any audit, whichever is later.

- d. **Public Records.** Provider acknowledges that this Agreement, all information received in accordance with this Agreement, and all records created and maintained on behalf of Health Plan are governed by the California Public Records Act (California Government Code, Section 7920.000 et seq.) and may be disclosed as public records except as specifically exempted in statute.

2.8 **Program Participation.**

- a. **Participation in Grievance Program.** Provider shall participate in the Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.
- b. **Participation in Quality Improvement Program.** Provider shall participate in the Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.
- c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with the Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.
- d. **Participation in Credentialing.** If Provider and Health Plan participate in and are members of the Health Industry Collaboration Effort, Inc. (“HICE”), Health Plan shall use HICE reports as the basis for its credentialing audit determinations, except that Health Plan shall have the right to request further documents, notes, or information related to the records reviewed from Provider at its sole discretion, including but not limited to for purpose of determining whether the scope of credentialing and minimum criteria are substantially similar to the standards set forth in Health Plan credentialing policies. Health Plan may also sample additional records if the results of the initial review suggest any issues that require a more detailed audit, or Medi-Cal-specific standards were not fully reviewed during the audit. If the HICE auditor did not complete the audit correctly, e.g., in accordance with HICE standards and protocols, Health Plan, may, at its sole discretion, conduct an independent audit. If Provider’s credentialed status is revoked, suspended or limited by HICE, Health Plan may at its discretion terminate this Agreement and/or reassign Members to another provider. Provider shall accept delegation of credentialing responsibilities for Provider’s subcontractors at Health Plan’s request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider’s organization. Provider will successfully complete a facility site review as described in DHCS All Plan Letter (“APL”) 20-006 (as may be amended from time to time or any successor APL), if deemed necessary by Health Plan in accordance with the Medi-Cal Agreement.
- e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which may be unilaterally amended from time to time by Health Plan or mutually amended from time to time by the parties. Health Plan’s Provider Manual is incorporated in this Agreement by this reference. To the extent there is

any conflict between this Agreement and the Provider Manual, the terms of the Provider Manual shall govern. If Health Plan materially amends the Provider Manual (“Provider Manual Modification”), Health Plan will provide sixty (60) days’ notice to Provider via publication of the Provider Manual Modification in the Provider Operations Bulletin.

- f. **Compliance with Health Plan Policies and Procedures.** Provider agrees to comply with all Health Plan policies and procedures, as may be modified from time to time by Health Plan in its sole discretion. In the event such Health Plan policies and procedures are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.
- g. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan’s provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the State, or federal government. Provider shall ensure that Provider promptly delivers to Provider’s subcontractors, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.
- h. **Cultural and Linguistic Services.** Provider shall provide Covered Services to Members in a culturally, ethnically and linguistically appropriate manner. Provider shall recognize and integrate Members’ practices and beliefs about disease causation and prevention into the provision of Covered Services. Provider shall comply with Health Plan’s language assistance program standards developed under California Health and Safety Code, Section 1367.04 and 28 CCR, Section 1300.67.04 and shall cooperate with Health Plan by providing any information necessary to assess compliance. Health Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program.
- i. **Interpreter Services.** Provider shall have twenty-four (24) hour, seven (7) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in the Provider Manual. Provider shall arrange interpreter services as necessary for Members at all Provider facilities.
- j. **Coordination of Care.** To the extent that Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use as it is able for the purpose of Member care coordination.
- k. **Alternative Format Selections (AFS).** Provider shall comply with the standards of Title II of the Americans with Disabilities Act (ADA), communicating effectively with Members with disabilities to ensure they benefit equally from government programs. Provider shall comply with Health Plan standards for AFS in accordance with the Health Plan Provider Manual and applicable All Plan Letters and shall cooperate with Health Plan by providing any information

necessary to assess compliance. Provider shall inform Members who state that they have difficulty reading print communications on account of a disability of their right to receive Auxiliary Aids and Services, including alternative formats, and shall provide appropriate Auxiliary Aids and Services to all qualified Members with disabilities, including authorized representatives (AR) or individuals with whom it is appropriate to communicate. Health Plan shall retain ongoing administrative and financial responsibility for implementing AFS. Health Plan will routinely share DHCS AFS data with Provider. Provider shall use the DHCS AFS file data to provide member documents in the requested alternative formats. Provider shall enter any new Member AFS data received at the time of request through the DHCS Alternative Format Database online screens or by calling the AFS Helpline.

## **2.9 Services Provided to CCS Eligible Members.**

- a. Provider agrees that for Members 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 Health Plan. Provider agrees to provide Health Plan with the names of all Members whose condition may make the Member eligible to receive CCS covered services. Provider will not seek payment from Health Plan, and Health Plan will not pay Provider, for Covered Services denied by CCS because the referral was not timely submitted by Provider to CCS.
- b. If Provider is certified by CCS to provide CCS covered services to eligible Members, Provider agrees that such services shall be provided by, or provided by order of, a CCS paneled provider. Provider will not seek payment from Health Plan, and Health Plan will not pay Provider, for Covered Services denied by CCS because the care or treatment was not provided by a paneled provider.
- c. If Provider is not certified by CCS to provide CCS covered services to eligible Members, Provider shall transfer the care and treatment of a CCS eligible Member to the nearest CCS certified Provider within the time limits set by CCS or Health Plan. When possible, the transfer shall be to a CCS paneled provider contracted with Health Plan. Provider will not seek payment from Health Plan, and Health Plan will not pay Provider, for CCS covered services provided to the Member if Provider fails to transfer a Member to a CCS certified Provider.
- d. Provider agrees that under no situation or circumstances will Provider bill, or seek payment from, Members for CCS covered services that were not paid.

## **2.10 Licensure and Standing.**

- a. **Licensure.** Provider shall maintain, and shall require its subcontractors to maintain any licenses or certificates necessary, if any, to provide Covered Services, including but not limited to those required for the vehicle transport of Members. Provider shall provide evidence of such licensure to Health Plan upon request. Provider and its subcontractors shall maintain licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this

Agreement. Provider shall notify Health Plan in accordance with Section 7.25 within five (5) days of Provider's learning of any action taken which results in restrictions on Provider's staff privileges, membership, or employment for a medical disciplinary cause or reason as defined in California Business and Professions Code, Section 805, regardless of the duration of the restriction or any disciplinary action proposed by any licensing agency responsible for oversight of Provider.

- b. **Unrestricted Status.** Provider represents and warrants that neither it nor its employees, agents, or subcontractors have been convicted of a felony; been convicted of a misdemeanor involving fraud, or abuse of the Medi-Cal program, or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service; been suspended from the federal Medicare or Medicaid programs for any reason; or lost or surrendered a license, certificate, or approval to provide health care, and is at all times eligible to participate in State or Medicare or Medicaid health care programs. Provider shall notify Health Plan at [compliance@goldchp.org](mailto:compliance@goldchp.org) within one (1) business day of any events, including the above, that would result in exclusion from State, Medicare, or Medicaid programs.
- c. **Malpractice and Other Actions.** Unless otherwise prohibited by law, Provider shall notify Health Plan within five (5) days at [Providercontracting@goldchp.org](mailto:Providercontracting@goldchp.org) of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.
- d. **Staffing Privileges for Providers.** Every Provider physician shall have staff privileges with at least one Health Plan contracted Hospital or have executed a formal agreement with another physician to admit and follow patients in the Health Plan contracted Hospital in order to ensure the necessary provision of services to Members under this Agreement. Provider shall authorize each Hospital at which Provider maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against Provider which could result in any suspension, reduction or modification of a Provider physician's Hospital privileges.

## 2.11 **Liability Insurance.**

- a. **Coverage.** At its sole cost and expense, Provider shall at all times maintain in force and shall provide to Health Plan satisfactory evidence of insurance in the following amounts and coverages, with insurers satisfactory to Health Plan:
  - i. General liability insurance in the minimum amount of one million dollars (\$1,000,000) per person for Provider's property together with a Combined Single Limit Body Injury and Property Damage Insurance of not less than two million dollars (\$2,000,000). This policy shall (i) provide that it is

primary to any other insurance available to any additional insured, with respect to any claims arising out of this Agreement; (ii) provide that it applies separately to each insured against whom claim is made or suit is brought; and (iii) if there are sub limits for Sexual Abuse and Molestation coverage then they must be listed on the certificate and must meet the minimum requirements above, or if silent to Sexual Abuse and Molestation coverage, then the certificate must state, "The General Liability Policy contains no exclusions or sublimits for Sexual Abuse or Molestation Coverage";

- ii. Errors and omissions insurance/Professional liability insurance covering acts, errors, mistakes, omissions arising out of the Covered Services performed by Provider, or any subcontractor, driver, agent, or person employed by Provider each in the minimum amount of one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) annual aggregate; and
  - iii. Workers' Compensation maintained by Provider for the benefit of Provider's employees in an amount required by applicable law (including, but not limited to, California Labor Code, Section 3602(d)).
- b. **Aggregate Limit.** If any policy includes an aggregate limit or provides that claims investigation or legal defense costs are included in such aggregate limit, the aggregate limit will be double the occurrence limits specified above.
- c. **Content.** Each liability policy described in Section 2.11.a hereof will:
- i. Provide for at least thirty (30) days' advance notice in accordance with Section 7.25 to Health Plan of cancellation or material modification; and
  - ii. Shall be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best rating of A:VIII or better.
- d. **Length of Coverage.** Provider shall maintain such coverage set forth in this Section 2.11, without lapse, for a period of not less than two (2) years following termination of this Agreement, provided however if any policy is on a claims-made form, Provider shall maintain such coverage, without lapse, for a period of three years after termination of this Agreement so that if any occurrence during the term of this Agreement gives rise to a claim made after such termination, such claim is covered.
- e. **Copies.** Provider shall promptly provide Health Plan with a certified copy of any required insurance policy within five (5) business days of a written request by Health Plan. Health Plan's acceptance or approval of any insurance will not limit Provider's liability under this Agreement.
- f. **Subrogation.** All insurance policies carried by Provider whether specified herein or otherwise shall contain endorsements waiving the insurer's rights of subrogation against Health Plan.

