VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
PROVIDER SERVICES AGREEMENT – COMMUNITY SUPPORTS

This Provider Services Agreement (this "Agreement") is made effective as of the 1st day of January 2023 (the "Effective Date"), by and between the VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION, a public entity doing business as Gold Coast Health Plan ("Health Plan"), and COUNTY OF VENTURA ("Provider"), a health care provider.

EFFECTIVE DATE of Agreement:

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

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

VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION
PROVIDER SERVICES AGREEMENT

RECITALS

A. Health Plan is a County Organized Health System established pursuant to 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 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 Eligible 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 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, and includes the constituent physicians, allied health care professionals, subcontractors, drivers, and staff persons who provide Community Supports to Members by and/or through the County of Ventura under this Agreement, identified in Attachment A hereto.

1.2 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 Community Supports**. Provider shall provide and cause its subcontractors to provide Community Supports as described in Attachment C of this Agreement to Members, within the scope of Provider's business and practice, in accordance with this Agreement, Health Plan's policies and procedures, the DHCS *ECM and Community Supports Standard Terms and Conditions*, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care**. Provider shall provide and cause its subcontractors to provide Community Supports 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**. Provider shall obtain the prior authorization of Health Plan for Community Support Services, except for outreach services, in accordance with Health Plan's Community Supports policies and procedures and the Provider Manual. Provider shall comply with the referral procedures set forth in the Provider Manual, Health Plan's Community Supports policies and procedures and attachments thereto, which are in effect at the time of the referral, and shall not directly or indirectly engage in any method of referral not specifically authorized by the Health Plan's Community Supports policies and procedures and the Provider Manual. Upon and following such prior authorization, Provider shall coordinate the provision of such Community Supports to Members and ensure continuity of care. In addition to any other right or remedy under this Agreement, and except for outreach services, Health Plan may, at Health Plan's option, deny payment for Community Supports 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 unauthorized referral services to Members.

e. **Referrals**. Unless otherwise agreed to by Health Plan, Provider shall provide Community Supports to Members only if Members are assigned to Provider as a Community Supports Provider.

f. **Member Eligibility Verification**. Member eligibility for Community Supports will be determined by Health Plan in accordance with Attachment C. Provider shall verify Medi-Cal eligibility and Health Plan enrollment of Members and eligibility for Community Support Services prior to rendering services.

g. **Availability of Services**. Provider shall make necessary and appropriate arrangements to assure the availability and accessibility of Community Supports to Members in non-traditional settings and outside of normal business hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Non-Discriminatory and Equitable Provision of Services.** Provider shall ensure that Community Supports, including outreach and assessment, are conducted in a non-discriminatory manner. Provider shall ensure that Community Supports are rendered in a provider agnostic manner and that no preferential access to Community Supports shall be given to Members based on where they receive primary, specialty, emergency, and/or inpatient health care services.

i. **Consultation with Medical Director**. Provider may at any time seek consultation with Health Plan's Medical Director on any matter concerning the provision of Community Supports to a Member.

2.3 **Subcontract Arrangements**.

a. **Written Health Plan Approval**. Provider will not utilize the services of any subcontractors in providing the Community Supports 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).

b. **Binding to Agreement**. Any subcontract entered into by Provider for the delivery of Community Supports 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 Community Supports. All references to Provider in this Agreement in the context of providing Community Supports, where applicable, will also include Provider's approved subcontractors.

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 Community Supports and be responsible for the conduct and performance of each approved subcontractor as if Provider had performed all of the subcontracted Community Supports.

e. **Subcontract Template**. Upon Health Plan's request, 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 Community Supports. 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 subcontractor(s) for all Community Supports provided by its subcontractor(s), and to indemnify and hold harmless Health Plan, Members and DHCS for any mistake, failure, or breach of this Agreement committed by subcontractor(s).

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 the other party 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. **Enrollment**. Provider shall not differentiate or discriminate in providing Community Supports 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 Community Supports 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 provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder.

2.6 **Recordkeeping**.

a. **Maintaining Member Care Plan**. Provider shall maintain and require its subcontractors to maintain a Care Plan for each Member to whom Provider renders Community Supports specified in Attachment C. Provider or Provider's subcontractors shall open each Care Plan upon the Member's first encounter with Provider or Provider's subcontractor and shall complete initial documentation within thirty (30) days of the first encounter. The Member's Care Plan shall contain

all information required by this Agreement, 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 ten (10) years after rendering Community Supports 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 ten (10) years or such longer time period as may be required by law.

b. **Confidentiality of Member Health Information**. Provider and each party with which Provider has, or will have, a contractual relationship to provide the Community Supports 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 provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized State or federal agency, or other providers of health care upon authorized referral.

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 modified (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 or breach of the HIPAA Privacy Rule with respect to Health Plan or Members, Provider must notify Health Plan's privacy officer within ten (10) days of discovery of such use or breach.

d. **National Provider Identification ("NPI")**. In accordance with applicable statutes and regulations of HIPAA, 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 ("NPPES") 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, pursuant to Health Plan's policies and procedures, and applicable government sponsored health programs, Health Plan's contracts with the Governmental Agencies, or third party payers, and to the extent not prohibited by State or federal law, 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 or any appropriate State and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

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, upon five (5) calendar days' prior written notice and during normal business hours (or at such other time as may be mutually agreed). The inspection shall take place at Provider's principal business office location, or in the alternative, at Health Plan's request, upon ten (10) calendar days' prior written notice, at one of Provider's facilities or offices in Ventura County, 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. Provider 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 period of at least ten (10) years from the final date of the Agreement term or from the date of completion of any audit, whichever is later. When requested by Health Plan or Governmental Agency, Provider shall produce copies of any 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 goods and services furnished under the terms of this Agreement available for the purpose of an audit, inspection, evaluation, examination or copying by 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, including DHCS external quality review organization contractor at all reasonable times at Provider's place of business or at such other mutually agreeable location in California pursuant to 42 CFR, Section 438.3(h). Provider shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives of State or federal agencies in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

b. **Books and Documents**. Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, subcontracts, information systems and procedures, encounter data and any other documentation pertaining to medical and non-medical services rendered to Members. These books and documents will disclose the quantity of Community Supports provided under this Agreement, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Community Supports, 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 all of its subcontractors shall maintain all of these records and documents for a minimum of ten (10) years from the final date of the Agreement term or from the date of completion of any audit, whichever is later.

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 Public Records Act (Government Code, Section 6250 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 Community Supports.

d. **Participation in Credentialing**. Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by Health Plan, if Provider is of a type that is subject to credentialing requirements. If a State-level enrollment pathway exists, Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If APL 19-004 does not apply to Provider, Provider shall comply with Health Plan's process for vetting Provider, which may extend to individuals employed by or delivering services on behalf of Provider, to ensure it can meet the capabilities and standards required to be a Medi-Cal provider. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status, if credentialed, or to meet Health Plan's minimum standards to ensure adequate experience and acceptable quality of care for non-credentialed providers. If Provider's credentialed status is revoked, suspended or limited by Health Plan or Provider fails to meet Health Plan's minimum standards to ensure adequate experience and acceptable quality of care, as appropriate, Health Plan may at its discretion terminate this Agreement and/or reassign Members to another provider. Provider shall accept delegation of credentialing responsibilities for Provider's subcontractors at Health Plan's request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider's organization. If Health Plan delegates credentialing or related quality of care/minimum standards review activities, such requirements will be described in a delegation agreement, which will be included as an amendment to this Agreement. Provider will successfully complete a facility site review by Health Plan, if deemed necessary by Health Plan in accordance with the Medi-Cal Agreement.

e. **Provider Manual**. Provider shall comply and render Community Supports in accordance with the contents, instructions and procedures set forth in the Provider Manual, which may be amended from time to time. The Provider Manual is incorporated in this Agreement by this reference. In the event the Provider Manual is inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.

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, including Community Supports training, as well as Member education. 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 constituent providers, if any, all informational, promotional, educational, or

instructional materials prepared by Health Plan regarding any aspect of providing Community Supports to Members.

h. **Cultural and Linguistic Services**. Provider shall provide Community Supports 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 Community Supports. Provider shall comply with Health Plan's language assistance program standards developed under 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 it as it is able for the purpose of Member care coordination.

2.9 **Licensure and Standing**.

a. **Licensure**. Provider shall maintain, and shall require its subcontractors to maintain any licenses or certificates necessary, if any, to provide Community Supports, 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 their licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall notify Health Plan 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 the 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 warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (Title 42, United States Code ("U.S.C."), Section 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or State health care programs. Provider shall immediately notify Health Plan if Provider's unrestricted status under this subsection changes.

c. **Malpractice and Other Actions**. Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

2.10 **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 Three Hundred Thousand Dollars ($300,000) per person for Provider's property together with a combined single limit bodily injury and property damage insurance of not less than Three Hundred Thousand Dollars ($300,000). 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 a 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 the policy is silent as to sexual abuse and molestation coverage, then the certificate must state, "The General Liability policy contains no exclusions or sub limits for Sexual Abuse or Molestation coverage";

ii. Errors and omissions insurance/professional liability insurance covering acts, errors, mistakes, omissions arising out of the Community Supports 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 coverage maintained by Provider for the benefit of Provider's employees in an amount required by applicable law (including, but not limited to, 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 2.10.i hereof will provide for at least thirty (30) days' advance written notice to Health Plan of cancellation or material modification.

d. **Length of Coverage**. Provider shall maintain such coverage set forth in this Section 2.10 without lapse, for a period of not less than two (2) years following termination of this Agreement, provided however if any policy is on a claims-made form,

Provider shall maintain such coverage, without lapse, for a period of three (3) years after termination of this Agreement so that if any occurrence during the term of this Agreement gives rise to a claim made after such termination, such claim is covered.

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 reasonable written 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.

2.11 **Payment Requirements**.

a. **Submitting Claims**. Provider shall immediately submit to Health Plan claims for Community Supports rendered to Members. Provider will obtain, complete and submit all claims on a CMS-1500 form or successor form along with evidence of prior authorization (if required in accordance with Health Plan policies and procedures), or submit in ANSI ASC x12n 837 EDI format through Health Plan's electronic transfer for all services rendered to Members including capitated services. 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 one hundred and eighty (180) days of providing the Community Supports 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 (claims that can be processed without obtaining additional information from Provider or from a third party) for Community Supports provided to Members in accordance with applicable law and regulations and in accordance with the compensation schedules set forth in the applicable Exhibit to Attachment C. Provider shall accept such

payment as payment in full for services provided under this Agreement. Health Plan shall pay ninety percent (90%) of all Clean Claims within thirty (30) days of date of receipt and ninety-nine percent (99%) of all Clean Claims within ninety (90) days. The date of receipt shall be the date Health Plan receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

c. **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 Community Supports 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, to the extent that the scope of the claims covers Community Supports.

d. **Offset**. 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 within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment ("Overpayment"). 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 exercise Provider's appeal rights under this Agreement. 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 other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider. In the event that Provider identifies an Overpayment, Provider shall report within sixty (60) calendar days of the date of identification of the Overpayment to Health Plan's Compliance Officer at Gold Coast Health Plan, 711 E. Daily Drive, Suite #106 Camarillo, CA 93010-6082, Fax: (805) 437-5132, compliance@goldchp.org. The report shall include the amount of Overpayment identified and the reason for the Overpayment. Contractor also shall make repayment to Health Plan within sixty (60) calendar days of the date of identification of such Overpayment. This subdivision shall survive termination of this Agreement.

e. **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 billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS

multiple procedure billings rules, and FDA 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 Plan's policies and data to determine the appropriateness of the billing, coding and payment.

f. **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 Community Supports 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 Community Supports provided pursuant to this Agreement. Provider shall ensure that its subcontractors comply with this Section.

If Provider erroneously bills a Member in violation of this provision, Provider will refund the amount of the charge to the Member within fifteen (15) days of Provider becoming aware 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.

2.12 **Compliance with Applicable Law**. Provider shall comply with all applicable State and federal laws governing the delivery of Community Supports 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 Community Supports 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 D 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 Community Supports to Health Plan's Ethics Hotline at (888) 866-1366 or Health Plan's Ethics Officer at Health Plan's address for notices.

2.13 **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 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 Community Supports to Member. In the event of breach of this Section 2.13, in addition to any other of Health Plan's legal rights, Health Plan may at its sole discretion immediately terminate this Agreement. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.14 **Fraud and Abuse**. Provider shall report to Health Plan's Compliance Officer 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) working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall immediately notify Health Plan of investigations of Provider relating to fraud, waste or abuse, except where such disclosure is prohibited by law or court order. 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.), Employee Education About False Claims Recovery (42 U.S.C., Section 1396a(a)(68)), the California State False Claims Act (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 Community Supports to Health Plan's Ethics Hotline at (888) 866-1366 or Health Plan's Ethics Officer at Health Plan's address for notices.

2.15 **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.

2.16 **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 the making, awarding, or entering this Agreement, federal grant, or cooperative agreement, and the extension continuations, renewal, amendment, or modification of this Agreement, grant, or cooperative agreement.

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 2.16 shall be included in all subcontracts of Provider pertaining to this Agreement.

2.17 **Drug Free Workplace**. Provider agrees to notify all persons who perform Community Supports 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).

2.18 **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 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.

2.19 **Notification of Network Change**. Where Provider constitutes specialists, a medical group, IPA, or any other similar entity/organization, Provider shall provide Health Plan and Member with timely written notification in the event a constituent specialty provider that provides Community Supports services under this Agreement 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 schedules set forth in the applicable Exhibits to Attachment C.

a. **Payment Policy**. Health Plan has the sole authority to determine payment policies and methodology of reimbursement under this Agreement, which includes reduction of Provider's payment, if applicable, if rates from the State to Health Plan are reduced. Health Plan shall provide reasonable notice to Provider of any anticipated reduction of rates and Provider shall have the option to reject such reduction in rates or payments from Health Plan before they take effect.

b. **Changes in Payment**. Notwithstanding anything to the contrary set forth in this Agreement, Health Plan may adjust the rates or other compensation payable to Provider at any time or from time-to-time during the term of this Agreement as determined by Health Plan to reflect implementation of State or federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Community Supports, 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 adjustments to the rates or level of funding paid to Health Plan. The amount of such adjustment shall be determined by Health Plan and need not be in proportion to or in the same amount as the adjustment to the rates or level of funding paid to Health Plan. Provider will receive thirty (30) days advance notice of any such adjustment prior to its implementation for Community Supports under this Agreement. Health Plan's obligation to pay Provider any payment amount hereunder shall be subject to Health Plan's corresponding receipt of funding from DHCS, CMS or any other Governmental Agency providing revenue to Health Plan, as applicable. 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 Medi-Cal eligibility and Health Plan enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review**. Health Plan shall ensure initial authorization or a decision not to authorize Community Supports is made as soon as possible and in accordance with timeframes for medical authorization; but in any event not less than within five (5) working days for routine authorizations and within seventy-two (72) hours for expedited authorizations.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services shall govern. The primary concern with respect to all medical determinations shall be the interest of the Member. Health Plan will refer all Members not authorized for Community Supports to Health Plan's complex case management program.

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 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, Community Supports, limitations and exclusions, and coordination of benefits information. The Provider Manual, the receipt of which is acknowledged by Provider in Attachment F, is incorporated herein by this reference. 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 **Outreach Lists and Referrals.** Health Plan is responsible for identifying Members potentially eligible for participation in Community Supports through data mining activities and the acceptance of referrals from external sources.

a. Health Plan is responsible for sharing outreach lists comprised of potentially eligible Members with Provider at regular intervals mutually agreed by Health Plan and Provider for the purpose of outreach and assessment.

b. Health Plan may also receive external referrals for Community Supports from providers, community-based organizations, Members, and other sources. External Community Supports referrals received by Health Plan will be transmitted to Provider for outreach and assessment.

c. Health Plan shall ensure that appropriate patient authorizations have been obtained, or that disclosure of patient information is otherwise in accordance with State and federal law, prior to providing any outreach list to Provider.

3.9 **Assignment Files.** Health Plan will share information regarding Members assigned to Provider for Community Supports on a recurring basis in the context of a Member Information File conforming in content, format and frequency to DHCS guidance.

a. Health Plan will establish bidirectional communication processes for Provider to:

i. Acknowledge Member Information File receipt;

ii. Communicate or update Member Information File information, reconcile identified errors or other inaccurate or outdated information; and

iii. Notify Health Plan if Provider is unable to accept the Member for reasons including, but not limited to, capacity constraints, Member preferences, Members' decision to decline to participate, other reasons specified in the DHCS *ECM and Community Supports Standard Provider Terms and Conditions*.

3.10 **Oversight and Collaboration.** Health Plan will conduct oversight of Provider to ensure the quality of Community Supports and monitor compliance with program requirements no less than annually, which may include audits, interventions, and/or corrective

actions. Health Plan will collaborate and work with Provider to ensure compliance, conduct regular meetings with Provider and coordinate requests for assistance from Provider and assign staff with appropriate expertise to provide technical assistance to Provider. Health Plan will make best efforts to resolve any issues applicable to this Agreement identified by Provider or Health Plan.

3.11 **Readiness Review.** Health Plan will conduct a readiness review of Provider, which will be completed successfully prior to the start of this Agreement.

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: (i) for the initial Agreement, where DHCS has acknowledged receipt of the Agreement and neither approves or disapproves the Agreement within sixty (60) days of its receipt; (ii) for any amendment to the Agreement governing compensation, services, or term, where DHCS has acknowledged receipt of the amendment and neither approves or disapproves the amendment within thirty (30) days of its receipt. Health Plan and Provider mutually agree that if DHCS mandates revisions to this Agreement, such mandated revisions shall be incorporated into this Agreement as of the later of (i) the date of Provider's receipt of such DHCS mandatory revisions from Health Plan, or (ii) such effective date as may be required by DHCS.

4.2 **Term**. This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for a period of one (1) year; thereafter, it shall automatically renew for additional one (1) year terms, unless earlier terminated by either party in accordance with the provisions of 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 written notice to the other party.

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 written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

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 Community Supports 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 Community Supports 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; and

i. Health Plan determines that Community Supports 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 Community Supports to Members who are under the care of Provider at the time of termination until the services being rendered to the Medi-Cal Members by Provider are completed, unless Health Plan has made appropriate provision for the assumption of such services by another provider. Provider will ensure an orderly transition of care for Members, including but not limited to the transfer of Members' Housing Plans. 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 Care Plans 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 $.10 per page.

4.8 **Transition**. Provider will assist Heath Plan in the orderly transfer of Members to the provider they choose or to whom they are referred after termination of this Agreement. Furthermore, Provider shall assist Health Plan in the transfer of care as set forth in the

Provider Manual, in accordance with the 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 Community Supports for the Member at termination. Such copying of records will be at Health Plan's expense if termination was not for cause. Health Plan will continue to have access to records in accordance with the terms of this Agreement.

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 **Termination of Community Support**. Provision of any Community Support identified in an exhibit to Attachment C of this Agreement may be separately terminated in accordance with the termination provisions of the applicable exhibit. Such termination shall not affect other Community Supports under this Agreement, which shall continue to be provided pursuant to the terms of this Agreement and the applicable exhibit(s). In the event of a termination of an individual Community Support, the provisions of Sections 4.6, 4.8 and 4.9 of this Agreement will apply with respect to the care of Members and the rights and obligations of the parties with respect to the terminated Community Support.

4.11 **DHCS Notification**. Health Plan and Provider agree 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;

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 Health Plan in effecting such cure will be payable upon demand, with interest from the date of incurrence at the maximum rate permitted by law; or

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 Health Plan's appeals and grievance policies set forth in the Provider Manual. Provider and Health Plan agree to and will be bound by the decisions of Health Plan's grievance and appeal mechanisms.

b. **Responsibility**. Health Plan is responsible for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system.