- g. **Tail Coverage.** If the coverage is claims made or reporting, Provider agrees to purchase similar “tail” coverage upon termination of Provider’s present or subsequent policy.
- h. **Claims.** Provider shall give Health Plan prompt notice, but in no event more than fifteen (15) business days’ notice, of any claims against Provider’s coverage by or regarding a Health Plan Member.
- i. **Primary.** Any insurance provided by Provider or its subcontractors shall be primary to any coverage available to Health Plan. Any insurance or self-insurance maintained by Health Plan and its officials, officers, employees, agents or volunteers, shall be in excess of Provider’s insurance and shall not contribute with it.
- j. **No Limitation.** Procurement of insurance by Provider shall not be construed as a limitation of Provider’s liability or as full performance of Provider’s duties to indemnify, hold harmless and defend Health Plan under the terms of this Agreement.

## 2.12 Payment Requirements.

- a. **Submitting Claims.** Provider shall submit to Health Plan claims for Non-Capitated Covered Services rendered to Members in accordance with the Provider Manual. Claims shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan’s policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within three hundred sixty-five (365) days of providing the Covered Services that are subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor.
- b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Non-Capitated Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Health Plan shall process Clean Claims in accordance with industry standards, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, Medi-Cal billing rules, National Correct Coding Initiatives (NCCI) Edits, and the American National Standards Institute (ANSI) X12 Standard for Electronic Data Interchange (EDI) format. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement.
- c. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, deductibles and co-insurance, if any, provided for in the Member’s Health Plan product. Provider agrees that Members eligible for both Medicare and Medi-Cal will not be held liable by Provider for Medicare Part A and B cost sharing when the State of California is responsible for paying such amounts, nor be held liable for cost-sharing that exceeds the amount a Member would be required to pay through Medi-Cal. Provider shall not refuse to provide Covered



Services in the event a Member is unable to pay their copayment or deductible except as may be specifically permitted in the Provider Manual or as approved in advance by Health Plan. Provider shall not balance bill Members for any Covered Services.

- d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether the Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall promptly notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.
- e. **Third Party Liability.** In the event that Provider renders services to Members for injuries or other conditions resulting from the acts of third parties, the State has the right to recover from any settlement, award, or recovery from any responsible third party the value of all Covered Services which have been rendered by Provider pursuant to the terms of this Agreement. Provider will report to Health Plan the discovery of any third party tort action or potential tort action for a Member within ten (10) days of discovery. Provider will cooperate with DHCS and Health Plan in their efforts to obtain information and collect sums due the State as a result of third party tort liability, including but not limited to workers compensation claims for Covered Services.
- f. **Overpayment.** In the event that Health Plan determines that Provider has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan of any undisputed overpayment within thirty (30) working days (in accordance with the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code, Section 1371.1) of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment (“Overpayment”) in accordance with Section 7.25. Health Plan’s Overpayment notification shall include an explanation of the basis upon which Health Plan believes the amount paid on the claim was in excess of the amount due, including information about impacted claims and supporting documentation. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days’ notice in which to dispute Health Plan’s determination of the Overpayment, in which case the dispute will be treated as a provider Dispute subject to Article 6 of this Agreement. Except in instances where an Overpayment is attributable to the fraud or misrepresentation of Provider, Health Plan will not issue a notice of Overpayment later than three hundred sixty-five (365) days after the date of payment of an overpaid claim. As a material condition to Health Plan’s obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in State and federal

law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or Governmental Agency. In the event that Provider identifies an Overpayment, Provider shall report within sixty (60) calendar days of the date of identification of the Overpayment to Gold Coast Health Plan, P.O. Box 9152, Oxnard CA, 93031 Attn: GCHP Overpayments. The report shall include the amount of Overpayment identified and the reason for the Overpayment. Provider shall make repayment to Health Plan within thirty (30) working days of the date of identification of such Overpayment. This subsection shall survive termination of this Agreement.

- g. **Claims Review and Audit.** Health Plan has the right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, Medi-Cal billing rules, CMS NCCI Edits, and Food and Drug Administration definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Health Plan has the right to conduct such review and audit on a line-by-line basis or such other basis as Health Plan deems appropriate, and Health Plan has the right to exclude inappropriate line items, to adjust payment and reimburse Provider at the revised allowable level. Health Plan has the right to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, State and federal guidelines, and/or Health Plans' policies and data to determine the appropriateness of the billing, coding and payment.
- h. **Payments which are the Responsibility of a Capitated Provider.** Provider acknowledges that Health Plan maintains contracts with providers who receive capitation from Health Plan for professional and/or facility services and are responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"). Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers. If Provider is or becomes a party to a subcontract or other agreement with such Capitated Provider, Provider shall accept payment under said subcontract or other agreement with Capitated Provider as payment in full for Covered Services rendered to Members. Where Provider does not have a contract with Capitated Provider, Provider shall accept the Medi-Cal fee-for-service payment amount by Capitated Provider as payment in full for emergency-based Covered Services, for Members that have no other third party coverage.
- i. **No Billing of Members.** Except as specifically provided for in this Section, Provider agrees to seek payment from only Health Plan or a Capitated Provider for all Covered Services provided to a Member. In no event, including but not limited to, nonpayment by Health Plan or a Capitated Provider, insolvency by Health Plan or a Capitated Provider, or breach of the Agreement, shall Provider,

or any person acting on Provider's behalf, bill, charge, collect a deposit or surcharge from, seek compensation from, maintain an action in law, or have any other recourse against a Member, a person acting on the Member's behalf, or a Governmental Agency for Covered Services provided pursuant to this Agreement. Provider shall ensure that its subcontractors comply with this Section.

This prohibition does not apply to the following:

- i. Provider may bill a Member for any permitted co-payment, deductible or co-insurance obligation in accordance with Section 2.12(c).
- ii. Provider may seek payment from Member for services that are not Covered Services under the terms of this Agreement provided the payment is not for otherwise Covered Services which Health Plan determined not to be payable under the terms of this Agreement and provided the Member signs a written waiver that meets the following criteria:
  - (a) The waiver notifies the Member that the service is a non-Covered Service;
  - (b) The waiver notifies the Member of the service being provided and the date(s) of service;
  - (c) The waiver notifies the Member of the approximate cost of the service; and
  - (d) The waiver is signed by the Member prior to receipt of the service.

If Provider erroneously bills a Member in violation of this Section, Provider will reimburse the amount paid by the Member within fifteen (15) days of the occurrence and will notify Health Plan of the action taken. Upon notice of such an erroneous billing by Provider, Health Plan may, at its sole discretion, repay the Member and deduct the amount of the expense incurred by Health Plan by way of offset against Provider's future payments.

- 2.13 **Compliance with Applicable Law.** Provider shall comply with all applicable State and federal laws governing the delivery of Covered Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; the Americans with Disabilities Act, as amended; and Section 1557 of the Patient Protection and Affordable Care Act. Provider acknowledges that all Covered Services are subject to those laws applicable to the Medi-Cal Managed Care Program. Provider shall comply with the additional Medi-Cal Managed Care Program provisions set forth in Attachment E, and all applicable provisions of the Medi-Cal Agreement. Provider agrees to report any violation of law or Health Plan policies or procedures committed by Provider or its employees, agents, workforce members, or subcontractors in the performance of the Covered Services to Health Plan's Ethics Hotline at (888) 866-1366 or Health Plan's ethics officer at Health Plan's address for notices.
- 2.14 **Provider Non-solicitation Obligations.** Provider will not engage in any activities involving the direct marketing of Eligible Beneficiaries or Members without the approval

of Health Plan and DHCS. Provider will not engage in direct solicitation of Eligible Beneficiaries for enrollment. Provider shall not unilaterally assign or transfer Members served under this Agreement to another provider without the prior written approval of Health Plan, nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. During the period of this Agreement and for a period of one (1) year after termination, Provider and Provider's employees, agents and subcontractors shall not solicit or attempt to persuade any Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which Provider rendered Covered Services to Member. In the event of breach of this Section 2.14, in addition to any other of Health Plan's legal rights, Health Plan may at its sole discretion immediately terminate this Agreement. Nothing in this Section is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

- 2.15 **Fraud and Abuse.** Provider shall report to Health Plan's compliance officer at [compliance@goldchp.org](mailto:compliance@goldchp.org) all cases of suspected fraud and/or abuse, as defined in 42 CFR, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) business days of the date when Provider first becomes aware of, or is on notice of, such activity. Unless otherwise prohibited by law, Provider shall notify Health Plan of investigations of Provider relating to fraud, waste or abuse within ten (10) business days of the date when Provider first becomes aware of, or is on notice of, such investigation. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal Managed Care Program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations. Provider shall comply with Health Plan's antifraud plan, including its policies and procedures relating to the investigation, detection and prevention of and corrective actions relating to fraud, waste and abuse. Provider represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, the program integrity requirements of 42 CFR, Section 438.608, the Federal False Claims Act (31 U.S.C., Section 3729 et seq.), federal requirements for employee education about false claims recovery (42 U.S.C., Section 1396a(a)(68)), the State False Claims Act (California Government Code, Section 12650 et seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act). Provider agrees to report any violation of law or Health Plan policies or procedures committed by Provider or its employees, agents, workforce members, or subcontractors in the performance of the Covered Services to Health Plan's ethics hotline at (888) 866-1366 or Health Plan's ethics officer at Health Plan's address for notices.
- 2.16 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

**2.17 Federal Lobbying Certification.**

- a. Provider shall comply with 31 U.S.C., Section 1352, which prohibits the use of federal funds for lobbying. By signing this Agreement, the authorized agent executing this Agreement certifies that to the best of his or her knowledge and belief that:
  - i. No federal appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person influencing or attempting to influence an officer or employee of any agency of the United States government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with making, awarding, or entering this Agreement, any federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Agreement, grant, or cooperative agreement.
  - ii. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Agreement, Provider shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.
- b. In the event the aggregate consideration under this Agreement is one hundred thousand dollars (\$100,000) or more, then the language in this Section 2.17 shall be included in all subcontracts of Provider pertaining to this Agreement.