6.2 Dispute Resolution

a. **Government Claims Act**. For disputes unresolved by Health Plan's provider grievance and appeals process, Health Plan and Provider agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, Provider shall comply with the provisions of the Government Claims Act (Government Code, Section 900 et. seq.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

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 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 California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California 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 for Health Plan: for Provider:

c. **Time Limitation**. Provider must comply with the claim procedures set forth in the Government Claims Act (Government Code, Section 900 et. seq.) prior to filing any legal proceeding, including judicial reference, against Health Plan. If no such 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 (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 the County of Ventura, State of California.

e. **Cut-Off for Disputes Against Health Plan**. Within ninety (90) days of the expiration or termination of this Agreement or any applicable Scope of Work ("SOW") that may be added to this Agreement by means of a written amendment, Provider shall provide to Health Plan formal written notice of any unresolved Disputes Provider has against Health Plan relating to this Agreement or under any applicable SOW. The formal written notice shall describe any unresolved Dispute and identify the amount Provider demands in satisfaction of the Dispute, and it shall include any supporting documentation. Provider's failure to submit timely notice shall constitute a waiver of all unresolved Disputes against Health Plan. To the extent a Dispute arises after the time for providing notice, and Provider could not have timely discovered the dispute, Provider shall provide formal written notice of the Dispute 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.

6.3 **Peer Review and Fair Hearing Process**. To the extent that Provider is of a type that is subject to Peer Review and Provider is determined to constitute a threat to the health, safety

or welfare of Members, Provider will be referred to the Health Plan Peer Review Committee. Provider will be afforded an opportunity to address the committee. Provider will be notified in writing of the Peer Review Committee's recommendations. The Peer Review Committee can recommend suspending, restricting or terminating the provider affiliation or instituting a monitoring procedure.

6.4 **Credentialing**. To the extent that Provider is of a type that is subject to credentialing, a Credentialing Committee will review all Provider files to determine whether Provider meets the Health Plan credentialing or recredentialing requirements. Provider will be afforded an opportunity to address this Committee if there is an adverse recommendation by the Committee regarding Provider's' credentials. Provider will be advised in writing of the Credentialing Committee's recommendations. The Credentialing Committee can recommend denial of Provider's initial application or can deny Provider's recredentialing. If Provider is not of a type that is subject to credentialing, Provider shall comply with Health Plan's minimum standards to ensure adequate experience and acceptable quality of care standards are maintained.

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, damages, claims, and expenses of any kind, including costs and attorneys' fees, arising from the acts or omissions 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, nor shall any third party have any right to enforce the terms of this Agreement.

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 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 Community Supports, 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 Health 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; and/or (iv) 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). The monitoring activities will be either announced or unannounced. To assure compliance with this Agreement and for any other reasonable purpose, Health Plan and State and federal agencies shall have the right to access Provider's premises, with or without notice to Provider. This will include the Management Information System ("MIS") operations site or such other place where duties under the Agreement are being performed. Staff designated by Health Plan or the 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 State or federal agencies in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

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 the Provider at any time. . Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal 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.

7.5 **Patient-Provider 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 Community Supports 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 Community Supports 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 United States 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 Community Supports 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, Section 503 of the Rehabilitation Act of 1973, the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C., Section 4212) and of 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, Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor. Such notices shall state Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

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, which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Agreement may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in 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, Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

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 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, Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C., Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor. Provider will take such action with respect to any subcontract as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event Provider becomes involved in, or is threatened with litigation by any subcontractor as a result of such direction by DHCS, Provider may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

7.11 **Governing Law**. This Agreement shall, in all respects, be interpreted, construed, enforced and given effect according to the laws of the State of California, excluding its principles of conflicts of laws.

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 upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Health Plan may otherwise materially amend this Agreement only after sixty (60) days prior written notice to Provider. Unless DHCS notifies Health Plan that it does not accept such amendment or unless Provider gives written notice of termination within sixty (60) days, as authorized by this Agreement, Provider agrees the amendment will become effective sixty (60) days after the date of Health Plan's notice of proposed amendment and will be a part of the Agreement.

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 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 Community Supports 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 the Medi-Cal Managed Care Program as requested by Health Plan prior to commencing services under this Agreement. Provider shall notify Health Plan immediately 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 immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to the Medi-Cal Agreement, except where such disclosure is prohibited by law or court order'. 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 Sheet
Attachment B – Definitions
Attachment C – Scope of Services
Attachment D – Medi-Cal Managed Care Program Provisions
Attachment E – Attestation of Non-Duplication and Non-Supplantation of Medi-Cal Services
Attachment F – Acknowledgment of Receipt of Provider Manual
Attachment G – 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, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The notice addresses set forth on the first page of the Agreement shall be the particular party's address for delivery or mailing of notice purposes.

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

Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

ATTACHMENT A

PROVIDER IDENTIFICATION SHEET

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

_____ Primary Care Physician _____

Specialist: type _____

_____

_____ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated here)

_____ Hospital _____

_____ Ancillary Provider: type _____

_____

_____ Pharmacy _____

_____ Other: type _____

Please enter "N/A" for the following if not applicable or not available. List under each applicable provider name, the location(s) and hours of operation, mid-level practitioners supervised and languages spoken that shall apply to this Agreement:

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	_____	

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

Provider Signature:	
Signatory Name (Printed):	
Signatory Title (Printed):	
Signature Date:	

ATTACHMENT A
Provider Identification Sheet (Continuation Page)

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

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	_____	

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 A
Provider Identification Sheet (Continuation Page)

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	_____	

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	_____	

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. **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.

2. **Agreement** means this Provider Services Agreement, all Attachments, and incorporated documents or materials.

3. **At Risk of Homelessness** as defined in 24 CFR, Section 91.5 and modified by the Standard Terms and Conditions of the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, means

   a. an individual or family who:(i) Has an annual income below 30 percent of median family income for the area, as determined by the Department of Housing and Urban Development ("HUD"); (ii) does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place that would cause them to be housed; and (iii) meets one of the following conditions: (A) has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance; (B) is living in the home of another because of economic hardship; (C) has been notified in writing that their right to occupy their current housing or living situation will be terminated within thirty (30) days after the date of application for assistance; (D) lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals; (E) lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau; (F) is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution), if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization; or (G) otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan; or

   b. A child or youth who does not qualify as "homeless" pursuant to the definition in 24 CFR, Section 91.5 but qualifies under various federal statutes described at 24 CFR Section 91.5 subdivisions (1) and (2).

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 21 years who have CCS eligible conditions, as defined in 22 CCR, Section 41800.

5. **Care Plan** is comprehensive and person-centered and builds off of Recipient's strengths and existing natural supports to support Recipients in monitoring and managing their health, as well as actively engaging in their health care as evidenced by identifying and accessing any resources that may be needed to manage their conditions. At a minimum, Care Plans should cover four (4) domains: (1) physical health, (2) behavioral health, (3) social determinants of health (housing insecurity, food insecurity, safety in the home, etc.) and (4) coordination with current services being provided to the Recipient.

6. **Community Supports** are, pursuant to 42 CFR, Section 438.3(e)(2), services or settings that are offered in place of services or settings covered under the Medi-Cal Managed Care Program and are medically appropriate, cost-effective alternatives to services or settings under the Medi-Cal. Community Supports are optional for both Health Plan and the Member and must be approved by DHCS. For purposes of this Agreement, Community Supports means the services described in the Exhibits to Attachment C.

7. **Community Supports Provider** is a contracted provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and/or training providing one or more of the Community Supports approved by DHCS.

8. **DHCS** is the State of California 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 'in the Service Area.

10. **Enhanced Care Management** is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. Enhanced Care Management is a Medi-Cal benefit.

11. **Enhanced Care Management Care Team** is a multi-disciplinary, community-based team serving Enhanced Care Management participants that provides intensive care coordination and linkages to necessary services including social services and benefits, health care services, available Community Supports and other community-based resources.

12. **Enhanced Care Management Populations of Focus** are categories of adult and children/youth Members who are eligible to receive Enhanced Care Management services and are defined by DHCS as follows:

    a. Adult Populations of Focus
        i. Experiencing Homelessness
        ii. Members with High Utilization Patterns
        iii. Serious Mental Illness ("SMI") or Substance Use Disorder ("SUD")
        iv. Transitioning from Incarceration

v. Individuals At Risk for Institutionalization who are Eligible for Long-Term Care Services

vi. Nursing Facility Residents Transitioning to the Community

b. Children/Youth (up to Age 21) Populations of Focus

i. Experiencing Homelessness

ii. Members with High Utilization Patterns

iii. Serious Emotional Disturbance ("SED") or Identified to be At Clinical High Risk ("CHR") for Psychosis or Experiencing a First Episode of Psychosis

iv. Enrolled in CCS with Additional Needs Beyond the CCS Qualifying Condition

v. Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26)

vi. Transitioning from Incarceration

13. **Enhanced Care Management Provider** is a provider of Enhanced Care Management services. Enhanced Care Management Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Enhanced Care Management Populations of Focus.

14. **Excluded Services** are those excluded services as defined in Attachment C for which the Health Plan is not responsible.

15. **Experiencing Homelessness** is defined by DHCS as:

a. an individual or family who lacks adequate nighttime residence;

b. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation; •

c. An individual or family living in a shelter;

d. An individual exiting an institution into homelessness;

e. An individual or family who will imminently lose housing in next 30 days;

f. Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes; or

g. Individuals fleeing domestic violence.

16. **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"), and California Attorney General and any other agency which has jurisdiction over Health Plan or Medi-Cal (Medicaid).

17. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

18. **Health Plan** means Ventura County Medi-Cal Managed Care Commission, a public entity doing business as Gold Coast Health Plan.

19. **HEDIS** Studies means Health Employer Data and Information Set.

20. **Homeless,** as defined in 24 CFR, Section 91.5 and modified by the Standard Terms and Conditions of the California Advancing and Innovating Medi-Cal (CalAIM) Demonstration, is an individual or family who meet any of the following criteria:

    a. An individual or family who lacks a fixed, regular, and adequate nighttime residence
    b. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings
    c. An individual or family living in a supervised public or privately operated shelter designated to provide temporary living arrangements
    d. An individual exiting an institution to homelessness (if exiting an institution, individuals are considered homeless if they resided in an emergency shelter or place not meant for human habitation immediately prior to entering that institutional stay, regardless of the length of the institutionalization)
    e. An individual or family who will imminently lose their primary nighttime residence in next thirty (30) days, provided that (i) no subsequent residence has been identified, and (ii) the individual or family lacks the resources or support networks, to obtain other permanent housing
    f. Unaccompanied youth and homeless families and children and youth who do not qualify as "homeless" under 24 CFR, Section 91.5, but who are defined as homeless under other federal statutes described in the definition of "homeless" at 24 CFR, Section 91.5, subsection (3)
    g. Victims fleeing domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence and (i) has no other residence or (ii) lacks the resources to obtain other permanent housing.

21. **Lead Agency** is a County of Ventura agency or department designated by Provider to serve as the lead coordinating Community Supports Provider for one or more Community Supports.

22. **Lead Care Manager** is a Member's designated care manager for Enhanced Care Management services, for those Members authorized to receive Enhanced Care Management services. The Lead Care Manager operates as part of the Member's multi-disciplinary Enhanced Care Management Care Team and is responsible for coordinating all aspects of Enhanced Care Management and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for

coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

23. **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 Eligible Beneficiaries who may enroll in Health Plan's Medi-Cal Managed Care Program. The required elements of this Agreement will, among other things, conform to the Medi-Cal Agreement.

24. **Medi-Cal Managed Care Program or Medi-Cal** shall mean the federal and State funded health care program established by Title XIX of the Social Security Act, as amended, which is administered in the State of California by DHCS.

25. **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 by passenger car, taxicabs or other forms of public or private conveyances.

26. **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.

27. **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.

28. **Member(s)** is an Eligible Beneficiary who is enrolled in Health Plan.

29. **Member Information File** is a file produced by the Health Plan and shared with Provider in accordance with DHCS guidance inclusive of demographic, utilization and other information about Members assigned to Provider to receive Community Supports.

30. **Member Information File Return Transmission** is a file produced by Provider and shared with Health Plan in accordance with DHCS guidance inclusive of new and updated Member engagement information.

31. **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,

obstetrician-gynecologists and pediatricians. A resident or intern will not be a Primary Care Physician.

32. **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.

33. **Provider** means the County of Ventura, and includes the constituent physicians, allied health care professionals, subcontractors, drivers and staff persons who provide Community Supports to Members by and/or through the County of Ventura under this Agreement, identified in Attachment A hereto.

34. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

35. **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.

36. **Recipient** is a Member who is for eligible for, has consented to receive, and has been authorized by Health Plan to receive Community Supports by Provider.

37. **Service Area** is the County of Ventura.

38. **State** is the State of California.

39. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Community Supports by Members, including but not limited to under-utilization and over-utilization.

40. **Whole Person Care ("WPC")** is a DHCS program authorized under the Medi-Cal 2020 Waiver through December 31, 2021. Pilot programs throughout California developed services and infrastructure to support the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved health and wellbeing through more efficient and effective use of resources for Eligible Beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Ventura County Health Care Agency is the lead entity responsible for administering the Ventura County's Whole Person Care program.

ATTACHMENT C

SCOPE OF SERVICES
COMMUNITY SUPPORTS

ARTICLE I -BACKGROUND

1.1 On January 1, 2022, Medi-Cal Managed Care Plans are required to provide a new Medi-Cal benefit to eligible high-need Members called Community Supports. This new benefit is provided under California Advancing and Innovating Medi-Cal ("CalAIM"), a multi-year and multi-faceted Medicaid waiver initiative from DHCS.

Designed to implement broad delivery system and payment reform across Medi-Cal, CalAIM is DHCS' primary vehicle for addressing the social determinants of health and health care inequities through Medi-Cal. Community Supports are, pursuant to 42 CFR, Section 438.3(e)(2), services or settings that are offered in place of services or settings covered under the Medi-Cal Managed Care Program and are medically appropriate, cost-effective alternatives to services or settings under Medi-Cal. Community Supports are optional for both Health Plan and the Member and must be approved by DHCS.

1.2 Medi-Cal Managed Care Plans are required to collaborate and contract with Whole Person Care ("WPC") pilot programs to support a seamless transition from WPC to Community Supports to ensure broader integration and coordination of services across the safety net. DHCS' CalAIM proposal is available here:

https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf

1.3 Provider, through the Ventura County Health Care Agency ("VCHCA"), is the lead entity for Ventura County's WPC pilot program. This program currently serves individuals Experiencing Homelessness and high-utilizers, providing outreach, care coordination, medical respite, and housing services both in the field and in traditional care delivery settings. VCHCA care coordinators, CHWs, and clinical staff work closely across Ventura County agencies, including Ventura County Behavioral Health Department, the County of Ventura Housing Authority and Continuum of Care, Ventura County Public Health Department, and Ventura County Human Services Agency, as well as community-based organizations, community clinics, health systems, and specialty providers to coordinate care and provide wraparound services.

1.4 In line with DHCS' requirement that Medi-Cal Managed Care Plans partner with WPC providers, Health Plan and Provider have engaged in numerous planning activities to prepare for the successful transition from WPC to Community Supports. These planning and coordination activities have included the formation of Clinical and Data/IT Subcommittees that meet regularly to align on overarching approaches to Community Supports delivery and establish workflows and processes.

ARTICLE II -GENERAL

2.1 **Referrals.** Provider is responsible for responding to referrals within five (5) business days, or three (3) business days for urgent needs, of receiving the referral. Provider shall prioritize potentially eligible Members with the highest utilization, acuity, and/or need for outreach efforts, as identified by Health Plan and/or Provider. Provider will ensure that Member prioritization processes are equitable and do not exacerbate or contribute to existing racial and/or ethnic disparities.

2.2 **Eligibility Assessment.** Upon receipt of a Health Plan referral, Provider shall conduct a prompt eligibility assessment for the purpose of determining a Member's eligibility for Community Supports and determining the appropriateness of the Community Supports. Members may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.3 **Authorization Requests.** Provider is responsible for submitting requests for authorization to Health Plan Utilization Management for review and determination in accordance with the format and mode of submission set forth by Health Plan. Provider must send authorization request(s) to Health Plan prior to the commencement of Community Supports. With the exception of outreach services, Provider will be reimbursed only for services that are authorized by Health Plan.

2.3.1 Health Plan is responsible for determining Member eligibility status and authorization to participate in Community Supports. Health Plan shall ensure initial authorization or a decision not to authorize occurs as soon as possible and in accordance with timeframes for medical authorization; within five (5) working days for routine authorizations and within seventy-two (72) hours for expedited authorizations.

2.3.2 Health Plan authorizations for Community Supports will be effective for a one (1) month period. Provider shall submit an authorization for Recipient for requests for continued Community Supports past the initially authorized one (1) month of service.

2.3.3 Provider will immediately notify Health Plan if Provider does not have capacity to accept a referral for a Member authorized for Community Supports by Health Plan. Provider shall report sixty (60) days in advance or as soon as possible on its Community Supports Provider capacity whenever there are significant changes. If Provider does not have capacity to serve an eligible and authorized Member, Provider shall refer the Member to Health Plan care management services.

2.4 **Members Not Authorized for Community Supports.** Health Plan will refer Members not authorized for Community Supports to complex care management services offered through Health Plan. As part of the eligibility assessment, following Provider determination that the Member does not meet Community Supports eligibility criteria, Provider will provide a warm handoff and connection to the appropriate level of services based on the principles of nonduplication of services, Member's level of activation and

engagement, and efficiency: Enhanced Care Management, Health Plan care management, or community-based services.

2.5 **Discontinuance of Community Supports.** Provider shall discontinue Community Supports for Recipients when any of the following circumstances are met:

i. Member no longer meets criteria upon review of request for reauthorization, or is determined to no longer require Community Supports.
ii. Member has exhausted Member's limits as set forth in Section 2.3.2 or in the Exhibits hereto.
iii. Member is no longer a Health Plan member.
iv. Member's Medi-Cal status changes to ineligible aid code or ineligible.
v. Member moved out of Service Area.
vi. Member is in long-term institutionalization (except where Member is receiving Nursing Facility Transition/Diversion to Assisted Living Facilities Services).
vii. Member no longer wishes to receive Community Supports or is unresponsive or unwilling to engage.
viii. Provider has not been able to connect with the Recipient after multiple attempts.
ix. Member is deceased.

2.5.1 Health Plan shall notify Provider of discontinuance of Community Supports for Recipients within five (5) business day of when any of the following circumstances are met:

i. Medi-Cal status changes to ineligible aid code or ineligible
ii. No longer a Health Plan Member
iii. Long-term institutionalization
iv. Moved out of County
v. Death

2.5.2 If Community Supports are discontinued through the request of Provider and or the Member, Provider shall notify the Member and Health Plan of discontinuation within five (5) business days. Notification to Recipients must also include their rights to appeal the decision, as well as information about Health Plan complex care management services should continuing or new needs be identified.

2.5.3 If Community Supports discontinuation occurs as a part of the Health Plan reauthorization process, Health Plan communication will follow Health Plan's authorization notification timelines. If discontinuation occurs outside of the reauthorization process, Health Plan will notify the Member and Provider within five (5) business days of decision.

2.6 **Outreach Following Authorization and Assignment.** Provider shall conduct outreach to the referred Member for authorized Community Supports as soon as possible, including by conducting initial outreach within twenty-four (24) hours of assignment.

2.6.1 Provider shall be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail twenty-four (24) hours a day, seven (7) days a week.

2.7 **Coordination with Member's Providers and Care Team.** Provider shall coordinate with other providers in the Member's Enhanced Care Management Care team, including the Member's Enhanced Care Management Provider and any other Community Supports Provider, if applicable, and Health Plan.

2.8 **Training.** Provider shall participate in Health Plan Community Supports training and technical assistance to ensure consistency in care coordination, data sharing, billing, and reporting processes and in required Health Plan network provider trainings. Provider will provide on-going training to Community Supports staff to ensure services are appropriate and to promote continuous quality improvement.