**2.18 Drug Free Workplace.** Provider agrees to notify all persons who perform Covered Services under this Agreement of Health Plan's policy concerning drug and alcohol use that prohibits (a) the use, possession, distribution, purchasing or selling drugs or alcohol on Health Plan's premises or while engaged in Health Plan's business and (b) reporting to and/or performing work for Health Plan while under the influence of same (except for authorized amounts of prescribed drugs required for health reasons).

**2.19 Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by Provider. When the Health Plan reassigns Member(s), Provider shall forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

**2.20 Notification of Network Change.** Provider shall provide Health Plan and Member with timely written notification in the event a subcontractor specialty provider terminates its contract with Provider. Said written notification shall be in compliance with all State and federal laws or government sponsored program requirements.

**ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS**

- 3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.
- a. **Payment Policy.** Health Plan has the sole authority to determine payment policies under this Agreement, which includes reduction of Provider's reimbursement rates as set forth below.
- b. **Changes in Payment.** Notwithstanding anything to the contrary set forth in this Agreement, Health Plan may reduce the rates or other compensation payable to Provider at any time or from time-to-time during the term of this Agreement as determined by Health Plan to reflect implementation of State or federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Covered Services, or changes in rates implemented by the DHCS, CMS or any other Governmental Agency providing revenue to Health Plan, or any other change that results in decreases to the rates or level of funding paid to Health Plan. The amount of such adjustment shall be determined by Health Plan on a retrospective basis to the date on which the change was made by the Governmental Agency and need not be in proportion to or in the same amount as the decrease to the rates or level of funding paid to Health Plan. Adjustments shall be made within one hundred eighty (180) calendar days of communication of any of the changes described above by any Governmental Agency providing revenue to Health Plan. All other rate changes or adjustments shall be made only if the parties have executed a formal amendment to this Agreement to provide for same.
- 3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify and provide access to Member eligibility information at the request of Provider.
- 3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.
- 3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determinations shall be the interest of the Member.
- 3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a Primary Care Physician, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.
- 3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Receipt of the Provider Manual is acknowledged by Provider in Attachment G. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

- 3.7 **Medical Director.** Health Plan will employ a physician as Medical Director who shall be responsible for the management of both the; (i) medical, and (ii) medically-related scientific and technical, aspects of Health Plan.
- 3.8 **Insurance Requirements.**
- a. Health Plan, at its sole cost and expense, will obtain and maintain in full force during the term of this contract the following types of insurance with respect to any work performed by Health Plan under this Agreement:
    - i. General liability “occurrence” coverage in the minimum amount of one million dollars (\$1,000,000) combined single limit (CSL) bodily injury and property damage each occurrence and two million dollars (\$2,000,000) aggregate, including personal injury and property damage.
    - ii. Workers’ compensation coverage, in full compliance with State statutory requirements, for all employees of Health Plan and employer’s liability in the minimum amount of one million dollars (\$1,000,000).
  - b. The County of Ventura will be listed as an additional insured as respects work done by Health Plan under the terms of this Agreement on all policies required (except worker’s compensation).

#### **ARTICLE FOUR - TERM AND TERMINATION**

- 4.1 **DHCS Approval.** Provider acknowledges that this Agreement, and any subsequent amendment to this Agreement, shall become effective only upon the written approval by DHCS, or by operation of law as follows: where DHCS has acknowledged receipt of the Agreement or amendment and neither approves, disapproves, or extends the time for review of the Agreement, within sixty (60) days of its receipt, provided that if the Agreement or amendment is subsequently disapproved or modified by DHCS, then Health Plan may implement the changes or terminate the Agreement or amendment..
- 4.2 **Term.** This Agreement shall commence on the Effective Date and shall continue in effect for one (1) year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with this Agreement.
- 4.3 **Termination without Cause.** This Agreement may be terminated without cause and for convenience by either party upon at least ninety (90) days’ notice to the other party in accordance with Section 7.25.
- 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.

- 4.5 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:
- a. Provider's license or certificate to render Covered Services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the State licensing authority;
  - b. Provider fails to maintain insurance required by this Agreement;
  - c. Provider loses credentialed status;
  - d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;
  - e. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;
  - f. Health Plan determines that Provider's facility, vehicles and/or equipment is insufficient to render Covered Services to Members;
  - g. Provider is excluded from participation in Medicare and State health care programs pursuant to Section 1128 of the Social Security Act or otherwise terminated as a provider by any State or federal health care program;
  - h. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement; or
  - i. Health Plan determines that Covered Services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.
- 4.6 **Continuation of Services.** Should this Agreement be terminated, Provider will, at Health Plan's option, continue to provide Covered Services to Members who are under the care of Provider at the time of termination until the services being rendered to Members by Provider are completed, unless Health Plan has made appropriate provision for the assumption of such services by another physician and/or provider. Provider will ensure an orderly transition of care for Members, including but not limited to the transfer of Member's medical records. Payment by Health Plan for the continuation of services by Provider after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein.
- 4.7 **Termination of Medi-Cal Agreement.** In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, Provider will allow DHCS and Health Plan to copy medical records of all Members, at Health Plan's expense, in order to facilitate the transition of such Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, Provider will assist DHCS in the orderly transfer of Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of Provider's subcontractors, necessary for efficient case management of Members, as determined by DHCS. Costs of reproduction



of all such medical records will be borne by Health Plan. Under no circumstances will a Member be billed for this service. The cost to Health Plan for Provider's photocopying of such records will not exceed fifteen (15) cents per page.

- 4.8 **Transition.** Provider will assist Health Plan in the orderly transfer of Members to the provider they choose or to whom they are referred after termination of this Agreement. Furthermore, Provider shall assist Health Plan in the transfer of care as set forth in the Provider Manual, in accordance with the phaseout requirements set forth in the Medi-Cal Agreement. Upon request by Health Plan, Provider will allow the copying and transfer of Provider's records for each Member to the provider assuming Covered Services for the Member at termination. Such copying of records will be at Health Plan's expense unless Health Plan terminates the Agreement for cause. Health Plan will continue to have access to records in accordance with the terms of this Agreement.
- 4.9 **Survival of Obligations.** Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement.
- 4.10 **DHCS Notification.** Provider agrees to timely notify DHCS of the termination of this Agreement. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached to:

California Department of Health Care Services  
Managed Care Operations Division  
Attn: Contracting Officer  
MS 4407  
P.O. Box 997413  
Sacramento, CA 95899-7413

## **ARTICLE FIVE - DEFAULT**

- 5.1 **Default.** Provider will be in default if:
- a. Provider fails to perform any covenant (including a lapse in insurance coverage) required by this Agreement;
  - b. Any representation or warranty made by Provider in conjunction with this Agreement is false or materially misleading;
  - c. Provider files or is the subject of a petition for bankruptcy or insolvency; or
  - d. Provider has a court-ordered receiver or trustee appointed with respect to Provider's assets.
- 5.2 **Remedies.** If a default under Section 5.1 has occurred and is continuing, Health Plan may, individually or in combination with any other remedy:
- a. Terminate this Agreement in accordance with Sections 4.4 or 4.5;
  - b. Offset the amount of any outstanding liability of Health Plan against funds otherwise due and owing under this or any other agreement Provider has with Health Plan;

- c. Withhold funds due hereunder;
  - d. Cure the default, in which event all amounts expended by Provider in effecting such cure will be payable upon demand, with interest from the date of incurrence at the maximum rate permitted by law; or
  - e. Exercise any other remedy available by law
- Health Plan will have no obligation to exercise any of the foregoing remedies.

## **ARTICLE SIX - PROVIDER GRIEVANCES AND DISPUTES**

### **6.1 Appeals and Grievances**

- a. **Process.** Provider complaints, concerns, or differences, which may arise as a health care provider under contract with Health Plan will be resolved as outlined in the Grievance Program.
- b. **Responsibility.** It is the responsibility of the Health Plan for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance Program.

### **6.2 Dispute Resolution**

- a. **Government Claims Act.** Health Plan and Provider agree to meet and confer in good faith to resolve any Disputes that may arise under or in connection with this Agreement which are not resolved through the Grievance Program. In all events and subject to the provisions of this Section which follow, Provider shall comply with the Government Claims Act (California Government Code, Section 900 et seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").
- b. **Judicial Reference.**
  - i. At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure, Section 640 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by State law, and in accordance with Chapter 6 (References and Trials by Referees) of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the State superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 640 for appointment of a referee before the appropriate judge of the Ventura Superior Court. The parties acknowledge that they forego any right to trial by jury in any judicial reference proceeding, and that each party shall be responsible for paying an equal

share of all costs for the referee until such time as a judgment is entered. Any counterpart or copy of this Agreement, filed with such court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated non prevailing party in any Dispute shall be required to fully compensate the prevailing party for its payments to the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

- ii. Acknowledgement of Waiver of Jury and Payment of Referee Fees  
(Initials) for \_\_\_\_\_  
Health Plan: \_\_\_\_\_ for Provider: \_\_\_\_\_

- c. **Time Limitation.** Provider must comply with the claim procedures set forth in the Government Claims Act (California Government Code, Section 900 et seq.) prior to filing any legal proceeding, including judicial reference, against Health Plan. If no such Government Code claim is submitted, no action against Health Plan may be filed. Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date that the facts giving rise to a Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (California Government Code, Section 900 et seq.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.
- d. **Venue.** Unless otherwise specified in this Section, all actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the State or federal (if permitted by law and a party elects to file an action in federal court) courts located in Ventura County.
- e. **Cut-Off for Disputes Against Health Plan.** Within ninety (90) days of the expiration or termination of this Agreement, Provider shall notify Health Plan, in accordance with Section 7.25, of any unresolved Disputes Provider has against Health Plan. The notice shall describe any unresolved Dispute and identify the amount Provider demands in satisfaction of the Dispute, and it shall include any supporting documentation. Provider's failure to submit timely notice shall constitute a waiver of all unresolved Disputes against Health Plan. To the extent a Dispute arises after the time for providing notice, and Provider could not have timely discovered the dispute, Provider shall notify Health Plan within ten (10) days of discovery. Nothing herein shall modify Provider's duty to comply with the Government Claims Act and the requirements of this Section.

## ARTICLE SEVEN - GENERAL PROVISIONS

- 7.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses (including but not limited to sanctions or penalties imposed by Governmental Agencies), damages, claims, and expenses of any kind, including costs and

attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement. The terms of this Section shall survive the termination of this Agreement.