2.9 **Adoption of Best Practices.** Provider shall participate in case conferencing with the Recipient's Enhanced Care Management Care Team members and external partners to not only engage in care planning, but to also share best practices and procedures; identify challenges and barriers; and develop shared philosophies and approaches. Provider will adopt best practices developed for addressing the needs of Recipients, including but not limited to trauma-informed care, motivational interviewing, harm reduction, and housing first.

2.10 **Participation in Health Plan Communications Activities.** Provider shall support and engage in Health Plan communications efforts, both internally and externally with the public, media, and elected officials, by sharing program outcomes and documenting Recipient stories (and obtaining and maintaining informing consent forms for any video, written, photographic, or verbal documentation that identifies the Recipient).

2.11 **Oversight and Compliance.** Provider shall provide ongoing oversight of the structures, processes, and outcomes of its operations, including oversight of Lead Agencies and subcontracted entities providing Community Supports.

2.11.1 Provider shall continually assess its ability to perform required activities through initial reviews, on-going monitoring, analysis of data, and utilization of benchmarks and maintain documentation of oversight activities.

2.11.2 Provider shall comply and deliver services in accordance with this Agreement and the deliverables, all applicable State and federal laws, All Policy Letters ("APLs"), and other DHCS guidance including but not limited to Policy Letters or the Community Supports (ILOS) Policy Guide.

2.11.3 Provider shall respond to all Health Plan requests for information and documentation to permit ongoing monitoring of Community Supports and submit monthly activity reports that detail the utilization of Community Supports provided.

2.11.4 Provider shall participate in a minimum of quarterly joint operating meetings with Health Plan.

2.12 **Readiness Review.** Provider will successfully complete a Readiness Review conducted by Health Plan prior to the commencement of Community Supports under this Agreement.

2.13 **Billable Services.** Authorized Community Supports services shall be billed utilizing the procedure codes set forth in the applicable Exhibit to this Attachment C.

2.14 **Interpreter Services.** Provider will arrange interpreter services as necessary for Members at all facilities and service locations.

ARTICLE III -DATA SHARING, DOCUMENTATION, & REPORTING

3.1 **Health Plan Data Sharing.** Health Plan will provide to Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (a) Member Assignment Files, defined as a list of Medi-Cal Members authorized for Community Supports and assigned to Provider; (b) encounter and/or claims data; (c) physical, behavioral, administrative and social determinants of health data for all assigned Members; (d) reports of performance on quality measures and/or metrics, as requested, and (e) any billing information necessary to support Provider's ability to submit invoices or claims to Plan.

3.2 **Care Management Documentation System.** Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service and administrative data and information from other entities to support the management and maintenance of a Recipient Care Plan that can be shared with other providers and organizations involved in each Recipient's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long term care facility, housing status).

3.3 **Data Sharing with Providers.** Plan and Provider shall share relevant Recipient information with other entities providing services to the Recipient as needed for effective care coordination and reporting and subject to State and federal laws regarding confidentiality of health information.

3.3.1 Protected Health Information ("PHI") shared under data sharing agreements shall be the minimally necessary PHI needed for treatment, payment, coordination of care, and/or health care operations for Community Supports delivery.

3.4 **Member Information File Transmission.** Provider shall follow the communication processes established by Health Plan for the transmission of the Member Information File, including acknowledgement of receipt of Member Information File, communicating or updating Member Information File information and reconciling identified errors or other inaccurate or outdated information.

3.4.1 Provider shall notify Health Plan if Provider is unable to accept the Member for reasons including, but not limited to, capacity constraints, Member preferences, Members' decision to decline to participate, other reasons specified in the DHCS *ECM and Community Supports Standard Provider Terms and Conditions*.

3.4.2 Provider shall communicate new and updated Member information back to the Health Plan in a Member Information File Return Transmission.

3.5 **Health Plan Data and Information Requests.** Provider shall share requested data and information with Health Plan in a mutually agreed format and timeframe that is consistent with Health Plan protocols or provide a valid justification if request cannot be met within this timeframe.

3.6 **Consent Management.** Provider shall obtain, document, and manage Recipient authorization for the sharing of Personally Identifiable Information between Health Plan and Enhanced Care Management Providers, Community Supports Providers, and other providers involved in the provision of Recipient care to the extent required by federal law. Recipient authorization for Community Supports-related data sharing is not required for Provider to initiate delivery of Community Supports unless such authorization is required by federal law. Provider shall provide Health Plan timely access to Community Supports authorization forms.

3.7 **Homeless Management Information System Documentation ("HMIS").** Provider shall document housing status information and housing services for Community Supports Recipients Experiencing Homelessness in the HMIS administered by the Ventura County Continuum of Care when applicable.

3.8 **Encounter Data Submission.** Provider shall submit complete and accurate encounter data as requested by Health Plan in a timely manner and in accordance with Health Plan processes and format to satisfy DHCS requirements using national standard specifications and code sets.

3.9 **Documentation of Social Determinants of Health Diagnoses.** Provider shall screen, document, and report DHCS Priority Social Determinants of Health ICD-10-CM codes for Community Supports Recipients in accordance with Health Plan encounter coding and billing guidance.

3.10 **Reporting.** Provider shall report data on Community Supports, quality measures, and outcomes to Health Plan, as per DHCS Community Supports reporting requirements, and as requested by Health Plan, at regular intervals. Health Plan will work with Provider to determine which specific data Provider will be responsible for reporting, depending on services provided and access to data sources.

3.11 **Quality Improvement and Utilization Management Programs**. Provider will participate in Health Plan's Quality Improvement and Utilization 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 ensuring medical records are readily available to staff as requested.

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

3.11.2 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.

3.11.2.1 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 Quality and Utilization Review Committee.

3.11.2.1.1 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) DHCS Community Supports Supplemental Reports in accordance with forthcoming DHCS reporting guidelines.

ARTICLE IV - EXCLUSIONS FROM AND LIMITATIONS OF COMMUNITY SUPPORTS

4.1 **Excluded Services Neither Covered nor Compensated**. Service provided to Members which are not Community Supports as described in the Exhibits to this Attachment C will not be reimbursed by the Health Plan. Subject to any additional exclusions from Community Supports 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:

4.1.1 Primary Care Services; specialty care, medical, hospital, ancillary, emergency services; and prescription drugs.

4.1.2 Enhanced Care Management Services. However, Provider may identify Community Supports Recipients potentially eligible for Enhanced Care Management services and submit a referral for Enhanced Care Management services to either the Enhanced Care Management Provider or Health Plan.

4.1.3 Medical Transportation Services and non-medical transportation services. However, Provider may help coordinate non-emergency medical transportation and non-medical transportation services for the Member.

4.1.4 Durable medical equipment and medical supplies for Members.

4.1.5 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).

4.1.6 Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in 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;

4.1.7 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);

4.1.8 CCS are not covered in Ventura County;

4.1.9 Services rendered in a State or federal governmental hospital;

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

4.1.11 Fabrication of optical lenses;

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

4.1.13 Direct Observed Therapy for tuberculosis;

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

4.1.15 Childhood lead poisoning case management services provided by the local health department;

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

4.1.17 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;

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

4.1.19 Community Supports provided to Members under this Agreement that duplicate services from other sources and/or supplant Medi-Cal services or are not in accordance with DHCS requirements. Provider shall execute and provide to Health Plan the Attestation set forth in Attachment E. Such Attestations shall be executed by the Chief Executive Officer of Provider, or such other authorized representative of Provider as agreed to in writing by Health Plan. Provider acknowledges and agrees that should Provider have received payments as provided in this Agreement that duplicate and/or supplant Medi-Cal services or are not in accordance with DHCS requirements as determined by Health Plan, Health Plan shall demand repayment of any such payments, and Provider shall repay such demanded amounts within thirty (30) days of such demand. Further, Health Plan may deem any such payments to be an Overpayment to Provider as described in Section 2.11(d) of this Agreement and may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. The terms of this section shall survive expiration or termination of this Agreement.

EXHIBIT A

COMMUNITY TRANSITION SERVICES/NURSING FACILITY TRANSITION TO A HOME SERVICES

1. DEFINITIONS

"Community Transition Services/Nursing Facility Transition to a Home Services" are those services described in this Exhibit A to Attachment C to the Agreement.

2. TERM

2.1 This Exhibit A shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for additional one (1) year terms, unless earlier terminated by either party in accordance with the provisions of this Exhibit A.

2.2 This Exhibit A may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit A, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit A. 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 Exhibit A unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Qualified Community Supports Providers. Community Supports Providers qualified to provide Community Transition Services/Nursing Facility Transition to a Home Services include but are not limited to the following:

3.1.1 Case management agencies

3.1.2 Home Health agencies

3.1.3 Medi-Cal managed care plans

3.1.4 County mental health providers

3.1.5 1915c HCBA/ALW providers

3.1.6 CCT/Money Follows the Person providers

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Community Transition Services/Nursing Facility Transition to a Home Services requires the Member to meet the following criteria defined and required by DHCS:

4.1.1 Currently receiving medically necessary nursing facility Level of Care (LOC) services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and

4.1.2 Has lived 60+ days in a nursing home and/or Medical Respite setting; and

4.1.3 Interested in moving back to the community; and

4.1.4 Able to reside safely in the community with appropriate and cost-effective supports and services.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. The following restrictions and limitations apply for Community Transition Services/Nursing Facility Transition to a Home Services:

5.1.1 Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

5.1.2 Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

5.1.3 Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

6. COMMUNITY TRANSITION SERVICES/NURSING FACILITY TRANSITION TO A HOME SERVICES

6.1 Community Transition Services/Nursing Facility Transition to a Home Services. Provider shall provide and shall cause its subcontractors to provide Community Transition Services/Nursing Facility Transition to a Home Services in accordance with DHCS ECM and Community Supports Standard Terms and Conditions, DHCS Community Supports Policy Guide, the Provider Manual, and Health Plan

policies and procedures. Community Transition Services/Nursing Facility Transition to a Home Services include but are not limited to the following services for Members who meet Health Plan eligibility criteria and are authorized to receive services:

6.1.1 Non-recurring set-up expenses for Members who are transitioning from a licensed facility to a living arrangement in a private residence where the Member is directly responsible for his or her own living expenses;

6.1.2 Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

6.1.2.1 Assessing the Member's housing needs and presenting options;

6.1.2.2 Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

6.1.2.3 Communicating with landlord (if applicable) and coordinating the move;

6.1.2.4 Establishing procedures and contacts to retain housing;

6.1.2.5 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day; and

6.1.2.6 Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

6.1.3 Identifying the need for and coordinating funding for services and modifications necessary to enable the Member to establish a basic household that does not constitute room and board, including:

6.1.3.1 Security deposits required to obtain a lease on an apartment or home;

6.1.3.2 Set-up fees for utilities or service access;

6.1.3.3 First month coverage of utilities, including telephone, electricity, heating and water;

6.1.3.4 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy;

6.1.3.5 Home modifications, such as an air conditioner or heater; and

6.1.3.6 Other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.

EXHIBIT A-1

COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Exhibit A-1 and the reimbursement terms set forth in the Agreement.

ARTICLE I COMPENSATION TERMS

1.1 Payment Terms. For Clean Claims for Community Transition Services/Nursing Facility Transition to a Home Services Community Supports rendered to Members, Health Plan shall reimburse Provider on a per member per month (PMPM) basis in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable PMPM rates set forth below:

1.1.1 Payment Rate. $459/PMPM

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 Adequacy of Compensation. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT A-2

COMMUNITY SUPPORTS PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Community Transition Services/Nursing Facility Transition to a Home Services Community Supports. The HCPCS code and modifier combined define the service as a Community Supports Service. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as a Community Support.

HCPCS Code	HCPCS Description	Modifier	Modifier Description
Community Transition Services/Nursing Facility Transition to a Home Services			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Nursing Facility Transition/Diversion to Assisted Living Facilities.	U5	Used by Managed Care with HCPCS code T2038 to indicate Community Supports Community Transition Services/Nursing Facility Transition to a Home

EXHIBIT B

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME MODIFICATIONS)

1. DEFINITIONS

"Environmental Accessibility Adaptations (Home Modifications)" are those services within the normal scope of practice of Provider, as described in this Exhibit B to Attachment C to the Agreement.

2. TERM

2.1 This Exhibit B shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or the applicable provisions set forth in this Exhibit B.

2.2 This Exhibit B may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit A, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit B. 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 Exhibit B unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Qualified Community Supports Providers. Community Supports Providers must have experience and expertise with providing Environmental Accessibility Adaptations (Home Modifications) Services. Community Supports Providers qualified to provide such services under this Agreement include, but are not limited to, the following:

3.1.1 Area Agencies on Aging

3.1.2 Local health departments

3.1.3 Community-based providers and organizations

All Environmental Accessibility Adaptations (Home Modifications) that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of PERS installation. PERS installation may be performed in accordance with the system's installation requirements.

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Environmental Accessibility Adaptations (Home Adaptations) Services requires the Member to be at risk for institutionalization in a nursing facility.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. The following restrictions and limitations apply for Environmental Accessibility Adaptations (Home Modifications) Services:

5.1.1 If another State Plan service is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

5.1.2 Environmental Accessibility Adaptations (Home Modifications) must be conducted in accordance with applicable State and local building codes.

5.1.3 Environmental Accessibility Adaptations (Home Modifications) Services are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

5.1.4 Environmental Accessibility Adaptations (Home Modifications) may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

5.1.5 Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

5.2 Documentation Requirements. Health Plan shall receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member. Such documentation shall include any

supporting documentation describing the efficacy of the equipment where appropriate. Additionally, Health Plan shall also receive and document:

5.2.1 A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless Health Plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

5.2.1.1 An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

5.2.1.2 An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item; and

5.2.1.3 A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

5.2.2 If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

5.2.3 That a home visit has been conducted to determine the suitability of any requested equipment or service.

5.3 Authorization Timeframe. The assessment and authorization for Environmental Accessibility Adaptations (Home Modifications) Services must take place within a 90-day time frame beginning with the request for the service, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

6. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (HOME MODIFICATIONS) SERVICES

6.1 Environmental Accessibility Adaptations (Home Modifications) Services. Provider shall provide and shall cause its subcontractors to provide Environmental Accessibility Adaptations (Home Modifications) Services in accordance with DHCS ECM and Community Supports Standard Terms and Conditions, DHCS Community Supports Policy Guide, the Provider Manual, and Health Plan policies and procedures. Environmental Accessibility Adaptations (Home

Modifications) include but are not limited to the following services for Members who meet Health Plan eligibility criteria and are authorized to receive services:

6.1.1 Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home without which the Member would require institutionalization, including:

6.1.1.1 Ramps and grab-bars to assist Members in accessing the home;

6.1.1.2 Doorway widening for Members who require a wheelchair;

6.1.1.3 Stair lifts;

6.1.1.4 Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);

6.1.1.5 Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and/or

6.1.1.6 Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

Services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

EXHIBIT B-1

COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Exhibit B-1 and the reimbursement terms set forth in the Agreement.

ARTICLE I COMPENSATION TERMS

1.1 Payment Terms. For Clean Claims for Environmental Accessibility Adaptations (Home Modifications) Services Community Supports rendered to Members, Health Plan shall reimburse Provider on a direct reimbursement basis in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable direct reimbursement amount set forth below:

1.1.1 Payment Rate. Actual cost of modifications with 10% administrative fee up to allowable amount.

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 Adequacy of Compensation. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT B-2

COMMUNITY SUPPORTS PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Environmental Accessibility Adaptations (Home Modifications) Services Community Supports. The HCPCS code and modifier combined define the service as a Community Supports Service. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as a Community Support.

HCPCS Code	HCPCS Description	Modifier	Modifier Description
Environmental Accessibility Adaptations (Home Modifications)			
S5165	Home modifications; per service. Requires billed amount(s) to be reported on the encounter.	U6	Used by Managed Care with HCPCS code S5165 to indicate Community Supports Environmental Accessibility Adaptations/Home Modifications

EXHIBIT C

NURSING FACILITY TRANSITION/DIVERSION TO ASSISTED LIVING FACILITIES SERVICES

1. DEFINITIONS

"Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities, Services" or "Nursing Facility Transition/Diversion to Assisted Living Facilities" are those services described in this Exhibit C to Attachment C to the Agreement.

2. TERM

2.1. This Exhibit C shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or the applicable provisions set forth in this Exhibit C.

2.2 This Exhibit C may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit C, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit C. 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 Exhibit C unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Qualified Community Supports Providers. Community Supports Providers qualified to provide Nursing Facility Transition/Diversion to Assisted Living Facilities Services include but are not limited to the following:

3.1.1 Case management agencies

3.1.2 Home Health agencies

3.1.3 Medi-Cal managed care plans

3.1.4 ARF/RCFE Operators

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Community Supports requires the Member to meet the following criteria defined and required by DHCS:

4.1.1 For Nursing Facility Transition:

4.1.1.1 Has resided 60+ days in a nursing facility;

4.1.1.2 Willing to live in an assisted living setting as an alternative to a Nursing Facility; and

4.1.1.3 Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

4.1.2 For Nursing Facility :

4.1.2.1 Interested in remaining in the community;

4.1.2.2 Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

4.1.2.3 Must be currently receiving medically necessary nursing facility level of care (LOC) or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility;

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. Individuals are directly responsible for paying for their own living expenses.

6. NURSING FACILITY TRANSITION/DIVERSION TO ASSISTED LIVING FACILITIES

6.1 Nursing Facility Transition/Diversion to Assisted Living Facilities. Provider shall provide and shall cause its subcontractors to provide Nursing Facility/Diversion to Assisted Living Facilities Services in accordance with DHCS ECM and Community Supports Standard Terms and Conditions, DHCS Community Supports Policy Guide, the Provider Manual, and Health Plan policies and procedures. Nursing Facility/Diversion to Assisted Living Facilities Services include but are not limited to the following services for Members who meet Health Plan eligibility criteria and are authorized to receive services:

6.1.1 Services that assist Members to live in the community and/or avoid institutionalization when possible, including supporting nursing facility transitions back into a home-like, community settings and preventing skilled nursing admissions for Members with an imminent need for nursing facility level of care; and/or

6.1.2 For Members transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for Elderly (RCFE) or Adult Residential Facility (ARF), services and allowable expenses include those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

6.1.2.1 Assessing the Member's housing needs and presenting options;

6.1.2.2 Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF;

6.1.2.3 Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

6.1.2.4 Communicating with facility administration and coordinating the move;

6.1.2.5 Establishing procedures and contacts to retain facility housing;

6.1.2.6 Coordinating with the Health Plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE and/or ARF settings have other Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

EXHIBIT C-1

COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Exhibit C-1 and the reimbursement terms set forth in the Agreement.

ARTICLE I COMPENSATION TERMS

1.1 Payment Terms. For Clean Claims for Nursing Facility Transition/Diversion to Assisted Living Facilities Services Community Supports rendered to Members, Health Plan shall reimburse Provider on a per member per month (PMPM) basis in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable PMPM rates set forth below:

1.1.1 Payment Rate. $459 PMPM, $33/hour for ongoing support services.

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 Adequacy of Compensation. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT C-2

COMMUNITY SUPPORTS PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Nursing Facility/Diversion to Assisted Living Facilities Services Community Supports. The HCPCS code and modifier combined define the service as a Community Supports Service. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as a Community Support.

HCPCS Code	HCPCS Description	Modifier	Modifier Description
Nursing Facility/Diversion to Assisted Living Facilities Services			
T2038	Community transition; per service. Requires billed amount(s) to be reported on the encounter. Modifier used to differentiate from Community Transition Services/Nursing Facility Transition to a Home.	U4	Used by Managed Care with HCPCS code T2038 to indicate Community Supports Nursing Facility Transition/ Diversion to an Assisted Living Facility
H2022	Community wrap-around services, per diem. Requires billed amount(s) to be reported on the encounter.	U5	Used by Managed Care with HCPCS code H2022 to indicate Community Supports Community Transition Services/Nursing Facility Transition to a Home

EXHIBIT D

PERSONAL CARE AND HOMEMAKER SERVICES

1. DEFINITIONS

"Personal Care and Homemaker Services" are those services described in this Exhibit D to Attachment C to the Agreement.