- 7.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Members.
- 7.3 **Independent Contractor.** Provider shall act as an independent contractor having responsibility for and control over the means and details of performing the services, and shall not act as an agent or employee of Health Plan. Accordingly, Provider, its staff, employees, drivers, and agents, and that of any Provider subcontractor shall have no claim under this Agreement against Health Plan for vacation or sick leave, retirement benefits, Social Security, workers' compensation benefits, disability or unemployment insurance benefits, or employee benefits of any kind. To the extent that Provider asserts that it is eligible for any benefit programs maintained by Health Plan (regardless of the timing of or reason for eligibility), Provider hereby waives its right to participate in such programs. Provider also agrees that consistent with its independent contractor status, it will not apply for any government sponsored benefits that are intended to apply to employees, including, but not limited to, unemployment benefits or worker's compensation. The parties shall not make any commitments or incur any charges or expenses for or in the name of one another and shall, to the greatest extent possible, perform this Agreement in a manner consistent with Provider's status as an independent contractor. Provider will pay to the appropriate governmental authority all taxes levied in connection with this Agreement or the Covered Services, including any self-employment, social security, income, unemployment, disability insurance, franchise, possessory interest, payroll, gross receipts and sales or use taxes. Provider hereby waives any claim against Health Plan with respect to, any and all federal, State and local taxes, contributions and other amounts which are payable in connection with or are levied or assessed with respect to any and all fees which it receives from Health Plan hereunder, including without limitation, all income taxes, social security taxes, disability taxes and unemployment insurance taxes, and any and all penalties and interest due thereon.
- 7.4 **Oversight.** Nothing contained in this Agreement will limit the right of Plan to perform its oversight and monitoring responsibilities as required by applicable State and federal law, as amended, or programmatic requirements, or the Medi-Cal Agreement.
- a. **Monitoring and Oversight.** Provider understands and agrees that Health Plan is responsible for the monitoring and oversight of all duties of Provider under this Agreement, and that Health Plan has the authority and responsibility to: (i) implement, maintain and enforce Health Plan Policies governing Provider's duties

under this Agreement and/or governing Health Plan's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Agreement; (iii) require Provider to take corrective action if Health Plan or a Governmental Agency determines that corrective action is needed with regard to any duty under this Agreement; (iv) withhold from Provider's compensation if Provider fails to take corrective action, which may be returned upon Provider's demonstration of sustained compliance; and/or (v) revoke the delegation of any duty, if Provider fails to meet Health Plan standards in the performance of that duty. Provider shall cooperate with Health Plan in its oversight efforts and shall take corrective action as Health Plan determines necessary to comply with the laws, accreditation agency standards, and/or Health Plan policies governing the duties of Provider or the oversight of those duties.

- b. **Compliance with Monitoring.** Provider shall comply with all monitoring provisions of this Agreement and any monitoring requests by DHCS or Health Plan pursuant to 42 CFR, Section 438.3(h). In addition to the obligations under Section 2.7 of this Agreement and to assure compliance with this Agreement and for any other reasonable purpose, Health Plan and Governmental Agencies shall have the right to access to the premises and facilities of Provider with or without notice to Provider, including, but not limited to, the management information systems operations site or such other places where duties and obligations under this Agreement are performed. The monitoring activities will be either announced or unannounced. Staff designated by Health Plan or Governmental Agencies will have access to all security areas. Provider shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives of Governmental Agencies in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.
- c. **Risk of Fraud.** If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time, either announced or unannounced. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal Managed Care Program, seek recovery of payments made to Provider, impose other sanctions provided the Medi-Cal Managed Care Program, and direct Health Plan to terminate this Agreement due to fraud.

7.5 **Patient-Physician Relationship.** This Agreement is not intended to interfere with the professional relationship between Provider and Member. Provider will be responsible for maintaining the professional relationship with Members and is solely responsible to such Members for all medical services rendered by Provider and Provider's subcontractors. Health Plan will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by Members resulting from the acts or omissions of Provider or Provider's subcontractors.

7.6 **Immigration Compliance.** Provider warrants, represents and agrees that Covered Services will not be performed under this Agreement by any person who is an

unauthorized alien under the Immigration Reform and Control Act of 1986 (as the same has been or may be amended) or its implementing regulations. Provider shall ensure that each and every person performing Covered Services shall be a citizen or permanent resident of the United States, or have a valid United States visa authorizing employment in the United States, and shall be permitted to work for federal contractors, including but not limited to Medicare and Medicaid contractors.

- 7.7 **Export Regulations.** Provider acknowledges its obligations to control access to technical data under federal export laws and regulations and agrees to adhere to such laws and regulations with regard to any technical data received under this Agreement.
- 7.8 **Offshore Resources.** Provider or its agents or subcontractors shall not perform any Covered Services outside the United States of America without the prior written consent of Health Plan. If during the term of this Agreement, or at any time after the Effective Date, it is determined that Provider is in breach of this Section, Health Plan shall have, in its sole discretion, the right to immediately terminate this Agreement.
- 7.9 **Clean Water and Air Acts.** If payments under this Agreement are in excess of one hundred thousand dollars (\$100,000), Provider shall comply with the following provisions unless this Agreement is exempt under 40 CFR, Part 30:
- a. **Clean Water.** Provider shall comply with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 U.S.C., Section 1857 (h)), Section 508 of the Clean Water Act (33 U.S.C., Section 1368), Executive Order 11738, and the Environmental Protection Agency regulations (40 CFR, Part 15).
  - b. **Clean Air.** Provider shall comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C., Section 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C., Section 1251 et seq.), as amended.
- 7.10 **Federal Equal Opportunity Requirements.**
- a. **Discrimination.** Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship.
  - b. **Posting.** Provider shall post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government or DHCS, setting forth the provisions of the equal opportunity clause of Section 503 of the Rehabilitation Act of 1973 (29 U.S.C., Section 793), the affirmative action

clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C., Section 4212) and of Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR, Chapter 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor. Such notices shall state Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

- c. **Labor Unions.** Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. **Books and Records.** Provider will comply with and furnish all information and reports required by items described above in items (a) through (c) above and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- e. **Non-Compliance.** In the event of Provider's noncompliance with the requirements of this Section 7.10, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions as may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR, Chapter 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
- f. **Subcontracts.** Provider will include the provisions of subparagraphs (a) through (e) in every subcontract unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR, Chapter 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 (29 U.S.C., Section 793) or the Vietnam Era Veteran's Readjustment Assistance Act (38 U.S.C., Section 4212), so that such provisions will be binding upon each subcontractor. Provider will take such action with respect to any subcontract as the Director of the Office of Federal Contract

Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Provider becomes involved in, or is threatened with litigation by any subcontractor as a result of such direction by DHCS, Provider may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

- 7.11 **Governing Law.** This Agreement shall, in all respects, be interpreted, construed, enforced and given effect according to the laws of the State, excluding its principles of conflicts of laws.
- 7.12 **Third-Party Beneficiaries.** Nothing contained in this Agreement shall confer on any party the position of third party beneficiary of the obligations assumed by either party to this Agreement and no such individual shall have the right to enforce any such obligation.
- 7.13 **Waiver.** No assent or waiver, express or implied, of any breach of any one or more of the covenants, conditions or provisions hereof shall be deemed or taken to be a waiver of any other covenant, conditions or provision hereof, or a waiver of any subsequent breach of the same covenant, condition or provision hereof.
- 7.14 **Entire Agreement.** This Agreement, together with attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The Medi-Cal Agreement is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.
- 7.15 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.
- 7.16 **Counterparts.** This Agreement may be executed in two (2) or more counterparts, each one (1) of which will be deemed an original, but all of which will constitute one (1) and the same instrument.
- 7.17 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive agreement between Health Plan and Provider, nor shall it be deemed to be an agreement requiring Health Plan to refer Members to Provider for health care services.
- 7.18 **Amendment.** Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any State or federal law, policy, directive, or government sponsored program requirement or to implement changes necessary for Health Plan to fully comply with the Medi-Cal Agreement upon forty-five (45) business days' notice to Provider in accordance with Section 7.25 unless a shorter timeframe is necessary for compliance.
- 7.19 **Assignment.** Provider may not assign or delegate this Agreement without the prior written consent of Health Plan and DHCS. Provider may not subcontract with a third party to perform, in whole or in part, any rights, duties, or obligations under this Agreement without prior written consent of Health Plan. Subject to the foregoing, this



Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment. A change in ownership of Provider of ten percent (10%) or more shall be deemed an assignment.

- 7.20 **Non-Disclosure.** 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, including the payment provisions of this Agreement, 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 Covered Services to a Member; (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.
- 7.21 **Authority.** Provider represents and warrants that it has full right, power, and authority to execute and deliver this Agreement and to perform its obligations contemplated under its terms. In addition, Provider represents and warrants that all corporate acts or proceedings required to be taken by Provider to authorize the execution, delivery, and performance of this Agreement have been taken.
- 7.22 **Disclosure of Provider Ownership.** Provider shall provide Health Plan with the following information, as applicable: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; (c) names of stockholders owning more than ten percent (10%) of the stock issued by Provider; and (d) names of major creditors holding more than five percent (5%) of the debt of Provider. Provider shall complete any disclosure forms required under Health Plan programs as requested by Health Plan prior to commencing services under this Agreement. Provider shall notify Health Plan within five (5) business days of any changes to the information included by Provider in the disclosure forms submitted to Health Plan. Provider and any subcontractors shall provide written disclosure of any prohibited affiliation under 42 CFR, Section 438.610.
- 7.23 **Assistance with Litigation.** Upon request by DHCS, Provider shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege, and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to promptly notify DHCS and Health Plan within two (2) business days in accordance with Section 7.25 of any subpoenas, document production requests, or requests for records, received by Provider related to the Medi-Cal Agreement. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in the Medi-Cal Agreement.

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

Attachment A – Provider Identification Form

Attachment B – Definitions

Attachment C – Scope of Services

Attachment D – Compensation Schedule

Attachment E – Medi-Cal Managed Care Program Provisions

Attachment F – Acknowledgment of Receipt of Primary Care and Specialist Case Management Protocol

Attachment G – Acknowledgment of Receipt of Provider Manual

Attachment H – Disclosure Form

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

The parties may change the names and addresses for notification through notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier.

## ATTACHMENT A

### PROVIDER IDENTIFICATION ELEMENTS

The following elements will be included in the monthly roster provided by Provider:

Provider Name	_____	Billing Address:
Telephone No.	_____	_____
Facsimile No.	_____	_____
Email Address	_____	
Tax I.D. No.	_____	Physical Address (if different than above)
License No.	_____	_____
NPI (or UPIN if NPI not yet designated)	NPI: _____ UPIN: _____	
DEA No.	_____	
Hours	_____	Mid Level Practitioners Supervised:
		_____
Languages Spoken	_____	



## ATTACHMENT B

### Definitions

1. **Administrative Members** are Medi-Cal Members enrolled with Health Plan who have not been assigned to a Primary Care Physician for administrative reasons.
2. **Advance Directive** is a Member's written instructions, recognized under State law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under State law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
3. **Agreement** means this Provider Services Agreement -- Specialist, all attachments, and incorporated documents or materials.
4. **California Children's Services (CCS)** is the public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS eligible conditions, as defined in 22 CCR, Section 41800.
5. **Case Management Services** means those case management services described in Attachment C, Scope of Services.
6. **Clean Claim** means a claim that has no defect, impropriety (including any lack of any required substantial documentation), or particular circumstance requiring special treatment that prevents timely payment. Clean Claim(s) are timely claims complete in all aspects, including Member's identification number, Member's full name, coding, authorization, dates of service, and billed amounts in connection with Covered Services. Clean Claim(s) do not include claims which are the financial responsibility of a Capitated Provider.
7. **Covered Services** means those health care services within the normal scope of practice and licensure of Provider as described in Attachment C, Scope of Services.
8. **DHCS** is the State Department of Health Care Services.
9. **Eligible Beneficiary** means any Medi-Cal beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement, who resides in the Service Area and who is certified as eligible for Medi-Cal by the county agency responsible for determining the initial and continuing eligibility of persons for the Service Area.
10. **Emergency Medical Condition** is a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: i) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in

serious jeopardy; ii) serious impairment to bodily functions; or iii) serious dysfunction of any bodily organ or part.

11. **Emergency Services** are those health services needed to evaluate or stabilize an Emergency Medical Condition.
12. **Encounter Data** means electronically submitted information provided by Provider containing data relating to the Covered Services rendered to Members during each calendar month.
13. **Excluded Services** are those excluded services as defined in Attachment C for which the Health Plan is not responsible and for which it does not receive a capitation payment from DHCS.
14. **Governmental Agencies** means the Department of Managed Health Care (“DMHC”), DHCS, the Centers for Medicare and Medicaid Services (“CMS”), United States Department of Health and Human Services (“DHHS”), United States Department of Justice (“DOJ”), California Attorney General and any other agency which has jurisdiction over Health Plan or Medi-Cal (Medicaid).
15. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.
16. **Health Plan** means the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, a public entity doing business as Gold Coast Health Plan.
17. **HEDIS** means Health Employer Data and Information Set.
18. **Hospital** means any acute general care or psychiatric hospital licensed by DHCS.
19. **Limited Services** shall mean those restricted benefits available to Medi-Cal eligible undocumented aliens and specified classes of amnesty aliens, which may include (depending on the status of the alien) (1) care and services that are necessary for the treatment of an emergency medical condition (not related to any organ transplant procedure but including renal dialysis services and emergency labor and delivery) and medical care directly related to emergency, as defined in federal law, and medically necessary pregnancy-related services, and (2) long-term care services. Acute, ongoing, and maintenance renal dialysis services are covered as Emergency Services.
20. **Medi-Cal Agreement** shall mean the agreement entered into by and between Health Plan and DHCS under which Health Plan has agreed to arrange for or provide health benefits under the Medi-Cal Managed Care Program to Medi-Cal beneficiaries who may enroll in Health Plan’s Medi-Cal Managed Care Program.
21. **Medi-Cal Managed Care Program or Medi-Cal** shall mean the federal and State funded health care program established by Title XIX of the Social Security Act, as amended, which is administered in the State by DHCS.

22. **Medi-Cal Provider Manual** means the Medi-Cal Services Provider Manual of DHCS, issued by the DHCS Fiscal Intermediary.
23. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.
24. **Medical Transportation** means the transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, litter vans or wheelchair vans licensed, operated, and equipped in accordance with applicable State or local statutes, ordinances or regulations. Medical Transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.
25. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.
26. **Member(s)** is an Eligible Beneficiary who is enrolled in Health Plan.
27. **Member Handbook** is Health Plan's Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Member is entitled under the Medi-Cal Managed Care Program, the limitations and exclusions to which the Member is subject and terms of the relationship and agreement between Health Plan and the Member.
28. **Participating Referral Provider** is any health professional or institution contracted with Health Plan that meets the standards for participation in the Medi-Cal Managed Care Program to render medical services to Members.
29. **Primary Care Physician or PCP** is a physician who has executed an agreement with Health Plan to provide Primary Care Services. The physician must be duly licensed by the Medical Board of California and enrolled in the Medi-Cal Managed Care Program. The Primary Care Physician is responsible for supervising, coordinating, and providing initial and Primary Care Services to Members; initiating referrals; and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Physician. Primary Care Physicians include general and family practitioners, internists, and pediatricians. A resident or intern will not be a Primary Care Physician.
30. **Primary Care Services** are those services defined in the Medi-Cal Agreement to be provided to Members by a Primary Care Physician. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs.

31. **Provider** means the County of Ventura, including, where the context requires, the health care professional(s) or entity(ies) identified in monthly rosters provided by Provider which contain the elements identified in Attachment A to this Agreement.
32. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider.
33. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.
34. **Referral Physician** must be a qualified physician, duly licensed in California, who meets the standards of participation for the Medi-Cal Managed Care Program, has been enrolled in the Medi-Cal Managed Care Program in accordance with 22 CCR, Article 3, and who has executed an agreement with Health Plan. Provider may only refer Members to a Referral Physician for treatment or consultation, unless an exception is authorized by the Health Plan Chief Executive Officer and/or Medical Director.
35. **Service Area (or County)** is Ventura County.
36. **State** is the State of California.
37. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.
38. **Urgent Care Services** are medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).



## ATTACHMENT C

### SCOPE OF SERVICES SPECIALIST

#### ARTICLE I - GENERAL

1.1 **Specialty Services.** Provider shall render Medically Necessary Covered Services that are physician services, including specific diagnostic, treatment, or surgical procedures, to Members for those medical complaints and disorders that are within Provider's professional competence to diagnose and treat ("Specialty Services"). Provider shall render such Specialty Services with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community. Except as described in the Provider Manual, Provider shall provide Specialty Services to Members only upon receipt of an appropriate referral and prior authorization from the Member's Primary Care Physician or Health Plan, or such other treatment authorization as described in the Provider Manual.

1.1.1 The Member's Primary Care Physician has the right to refer a Member to Provider (or another Referral Physician) for Specialty Services if Provider (or Referral Physician) is contracted with Health Plan and located within the Service Area.

1.1.2 Referrals to Health Plan contracted providers outside the Service Area must be authorized by Health Plan's Medical Director or the Medical Director's designee.

1.1.3 Provider shall comply and render Specialty Services in accordance with the contents, instructions and procedures set forth in Health Plan's Primary Care and Specialist Physicians Case Management Protocol policy, which may be amended from time to time. Health Plan's Primary Care and Specialist Physicians Case Management Protocol policy is incorporated in this Agreement by this reference.

1.2 **Case Management Services.** Provider shall cooperate with the Member's Primary Care Physician and with Health Plan in the Primary Care Physician's monitoring, coordination, and case management of the Member's overall health care. Provider will promptly furnish a complete report of the Specialty Services rendered to a Member, to the Member's Primary Care Physician, and upon Health Plan's request, to Health Plan, on such form as may be prescribed in the Provider Manual.

1.2.1 Provider shall comply and render Case Management Services in accordance with the contents, instructions and procedures set forth in Health Plan's Primary Care and Specialist Physicians Case Management Protocol policy, which may be amended from time to time.

1.2.2 When the Member's Primary Care Physician has delegated the authority by a referral to proceed with treatment or the use of resources by Provider, Provider will be responsible for coordinating medical services performed or prescribed through Provider for the Member.

1.2.3 Provider will consult with the Member's Primary Care Physician and Health Plan's Medical Director as soon as possible when a Member who, for conscientious or other personal

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

1.3 **Catastrophic Case Management Services.** Provider acknowledges that Health Plan's Medical Director will assist Provider in the management of catastrophic cases. Provider will fully cooperate with Health Plan's Medical Director by providing information that may be required in the transfer of a Member into medical facilities designated by Health Plan for the care of catastrophic cases, including but not limited to, prompt notification of known or suspected catastrophic cases.

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

1.4.1 Provider agrees that Health Plan, through its utilization management and quality assurance process, may consult with the Health Plan Medical Director or with other physicians prior to authorizing services or supplies to be rendered by Provider and prior to termination of this Agreement.

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

1.4.2.1 In the event of such change, a thirty (30) day notice will be given to Provider. Provider will be entitled to appeal such action to the appropriate Health Plan reviewing committee.

1.4.2.1.1 The standards and requirements shall include, without limitation:

(a) Healthcare Quality Measures: patient satisfaction, patient access, emergency room utilization, grievance response compliance, credentialing issues, and health education compliance.

(b) HEDIS Measures, as applicable.

(c) Encounter Data Compliance: timely and accurate Encounter Data submission which meets expected volume thresholds.

(d) Utilization Management: aggregate claims expenses, related to all Members who received services from Provider for each review period, should be within an acceptable range either above or below the average costs of Provider's peers. This measure is intended to monitor that there is no over utilization and/or underutilization of specialist, Hospital, or ancillary services. Health Plan may periodically review Provider's compliance with the foregoing, which review will include a minimum of two (2) quarters of data for the purpose of evaluating such compliance. Non-compliance with the foregoing by Provider may result, at Health Plan's sole option, in: (i) the modification by Health Plan of Provider compensation in accordance with Section 3.1 of the Agreement; and/or (ii) termination of this Agreement upon thirty (30) days' prior notice in accordance with Section 4.4 of the Agreement.