2. TERM

2.1. This Exhibit D shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or the applicable provisions set forth in this Exhibit D.

2.2 This Exhibit D may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit D, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit D. 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 Exhibit D unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Qualified Community Supports Providers. Community Supports Providers qualified to provide Personal Care and Homemaker Services include but are not limited to the following:

3.1.1 Home health agencies

3.1.2 County agencies

3.1.3 Personal care agencies

3.1.4 AAA (Area Agency on Aging)

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Community Supports requires the Member to meet the following criteria defined and required by DHCS:

4.1.1 Individual is at risk for hospitalization or institutionalization in a nursing facility; or

4.1.2 Individual has functional deficits with no other adequate support system; or

4.1.3 Individual is approved for In-Home Supportive Services.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. The following restrictions and limitations apply to Personal Care and Homemaker Services:

5.1.1 Personal Care and Homemaker Services cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

5.1.2 Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

5.1.3 If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

6. PERSONAL CARE AND HOMEMAKER SERVICES

6.1 Personal Care and Homemaker Services. Provider shall provide and shall cause its subcontractors to provide Personal Care and Homemaker Services in accordance with DHCS ECM and Community Supports Standard Terms and Conditions, DHCS Community Supports Policy Guide, the Provider Manual, and Health Plan policies and procedures. Personal Care and Homemaker Services include but are not limited to the following services for Members who meet Health Plan eligibility criteria and are authorized to receive services:

6.1.1 Assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding;

6.1.2 Assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management; and/or

6.1.3 Services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

6.1.4 Personal Care and Homemaker Services can be utilized:

6.1.4.1 Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and

6.1.4.2 As authorized during any In-Home Supportive Services waiting period (Member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.

6.1.4.3 For Members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

EXHIBIT D-1

COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Exhibit D-1 and the reimbursement terms set forth in the Agreement.

ARTICLE I – COMPENSATION TERMS

1.1 Payment Terms. For Clean Claims for Personal Care and Homemaker Services Community Supports rendered to Members, Health Plan shall reimburse Provider on an hourly basis in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable hourly rates set forth below:

1.1.1 Payment Rate. $35/hour

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 Adequacy of Compensation. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT D-2

COMMUNITY SUPPORTS PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Personal Care and Homemaker Services Community Supports. The HCPCS code and modifier combined define the service as a Community Supports Service. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as a Community Support.

HCPCS Code	HCPCS Description	Modifier	Modifier Description
Personal Care and Homemaker Services			
S5130	Homemaker services; per 15 minutes	U6	Used by Managed Care with HCPCS code S5130 to indicate Community Supports Personal Care/Homemaker Services
T1019	Personal care services; per 15 minutes	U6	Used by Managed Care with HCPCS code T1019 to indicate Community Supports Personal Care/Homemaker Services

EXHIBIT E

RESPITE SERVICES

1. DEFINITIONS

"Respite Services" are those services described in this Exhibit E to Attachment C to the Agreement.

2. TERM

2.1 This Exhibit E shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or the applicable provisions set forth in this Exhibit.

2.2 This Exhibit E may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit E, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit E. 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 Exhibit E unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Qualified Community Supports Providers. Community Supports Providers qualified to provide Respite Services include but are not limited to the following:

3.1.1 Home health or respite agencies to provide services in:

3.1.1.1 Private residence

3.1.1.2 Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)

3.1.1.3 Providers contracted by county behavioral health

3.1.2 Other community settings that are not a private residence, such as:

3.1.2.1 Adult Family Home/Family Teaching Home

3.1.2.2 Certified Family Homes for Children

3.1.2.3 County Agencies

3.1.2.4 Residential Care Facility for the Elderly (RCFE)

3.1.2.5 Child Day Care Facility; Child Day Care Center; Family Child Care Home

3.1.2.6 Respite Facility; Residential Facility: Small Family Homes (Children Only)

3.1.2.7 Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)

3.1.2.8 Respite Facility; Residential Facility: Adult Residential Facilities (ARF)

3.1.2.9 Respite Facility; Residential Facility: Group Homes (Children Only)

3.1.2.10 Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)

3.1.2.11 Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs

3.1.2.12 Respite Facility: Residential Facility: Foster Family Homes (FFHs) (Children Only)

3.1.2.13 Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs

3.1.2.14 Community-Based Adult Services (CBAS) Facilities/Providers

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Community Supports requires the Member to meet the following criteria defined and required by DHCS:

4.1.1 Member lives in the community and is compromised in their Activities of Daily Living (ADLs) and is therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

4.1.2 Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in either California Children's Services or the Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. Respite Services are distinct from medical respite/recuperative care and provide rest for the caregiver only. Respite Services are provided to caregivers of Members who require intermittent temporary supervision. These services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. The following additional restrictions and limitations apply:

5.1.1 In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care.

5.1.2 Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

5.1.3 The service is only available to avoid placements for which Health Plan would be responsible.

5.1.4 Respite services cannot be provided virtually, or via telehealth.

6. RESPITE SERVICES

6.1 Respite Services. Provider shall provide and shall cause its subcontractors to provide Respite Services in accordance with DHCS ECM and Community Supports Standard Terms and Conditions, DHCS Community Supports Policy Guide, the Provider Manual, and Health Plan policies and procedures. Respite Services include but are not limited to the following services for Members who meet Health Plan eligibility criteria and are authorized to receive services:

6.1.1 Services provided to caregivers of Members who require intermittent temporary supervision, which are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature;

6.1.2 Home Respite Services are provided to the Member in his or her own home or another location being used as the home and Facility Respite Services are provided in an approved out-of-home location;

6.1.3 Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals;

6.1.4 Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals; and/or

6.1.5 Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

EXHIBIT E-1

COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Exhibit E-1 and the reimbursement terms set forth in the Agreement.

ARTICLE I COMPENSATION TERMS

1.1 Payment Terms. For Clean Claims for Respite Services Community Supports rendered to Members, Health Plan shall reimburse Provider on an hourly basis in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable hourly rates set forth below:

1.1.1 Payment Rate. $35/hour

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 Adequacy of Compensation. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT E-2

COMMUNITY SUPPORTS PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Respite Services Community Supports. The HCPCS code and modifier combined define the service as a Community Supports Service. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as a Community Support.

HCPCS Code	HCPCS Description	Modifier	Modifier Description
Respite Services			
H0045	Respite care services, not in the home; per diem	U6	Used by Managed Care with HCPCS code H0045 to indicate Community Supports Respite Services
S5151	Unskilled respite care, not hospice; per diem	U6	Used by Managed Care with HCPCS code S5151 to indicate Community Supports Respite Services
S9125	Respite care, in the home; per diem	U6	Used by Managed Care with HCPCS code S9125 to indicate Community Supports Respite Services

EXHIBIT F

MEDICALLY TAILORED MEALS

1. DEFINITIONS

"Medically Tailored Meals" are those services described of this Exhibit F to Attachment C to the Agreement.

2. TERM

2.1 This Exhibit F shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or the applicable provisions set forth in this Exhibit F.

2.2 This Exhibit F may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit F, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit F. 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 Exhibit F.

3. GENERAL

3.1 Qualified Community Supports Providers. Community Supports Providers qualified to provide Medically Tailored Meals include but are not limited to the following:

3.1.1 Home delivered meal providers

3.1.2 Area Agencies on Aging

3.1.3 Providers of nutritional education services to help sustain health cooking and eating habits

3.1.4 Meals on Wheels Providers

3.1.5 Medically-supportive food and nutrition providers

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Medically Tailored Meals requires the Member to meet the following criteria defined and required by DHCS:

4.1.1 Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus ("HIV"), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders;

4.1.2 Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placements; or

4.1.3 Members with extensive care coordination needs.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. The following restrictions and limitations apply for Medically Tailored Meals:

5.1.1 Up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if Medically Necessary.

5.1.2 Meals that are eligible for or reimbursed by alternate programs are not eligible.

5.1.3 Meals are not covered to respond solely to food insecurities.

5.2 Urgent Authorization Requests. For urgent authorization requests where a forty-eight (48) hour timeline would preclude the effective use of the service, Provider may directly authorize predefined Community Supports for no more than a forty-eight (48) hour time-period to allow Health Plan to follow its authorization process. Pre-authorization will be allowed only under specified circumstances when a delay would be harmful to the Member. Expedited meals will be provided within forty eight (48) hours after connecting with the Recipient to discuss their food preferences and allergies.

6. MEDICALLY TAILORED MEALS

6.1 Medically Tailored Meals. Provider shall provide and shall cause its subcontractors to provide Medically Tailored Meals in accordance with DHCS ECM and Community Supports Standard Terms and Conditions, DHCS Community Supports Policy Guide, the Provider Manual, and Health Plan policies and procedures. Medically Tailored Meals include but are not limited to the following

services for Members who meet Health Plan eligibility criteria and are authorized to receive services:

6.1.1 Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission;

6.1.2 Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases;

6.1.3 Meals that are tailored to the medical needs of the Member by a registered dietitian ("RD") or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes;

6.1.4 Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers; and/or

6.1.5 Behavioral, cooking, and/or nutrition education, when paired with direct food assistance as enumerated above.

EXHIBIT F-1

COMPENSATION SCHEDULE

Health Plan shall pay Provider in accordance with the terms and conditions of this Exhibit F-1 and the reimbursement terms set forth in the Agreement.

ARTICLE I – COMPENSATION TERMS

1.1 **Payment Terms**. For Clean Claims for Medically Tailored Meals Community Supports rendered to Members, Health Plan shall reimburse Provider on a basis in accordance with the applicable claims payment provisions of this Agreement, at the lesser of: (i) Provider's billed charges, or (ii) the applicable rates set forth below:

1.1.1 Payment Rate.

Service	Rate
Per Delivered Meal	$16.00-$18.00
Per Weekly Grocery Box	$81
Per Nutritional Assessment	$46.25

ARTICLE II - REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS

2.2 **Adequacy of Compensation**. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT F-2

COMMUNITY SUPPORTS
PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Medically Tailored Meals Community Supports. The HCPCS code and modifier combined define the service as a Community Support. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as an Community Supports.