## **ARTICLE II - COVERED SERVICES**

2.1 **Covered Services.** Covered Services are those healthcare services covered under the California Medi-Cal Managed Care Program and the Medi-Cal Agreement when they are Medically Necessary and appropriate for the care of that Member. Covered Services are specified in the Member Handbook, including Specialty Services, medical, Hospital, preventive, ancillary, emergency and health education services. With the exception of Excluded Services described in Article III, it is the responsibility of the Member's Primary Care Physician with the assistance of Provider to determine, to provide, to prescribe, and to manage Covered Services for Members, which have been determined to be Medically Necessary and appropriate for the control of disease, illness, or disability in accordance with professionally recognized standards.

2.1.1 **Accessible Services.** Provider shall render Specialty Services to Members on a readily available and accessible basis in accordance with Health Plan policies and procedures as set forth in the Provider Manual during normal business hours at Provider's usual place of business and will arrange for Emergency Services and Urgent Care Services at all other times. Any Emergency Services shall be subject to the terms set forth in the Provider Manual regarding contracting and non-contracting Emergency Service providers and post-stabilization. Provider will make suitable arrangements for personal contact with Members, or for services by appropriate personnel in accordance with customary medical practice and with the law, including referrals for a second professional opinions.

2.1.2 **Referrals.** Provider shall accept referrals and provide Covered Services to Members referred from Health Plan's contracted Primary Care Physicians, if the referral is authorized in accordance with this Agreement and the Provider Manual.

2.1.3 **Second Opinions.** All Provider recommended referrals to specialists for a second opinion are to be to Referral Physicians and to other professional or institutional providers who are Participating Providers unless otherwise authorized in writing by Health Plan. Nothing herein will be construed to impose liability on Provider for the clinical performance of any other physician, any Hospital, or any other health care provider rendering health care services to Members without the knowledge of Provider for the purpose of diagnosis, management, or treatment of diagnosed health impairment, or rehabilitation of the Member.

2.1.4 Medical Transportation Services. Provider shall ensure Members obtain Medically Necessary Medical Transportation services in accordance with 22 CCR, Section 51323 and the Provider Manual. Provider may not arrange non-medical transportation services.

2.1.5 Other Medically Necessary Services. Provider may provide or prescribe durable medical equipment and medical supplies for Members determined by Provider to be Medically Necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Member. All services and goods required or provided hereunder must be consistent with sound professional principles, community standards of care, and Medical Necessity and will be subject to Health Plan's claims review process.

2.1.6 Interpreter Services. Provider will arrange interpreter services as necessary for Members at all facilities.

### **ARTICLE III - EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES**

3.1 **Excluded Services Neither Covered nor Compensated**. Services which are not Covered Services will not be reimbursed by Health Plan. Subject to any additional exclusions from Covered Services as set forth in the Medi-Cal Agreement, Provider understands that Provider will not be obligated to provide Members with, and the Health Plan will not be obligated to reimburse Provider for, the following Excluded Services (services for which Plan does not receive capitation payment from DHCS):

3.1.1 Dental Services (as defined in 22 CCR, Section 51307) and Early Periodic Screening Diagnosis and Treatment supplement dental services (as described in 22 CCR, Section 51340.1(a)). However, medical services necessary to support dental services are Covered Services and are not excluded;

3.1.2 Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services (as defined in the California Welfare and Institutions Code, Section 9400 et seq.), Adult Day Health Care Services (as defined in 22 CCR, Section 54001), Pediatric Day Health Care Services (as defined in 22 CCR, Section 51184(j)), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services (as defined in 22 CCR, Sections 51360 and 51190);

3.1.3 Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Services and are not excluded: (i) outpatient mental health services within Provider's scope of practice; (ii) emergency room professional services except services provided by specialty mental health providers; (iii) facility charges for emergency room visits which do not result in a psychiatric admission; (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Member's mental health condition; (v) emergency Medical Transportation for emergency mental health services; (vi) certain prescribed non-emergency Medical Transportation services to access mental health services; (vii) initial health history and physical assessments required upon

admission for psychiatric inpatient Hospital stays and consultations related to Medically Necessary Covered Services; and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Managed Care Program and that are not excluded by the Medi-Cal Agreement;

3.1.4 CCS are not covered in Ventura County, except as otherwise provided in Section 2.9;

3.1.5 Services rendered in a State or federal governmental hospital;

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

3.1.7 Fabrication of optical lenses;

3.1.8 Targeted Case Management Services as specified in 22 CCR, Sections 51185 and 51351;

3.1.9 Direct Observed Therapy for tuberculosis;

3.1.10 Personal Care Services defined in 22 CCR, Sections 51183 and 51350;

3.1.11 Childhood lead poisoning Case Management Services provided by the local health department;

3.1.12 Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the Medi-Cal Agreement;

3.1.13 Drug benefits for full-benefit dual eligible Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 U.S.C., Section 1395w-101 et seq.), except as set forth in the Medi-Cal Agreement; and

3.1.14 Other services as may be determined by DHCS and Health Plan, and as noticed to Participating Providers. In the event of such a change, a thirty (30) day notice will be given to Provider.

### 3.2 **Restricted Services/Special Reimbursement.**

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

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

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

3.2.2.1 The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program and California Welfare and Institutions Code, Section 14007.5.

3.2.2.1.1 Any alien who is otherwise eligible for Medi-Cal services, and who is not a lawful permanent resident or permanently residing in the United States under color of law, shall only be eligible for care and services that are necessary for the treatment of an emergency medical condition as defined in 42 U.S.C., Section 130b (v) and 42 CFR Section 440.255 (not related to any organ transplant procedure but including renal dialysis services and emergency labor and delivery) and medical care directly related to the emergency, as defined in federal law, and for medically necessary pregnancy-related services.

3.2.2.1.2 Services provided to aliens must be Medically Necessary.

3.2.2.1.3 If an eligible individual receives treatment for an emergency medical condition and continues to receive care after the emergency ends, treatment after the emergency ends is not covered by Medi-Cal.

3.2.2.1.4 Medi-Cal coverage is not available for continuing or follow-up care that may be necessary to restore the patient to health.

3.2.2.1.5 Medi-Cal coverage for pregnancy-related services is available to all aliens who meet all other Medi-Cal eligibility requirements. Routine prenatal care, labor and delivery, routine post-partum care, and family planning are classified as pregnancy-related services. Medi-Cal also covers the treatment of conditions which complicate the pregnancy or delivery (such as hypertension, diabetes, and urinary tract infection). Routine post-partum care extends for the sixty (60) day period beginning on the last day of the pregnancy and ending on the last day of the month in which the 60th day occurs. All Medi-Cal family planning services are available to recipients of restricted benefits.

3.2.2.2 Family planning services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 CFR, Section 441.20. Family planning services are defined in the Provider Manual and include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.

3.2.3 Primary Care Physician referral is not required for beneficiaries designated as Administrative Members.

3.2.4 CCS must be authorized by the Ventura County CCS Program.

3.2.5 Genetically Handicapped Persons Program (“GHPP”) services must be authorized by the GHPP program.

## **ATTACHMENT D 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. Payment shall be made in accordance with Medi-Cal Fee-for-Service Program guidelines, unless otherwise specified herein.

### **ARTICLE I - COMPENSATION TERMS**

- 1.1 Payment Terms.** For Clean Claims for Covered Services rendered to Members, Health Plan shall reimburse Provider on a fee-for-service basis in accordance with Section 2.12(b) of this Agreement, at the lesser of: (i) Provider's billed charges, or (ii) the applicable fee-for-service rates set forth below less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other responsible third parties, if any:

- 1.1.1 Fee-For-Service Payment Rate.** For the period of July 1, 2023 – June 30, 2024, Health Plan will pay an amount equivalent to [REDACTED] of the payment Provider would have otherwise been entitled to had the Covered Services been billed directly under the prevailing Medi-Cal Fee-For-Service program payment rates. Effective July 1, 2024, Health Plan will pay an amount equivalent to [REDACTED] of the payment Provider would have otherwise been entitled to had the Covered Services been billed directly under the prevailing Medi-Cal Fee-For-Service program payment rates.

If there is no payment rate in the prevailing Medi-Cal Fee-For-Service program as of the date(s) of service, payment shall be at [REDACTED] of Provider's billed charges.

- 1.2 New Service/Technology.**

The rates in this compensation Attachment shall not apply to any new service or technology ("New Service/Technology") that is added by Provider in the future. For purposes of this Agreement, New Service/Technology is defined as "a service, procedure, device, test, or other Covered Service that, as of the first effective date of this Attachment, is not performed by Provider." The addition of a new code that is assigned as a change to an existing service, procedure, device, test, or Covered Service, does not constitute a New Service/Technology. If Provider offers a New Service/Technology, Provider shall notify Health Plan within thirty (30) days of adding such New Service/Technology. The parties shall enter into good faith negotiations to add new rate(s) and applicable "qualifier" code(s) for the New Service/Technology, as deemed necessary.

- 1.3 Medi-Cal Payment Guidelines.**

Health Plan shall pay Provider in accordance with the prevailing payment guidelines adopted by DHCS for the Medi-Cal Fee-for-Service Program in use by

DHCS at the time the service is provided, and the Medi-Cal Outpatient Rates published by DHCS, unless otherwise provided in this compensation Attachment.

- 2.1 **Funding.** Health Plan's obligation to pay Provider is subject to Health Plan's corresponding receipt of funding from DHCS, CMS or any other Governmental Agency providing revenue to Health Plan, as applicable. In the event funding to Health Plan is terminated or delayed, Health Plan's payment to Provider will be terminated or delayed, and Health Plan's obligation will only resume within fifteen (15) calendar days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members and Case Managed Members are listed on the most current enrollment information as transmitted by DHCS.
- 2.2 **Additional Funding.** Health Plan will make available a series of grants and incentives to participating providers through the Practice Transformation and Access Grant Program or another such program or programs, for which Provider may be eligible. Grants will be made to participating providers and other entities based on satisfaction of the eligibility criteria and impact on Health Plan Members. To the extent that Provider satisfies the program requirements, Provider will be eligible to receive up to [REDACTED] dollars.



**ATTACHMENT E**  
**Medi-Cal Managed Care Program Provisions**

The below provisions apply exclusively to Covered Services provided and activities engaged in under a subcontract pursuant to the Medi-Cal Managed Care Program contract requirements and the rules set forth in Title 22, California Code of Regulations and Title 42 of the Code of Federal Regulations. The below provisions are required to be included in Health Plan's subcontracts by either the MegaRule Amendments, the Medi-Cal Agreement, or are established in State regulations, or by one or all of these authorities. Authorities are cited in parentheses for ease of reference to relevant regulatory requirements.

1. All Medi-Cal Covered Services to be furnished by Provider are set forth in this Agreement and the Provider Manual. (22 CCR § 53250(c)(1); 42 C.F.R. § 438.230(c)(1); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(1).)

2. This Agreement shall be governed by and construed in accordance with all laws, regulations, and contractual obligations incumbent upon the Health Plan under the Medi-Cal Agreement, including but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act. Provider shall comply with the Medi-Cal Managed Care Program and all applicable provisions of the Medi-Cal Agreement. (22 CCR § 53250(c)(2); 42 C.F.R. § 438.230(c)(2); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(2).)

3. This Agreement shall become effective upon approval by DHCS in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within sixty (60) days of receipt. (22 CCR § 53250(c)(3); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(3).) Amendments to this Agreement shall be submitted to DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by DHCS, shall become effective by operation of law thirty (30) days after DHCS has acknowledged receipt of the amendment, or upon the date specified in the amendment, whichever is later. (22 CCR § 53250(c)(3); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(3).)

4. The term of this Agreement and the methods of extension, renegotiation, and termination are as set forth in the Agreement. (22 CCR § 53250(c)(4); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(4).)

5. Provider agrees to submit all of the reports required and requested by Health Plan, in a form acceptable to Health Plan. (22 CCR § 53250(c)(5); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(6).) Provider shall submit claims and Encounter Data to Health Plan that allow the Health Plan to meet its administrative functions and the requirements set forth in the Medi-Cal Agreement. (Medi-Cal Agreement, Ex. A, Att. 3, § 2.C.)

6. Provider shall comply with all of the monitoring provisions of this Agreement, the monitoring provisions in the Medi-Cal Agreement (as applicable), and any monitoring requests of

DHCS, including but not limited to, the following: (42 CFR § 438.3(h), Medi-Cal Agreement, Ex. A, Att. 6, Ex. A, Att. 6, § 14.B.(7).)

- a. Through the end of the records retention period, Provider shall allow DHCS to inspect, evaluate, and audit any and all premises, books, records, equipment, and facilities, contracts, computers, or other electronic systems maintained by Provider pertaining to these services at any time during normal business hours, pursuant to 42 CFR § 438.3(h).
- b. Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period Provider shall furnish any record, or copy of it, to DHCS or any other entity listed below at Provider's sole expense.
- c. If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a subcontractor at any time.
  - (i) DHCS shall conduct unannounced validation reviews on primary care sites, selected at the discretion of DHCS' to verify compliance of these sites with DHCS requirements.
  - (ii) Authorized State and federal agencies will have the right to monitor all aspects of Provider's operation for compliance with the provisions of this Agreement and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Provider and subcontractor facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during Provider's or other facility's normal business hours, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. Staff designated by authorized State agencies will have access to all security areas and Provider will provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of Provider. (42 CFR § 438.3(h), Medi-Cal Agreement, Ex. E, Att. 2, § 20.)

7. Provider shall make all of its premises, facilities, equipment, books and records, contracts, computer and other electronic systems, pertaining to the goods and services furnished

under the terms of this Agreement, available for purpose of audit, inspection, evaluation, examination or copying:

- a. By DHCS, CMS, the DHHS Inspector General, the Comptroller General, the DOJ, or their designees;
  - (i) At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;
  - (ii) In a form maintained in accordance with the general standards applicable to such book or record keeping;
  - (iii) For a term of at least ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.
  - (iv) Including all Encounter Data for a period of at least ten (10) years.
  - (v) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.
  - (vi) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal Managed Care Program; seek recovery of payments made to Provider; impose other sanctions provided under the State Plan, and direct Health Plan to terminate its subcontract with Provider due to fraud. (22 CCR § 53250(e)(1); 42 C.F.R. § 438.230(c)(3); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(8).)

8. The method and amount of compensation to be received by Providers is set forth in this Agreement. (22 CCR § 53250(e)(2); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(9).)

9. Provider shall maintain and make available to the DHCS, upon request, copies of all subcontracts. All subcontracts shall be in writing and require that:

- a. Subcontractor make all applicable premises, facilities, equipment, books, records, contracts, computer, or other electronic systems related to this Agreement available at all reasonable times for audit, inspection, examining or copying by the DHCS, CMS, DHHS, the Inspector General, at the Comptroller General, DMHC, and the DOJ, or their designees. (42 C.F.R. § 438(h); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(10).)
- b. Subcontractor agrees to retain all records and documents for a minimum of at least ten (10) years from the close of the final date of the contract period or from the date of completion of any audit, whichever is later. (42 C.F.R. § 438.3(u); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(10).)

10. To the extent applicable, Provider shall assist Health Plan in the transfer of care in the event Health Plan's Medi-Cal Agreement expires or terminates for any reason. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(11).)

11. To the extent applicable, Provider shall require its subcontractors to assist Health Plan in the transfer of care in the event of the termination of the subcontract for any reason. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(12).)

12. Provider agrees to notify DHCS in the event that this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached to:

California Department of Health Care Services  
Managed Care Operations Division  
Attn: Contracting Officer  
MS 4407  
P.O. Box 997413  
Sacramento, CA 95899-7413

(22 CCR § 53250(e)(4); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(13).)

13. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (22 CCR § 53250(e)(5); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(14).)

14. Provider agrees to hold harmless both the State of California and Members in the event that Health Plan cannot or will not pay for Covered Services performed by Provider pursuant to this Agreement. (22 CCR § 53250(e)(6); Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(15).)

15. Upon request by DHCS, Provider shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in Health Plan's contract with DHCS. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(16).)

16. To the extent applicable, Provider agrees to arrange for the provision of interpreter services for Members at all contracted provider sites. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(17).)

17. Provider acknowledges that it has a right to submit a grievance in accordance with Health Plan's formal process to resolve Provider Grievances. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(18).)

18. Provider agrees to participate and cooperate in Health Plan's Quality Improvement System. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(19)-(20).)

19. Provider agrees to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(21).)

20. Provider agrees that Health Plan's may revoke its delegation of activities or obligations, or specify other remedies in instances where DHCS or Health Plan determines that Provider has not performed satisfactorily. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(22).)

21. To the extent that Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use as they are able for the purpose of Member care coordination. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(23).)

22. Health Plan shall inform Provider of prospective requirements added by DHCS to this Agreement before the requirement would be effective, and obtain Provider's agreement to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS or as otherwise provided for under the Agreement and to the extent possible. (Medi-Cal Agreement, Ex. A, Att. 6, § 14.B.(24).)

23. Provider shall submit to Health Plan complete, accurate, reasonable and timely provider data needed by Health Plan in order for Health Plan to meet its provider data reporting requirements to DHCS. (Medi-Cal Agreement, Ex. A, Att. 3, § 1; APL 16-019.)

24. Provider shall not balance bill Members. (Medi-Cal Agreement, Ex. A., Att. 8, § 6.)

25. Health Plan shall provide cultural competency, sensitivity and diversity training. (Medi-Cal Agreement, Ex. A, Att. 9, § 13.E.)

26. Provider has a right to access Health Plan's dispute resolution process, as set forth in the Agreement. (Health & Safety Code §1367 (h)(1).)

27. Provider shall comply with language assistance standards developed pursuant to Health and Safety Code, Section 1367.04.

28. Provider understands that it is entitled to all protections afforded it under the Health Care Provider Bill of Rights. (Health & Safety Code § 1375.7.)

29. If Health Plan delegates Quality Improvement activities in this Agreement or any future amendment to this Agreement, then the Agreement or such amendment shall specify the following;

- a. Quality improvement responsibilities, and specific delegated functions and activities of Health Plan and provider.
- b. Health Plan's oversight, monitoring, and evaluation processes and Provider's agreement to such processes.
- c. Health Plan's reporting requirements and approval processes, including Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
- d. Health Plan's actions/remedies if Provider's obligations are not met. (Medical Agreement, Ex. A, Att. 6, §14.B.20 and Ex. A, Att. 4, § 6.A.)

30. To the extent that Provider is at risk for non-contracting Emergency Services in the Agreement or in any future amendment to such Agreement, Provider shall comply with the following:

- a. Provider shall be responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with Health Plan. Provider may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical condition. Further, Provider may not deny payment for treatment obtained when a representative of Provider instructs the enrollee to seek Emergency Services.
- b. Provider may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Provider, the plan, or DHCS of the enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- c. Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Provider or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized

for transfer or discharge and that determination is binding on Provider. Emergency Services shall not be subject to prior authorization by Health Plan or Provider.

- d. At a minimum, Provider must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.
- e. For all non-contracting providers, reimbursement by Provider, or by a subcontractor who is at risk for out of plan network Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with 42 U.S.C. § 1396u-2(b)(2)(D).
- f. Provider shall not refuse to cover reimbursement for Emergency Services rendered by a non-contracting provider based on the emergency room provider, hospital, or fiscal agent not notifying the Member's Primary Care Physician or Provider of the Member's screening and treatment within ten (10) calendar days of presentation for emergency. Provider shall not limit what constitutes and Emergency Medical Condition solely on the basis of lists of diagnoses or symptoms.
- g. In accordance with California Code of Regulations, Title 28, Section 1300.71.4, Provider or Health Plan, as applicable, shall approve or disapprove a request for post-stabilization inpatient services made by a non-contracting provider on behalf of a Member within 30 minutes of the request. If Provider or Health Plan, fails to approve or disapprove authorization within the required timeframe, the authorization will be deemed approved.
- h. Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R., Section 422.113(c). Provider is financially responsible for post-stabilization services obtained within or outside Provider's network that are pre-approved by a plan provider or other entity representative. Provider is financially responsible for post-stabilization care services obtained within or outside Health Plan's network that are not pre-approved by a Provider or Health Plan, as applicable, or Health Plan or Provider representative, but administered to maintain the enrollee's stabilized condition within one (1) hour of a request to Health Plan or Provider, as applicable, or for pre-approval of further post-stabilization care services.
- i. Provider is also financially responsible for post-stabilization care services obtained within or outside Health Plan's network that are not pre-approved by Health Plan, Provider, or other entity representative, as applicable, but administered to maintain, improve or resolve the enrollee's Member's stabilized

condition if Provider or Health Plan, as applicable, does not respond to a request for pre-approval within 30 minutes; Health Plan or Provider, as applicable, cannot be contacted; or Health Plan or Provider's representative and the treating physician cannot reach an agreement concerning the enrollee's Member's care and a plan physician is not available for consultation. In this situation, Provider must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of Section 422.133(c)(3) is met.

- j. Provider's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the enrollee's Member's care; or the enrollee Member is discharged.
- k. Consistent with 42 CFR 438.114(e), 422.113(c)(2), and 422.214, Provider is financially responsible for payment of post-stabilization services, following an emergency admission, at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital. For the purposes of this Section 27.k., the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts that are:

- (i) Published in the annual All Plan Letter issued by the Department in accordance with California Welfare and Institutions Code, Section 14091.3, which for the purposes of this Section 27.k. shall apply to all acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (Welfare and Institutions Code, Section 14081 et seq.), less any associated direct or indirect medical education payments to the extent applicable, which Item a) shall be applicable until it is replaced by the implementation of the payment methodology in Item (ii) below.

- (ii) Established in California Welfare and Institutions Code, Section 14105.28, upon the Department's implementation of the payment methodology based on diagnosis-related groups, which for the purposes of this Section 27.k shall apply to all acute care hospitals, including public hospitals that are reimbursed under the Certified Public Expenditure Basis methodology (Welfare and Institutions Code, Section 14166. et seq.), less any associated direct or indirect medical education payments to the extent applicable.

- (iii) Payment made by Provider to a hospital that accurately reflects the payment amounts required by this Section 27.k shall constitute payment in full under this Section 27.k, and shall not be subject to subsequent adjustments or reconciliations by Provider, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by Title 22 CCR § 51536 shall not have any effect on payments made by Provider pursuant to this Section 27.k.



(iv) Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under provisions of Welfare and Institutions Code, Section 14454 and, Title 22 CCR, Section 53620 et seq., except Section 53698. Provider agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within 30 calendar days of the effective date of a decision that Provider is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within 30 calendar days shall result in liability offsets in accordance with Welfare and Institutions Code, Sections 14454(c) and 14115.5, and California Code of Regulations, Title 22 CCR, Section 53702. (Medi-Cal Agreement, Ex. A, Att. 6, §14.B.5.)

31. Provider shall retain, as applicable, the following information: enrollee grievance and appeal records in § 438.416, base data in § 438.5(c), Medical Loss Ratio reports in § 438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years. (42 CFR § 438.3(h).)

32. In accordance with 42 C.F.R., Section 438.608(c), Provider agrees to:

- a. Provide written disclosure of any prohibited affiliation under 42 C.F.R., Section 438.610.
- b. Provide Health Plan with the disclosure statement set forth in Title 22, California Code of Regulations, Section 51000.35 (which incorporates the requirements of 42 C.F.R. Section 455.104) prior to commencing services under this Agreement. Specifically, Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (42 C.F.R. § 438.608(c), Medi-Cal Agreement, Ex E, Att. 2, §34, Cal. Welf & Inst. Code § 14452(a).)

33. In the event that Provider identifies an Overpayment, Provider shall report within sixty (60) calendar days of the date of identification of the Overpayment to Plan's Compliance Officer at Health Plan, 711 E. Daily Drive, Suite #106 Camarillo, CA 93010-6082, Fax: (805) 437-5132, [compliance@goldchp.org](mailto:compliance@goldchp.org). The report shall include the amount of Overpayment identified and the reason for the Overpayment. Provider shall also make repayment to Health Plan within sixty (60) calendar days of the date of identification of such Overpayment. (42 C.F.R. § 438.608(d), 42 U.S.C. § 1320a-7k, Medi-Cal Agreement, Ex. E, Att. 2, § 34.B.)

- a. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. (22 CCR § 53222.)
- b. Provider shall report to Health Plan for reporting to DHCS within ten (10) days after discovery any circumstances which may result in casualty

insurance payments, tort liability payments, or workers' compensation award. (22 CCR § 53222(b).)

34. Provider shall, in all solicitations or advertisements for employees placed by or on behalf of Provider, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of Provider's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

35. Provider shall not discriminate against Members or Eligible Beneficiaries because of race, color, national origin, creed, ancestry, religion, ancestry, language, age, marital status, sex, sexual orientation, national origin, age, sex, or physical or mental handicap gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in California Penal Code, Section 422.56, in accordance with Title VI of the Civil Rights Act of 1964, (42 U.S.C. Section 2000d et seq.), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Agreement, discrimination on the grounds of race, color, national origin, creed, ancestry, religion, ancestry language, age, marital status, sex, national origin, marital status, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in California Penal Code, Section 422.56 or physical or mental handicap include, but are not limited to, the following:

- a. Denying any Member any Covered Services or availability of a Facility;
- b. Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;
- c. Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;
- d. Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;
- e. The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in California Penal Code, Section 422.56, of the participants to be served.

Provider shall take affirmative action to ensure that Members are provided Covered Services without regard to race, color, national origin, creed, ancestry, religion, language, age, gender,

marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in California Penal Code, Section 422.56, except where medically indicated. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. (Medi-Cal Agreement, Ex. E, Att. 2, § 28.A.)

36. In addition to other obligations contained herein, Provider shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises commencing at Section 10115 of the California Public Contract Code. (Medi-Cal Agreement, Ex. E, Att. 2, § 30.)

37. Provider shall ensure that its personnel do not have conflicts of interest with respect to Health Plan and the Services. "Conflict of Interest" includes activities or relationships with other persons or entities that may result in a person or entity being unable or potentially unable to render impartial assistance or advice to Health Plan, or the person's objectivity in performing the contract work is or may be impaired, or a person has an unfair competitive advantage. (Medi-Cal Agreement, Ex. E, Att. 3, § 10.)

38. Provider shall report to Health Plan's compliance officer all cases of suspected fraud, waste, and/or abuse, as defined in 42 C.F.R., Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within (48) hours of the time when Provider first becomes aware of, or is on notice of, such activity. Provider shall immediately report to Health Plan any notices of investigations of Provider relating to fraud, waste, or abuse. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud, waste, and/or abuse in the provision of health care services under the Medi-Cal Managed Care Program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations. Provider shall comply with Health Plan's antifraud plan, including its policies and procedures relating to the investigation, detection, and prevention of and corrective actions relating to fraud, waste and abuse. Provider represents, certifies and warrants that it is currently, and for the duration of this Agreement shall remain in compliance with all applicable State and federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to, applicable provisions of the federal and State civil and criminal law, the program integrity requirements of 42 C.F.R., Section 438.608, the Federal False Claims Act (31 U.S.C. § 3729 et seq.), Employee Education About False Claims Recovery (U.S.C. § 1396a(a)(68)), the California State False Claims Act (Cal. Gov't Code, Section 12650 et seq.), and the anti-kickback statute (Social Security Act § 1128B(b)). Upon request by DHCS, Provider shall demonstrate compliance with this provision, which may include providing DHCS with copies of Provider's applicable written policies and procedures and any relevant employee handbook excerpts. Provider shall comply with 42 C.F.R., Sections 438.608(a)(8) and 438.610. Additionally, Provider is prohibited from employing, contracting or maintaining a contract with persons or entities for the provision of services related to this Agreement that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. Provider shall notify Health Plan immediately upon discovery of employment or contract with a person or entity that is excluded, suspended, or terminated. A list

of suspended and ineligible providers is updated monthly and available on line and in print at the DHCS Medi-Cal website (<http://medi-cal.ca.gov>). Lists of excluded individuals and entities are also available through the DHHS, Office of Inspector General, List of Excluded Individuals and Entities (<http://oig.hhs.gov>), and the Federal System of Award Management (<http://www.sam.gov>). Provider is deemed to have knowledge of any persons or entities on these lists. Provider must notify Health Plan within ten (10) business days of removing a suspended, excluded, or terminated provider from its employment or subcontract and confirm that the individual or entity is no longer receiving payments in connection with the Medicaid program. Medi-Cal Agreement, Ex. E, Att. 2, § 28.)

39. Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, California Code of Regulations, Division 1, Chapter 9, commencing with Section 37000. Provider shall document and appropriately follow up on blood lead screening test results.

Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's Medical Record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent(s) or guardian shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's Medical Record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

40. Where Provider or Provider's subcontractor is a health facility as defined in California Health and Safety Code, Section 1250, it shall allow a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child to visit, unless one of the following is met:

- a. No visitors are allowed.
- b. The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility.
- c. The patient has indicated to health facility staff that the patient does not want this person to visit.

This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

For purposes of this section, "domestic partner" has the same meaning as that term is used in California Family Code, Section 297.

**ATTACHMENT F**  
**Acknowledgement Of Receipt Of Primary Care And Specialist Physicians**  
**Case Management Protocol**

Provider hereby acknowledges receipt of Health Plan's Primary Care and Specialist Physicians Case Management Protocol.

Date of Receipt: \_\_\_\_\_

Initials of authorized  
Representative of Provider: \_\_\_\_\_

**ATTACHMENT G**  
**Acknowledgement Of Receipt Of Provider Manual**

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

Date of Receipt: \_\_\_\_\_

Initials of authorized  
Representative of Provider: \_\_\_\_\_

**ATTACHMENT H  
DISCLOSURE FORM**

(Welfare and Institutions Code, Section 14452(a); 42 C.F.R., Section 455.104)

Please attach a copy of DHCS 6207, Medi-Cal Disclosure Statement, that is current and accurate, as of the Effective Date of this Agreement.