HCPCS CODE	HCPCS DESCRIPTION	MODIFIER	MODIFIER DESCRIPTION
Medically Tailored Meals			
S5170	Home delivered prepared meal	U6	Used by Managed Care with HCPCS Code S5170 to indicate Community Supports Medically Supportive Food/Meals/Medically Tailored Meals
S9470	Nutritional counseling, diet	U6	Used by Managed Care with HCPCS Code S9470 to indicate Community Supports Medically Supportive Food/Meals/Medically Tailored Meals
S9977	Meals; per diem, not otherwise specified	U6	Used by Managed Care with HCPCS Code S9970 to indicate Community Supports Medically Supportive Food/Meals/Medically Tailored Meals

EXHIBIT G

HOUSING TRANSITION NAVIGATION SERVICES, HOUSING DEPOSITS, & HOUSING TENANCY AND SUSTAINING SERVICES

1. DEFINITIONS

"Housing Deposits" are those services described in this Exhibit G to Attachment C to the Agreement.

"Housing Plan" and/or "Housing Retention Plan" is a document or record that identifies and tracks a Member's housing goals and goal attainment status; allows for the development and assignment of tasks to support the achievement of Member's housing goals; defines and supports Member housing coordination needs; and allows for the gathering of information from other sources to identify other Member needs related to housing stability and support care coordination and communication.

"Housing Tenancy and Sustaining Services" are those services described in this Exhibit G to Attachment C to the Agreement.

"Housing Transition Navigation Services" are those services described in this Exhibit G to Attachment C to the Agreement.

2. TERM

2.1 This Exhibit G shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for additional one (1) year terms, unless earlier terminated by either party in accordance with the provisions of this Exhibit G.

2.2 This Exhibit G may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit G, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit G. 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 Exhibit G unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure

shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Designation of Lead Agency. Provider is responsible for designating a Lead Agency to provide each Community Supports described in this Exhibit G to Attachment C to the Agreement. Lead Agency designation is subject to prior written approval by Health Plan.

3.1.1 Lead Agencies providing Housing Transition Navigation Services and/or Housing Tenancy and Sustaining Services designated by Provider may include, but are not limited to:

3.1.1.1 Vocational service agencies

3.1.1.2 Providers of services for Members Experiencing Homelessness

3.1.1.3 Life skills training and education providers

3.1.1.4 County agencies

3.1.1.5 Public hospital systems

3.1.1.6 Mental health or substance use disorder treatment providers, including county behavioral agencies

3.1.1.7 Social services agencies

3.1.1.8 Affordable housing providers

3.1.1.9 Supportive housing providers

3.1.1.10 Federally qualified health centers and rural clinics

3.1.2 The Lead Agency providing Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator, or housing navigator, shall be the designated Lead Agency providing Housing Deposits.

3.1.3 Lead Agencies designated by Provider must meet the following minimum qualifications:

3.1.3.1 Has experience in housing and providing housing supports for individuals Experiencing Homelessness with complex needs, including medical and behavioral health conditions;

3.1.3.2 Has expertise in coordinating the delivery of Community Supports in an integrated and coordinated fashion and is not excluded, barred, or under any sanctions in the Medi-Cal program;

3.1.3.3 Has defined processes, resources, and strategies to support service delivery in non-traditional settings (e.g., shelters, encampments, Recipients' homes);

3.1.3.4 Has current capacity and staff to provide appropriate, timely, and expedited care to Recipients throughout the Service Area;

3.1.3.5 Has strong, engaged organizational leadership and management who agree to and will participate in joint governance committees and regularly scheduled calls;

3.1.3.6 Maintains robust relationships with local government agencies, shelters, Continuum of Care (CoC), housing providers and programs, landlords and rental management companies, and other housing providers, including, but not limited to, board and care, room and board, and senior housing facilities;

3.1.3.7 Has experience in participating on interdisciplinary teams and collaborating across disciplines;

3.1.3.8 Demonstrates experience in managing complex reporting requirements, including, but not limited to, HEDIS reporting;

3.1.3.9 Is able to produce reports on the services received and diagnoses of individual Recipients based on individual demographic data as specified by Health Plan;

3.1.3.10 Has data sharing agreements or arrangements with Health Plan, other county agencies, local health systems, primary care providers, and other providers as needed, to facilitate Community Supports coordination of care for Recipients; and

3.1.3.11 Demonstrates a willingness to participate in county-wide health information exchange and/or community information exchange through the execution of a Memorandum of Understanding.

3.2 Designation of Housing Coordinator. Provider, through its designated Lead Agencies, shall identify a Housing Coordinator for each Recipient who best meets the Recipients' needs and preferences.

3.2.1 The Housing Coordinator has primary responsibility for coordinating all aspects of the authorized Community Supports for the Recipient.

3.2.1.1 The Housing Coordinator will serve as the main point of contact for the Recipient and interact directly with the Recipient and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate. To the extent a Recipient has other care managers, including but not limited to the Recipient's Lead Care Manager, the Housing Coordinator will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Recipient and non-duplication of services.

3.2.2 Upon request from a Recipient, Provider shall change a Recipient's Housing Coordinator at any time.

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Community Supports requires the Member to meet the criteria defined and required by DHCS, described in Sections 4.2, 4.3, and 4.4 herein.

4.2 Housing Transition Navigation Services Eligibility.

4.2.1 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or

4.2.2 Member is Homeless and receives Enhanced Care Management, or has one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder; or

4.2.3 Member is At Risk of Homelessness, and meets at least one of the following criteria: (i) has one or more serious chronic conditions, (ii) has a serious mental illness, (iii) is at risk of institutionalization or overdose or is requiring residential services as a result of a substance use disorder or has a serious emotional disturbance (children and adolescents), (iv) is receiving Enhanced Care Management, or (v) is a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or has a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or has been a victim of trafficking or domestic violence.

4.3 Housing Deposits Eligibility.

4.3.1 An individual who received Housing Transition Navigation Services Community Support in counties that offer Housing Transition Navigation Services.

4.3.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or

4.3.3 Member is Homeless and receives Enhanced Care Management, or has one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder.

4.4 Housing Tenancy and Sustaining Services Eligibility.

4.4.1 An individual who received Housing Transition Navigation Services Community Support in counties that offer Housing Transition Navigation Services.

4.4.2 Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or

4.4.3 Member is Homeless and receives Enhanced Care Management, or has one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder; or

4.4.4 Member is At Risk of Homelessness, and meets at least one of the following criteria: (i) has one or more serious chronic conditions, (ii) has a serious mental illness, (iii) is at risk of institutionalization or overdose or are requiring residential services as a result of a substance use disorder or has a serious emotional disturbance (children and adolescents), (iv) is receiving Enhanced Care Management, or (v) is a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or has a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or has been a victim of trafficking or domestic violence.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations. Health Plan authorizations for Housing Deposits Services and Housing Tenancy and Sustaining Services are limited to once in a lifetime. For exceptions to the once in a lifetime limitation, Provider is responsible for submitting a special justification with the authorization request to the Health Plan that should include documentation as to what conditions have changed to demonstrate why providing Housing Deposits or Housing Tenancy and Sustaining Services would be more successful on the second attempt. Health Plan review of the authorization request with the special justification submission will consider Member utilization patterns and trends to determine cost-effectiveness when making the determination.

5.2 Urgent Authorization Requests. For urgent requests where a forty-eight (48) hour timeline would preclude the effective use of the service, Provider may directly authorize predefined Community Supports for no more than a forty-eight (48) hour time-period to allow Health Plan to follow its authorization process. Pre-authorization will be allowed only under specified circumstances when a delay would be harmful to the Member.

6. HOUSING TRANSITION NAVIGATION SERVICES, HOUSING DEPOSITS, & HOUSING TENANCY AND SUSTAINING SERVICES

6.1 Housing Transition Navigation Services. Provider, through its Lead Agencies, shall provide Housing Transition Navigation Services, including but not limited to the development of a Housing Plan and providing assistance with obtaining housing. This should include assistance with searching for housing and completing housing applications. Specific Housing Transition Navigation Services include but are not limited to:

6.1.1 Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.

6.1.2 Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

6.1.3 Searching for housing and present options;

6.1.4 Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

6.1.5 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

6.1.6 Identifying and securing available resources to assist with subsidizing rent (such as the U.S. Department of Housing and Urban Development ("HUD") Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members.

6.1.7 Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.

6.1.8 Assisting with requests for reasonable accommodation, if necessary.

6.1.9 Landlord education and engagement.

6.1.10 Ensuring that the living environment is safe and ready for move-in.

6.1.11 Communicating and advocating on behalf of the Member with landlords.

6.1.12 Assisting in arranging for and supporting the details of the move.

6.1.13 Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

6.1.14 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

6.1.15 Identifying coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility.

6.2 Housing Deposits. Provider, through its Lead Agencies, shall provide Housing Deposits services. Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

6.2.1 Security deposits required to obtain a lease on an apartment or home.

6.2.2 Set-up fees/deposits for utilities or service access and utility arrearages.

6.2.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

6.2.4 First month's and last month's rent required by landlord prior to occupancy.

6.2.5 Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

6.2.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individual's health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

6.3 Housing Tenancy and Sustaining Services. Provider, through its Lead Agencies, shall provide Housing Tenancy and Sustaining Services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

6.3.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance abuse, and other lease violations.

6.3.2 Education and training to Members on the role, rights and responsibilities of the tenant and landlord.

6.3.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

6.3.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability

6.3.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

6.3.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

6.3.7 Assistance with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

6.3.8 Assistance with the annual housing recertification process.

6.3.9 Coordinating with Members to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

6.3.10 Continuing assistance with lease compliance, including ongoing support with activities related to household management.

6.3.11 Health and safety visits, including habitability inspections.

6.3.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

6.3.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

EXHIBIT G-1
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 and any applicable sub-attachments referenced hereto and incorporated herein.

ARTICLE I COMPENSATION TERMS

1.1 **Housing Navigation Transition Services Payment Terms**. For Clean Claims for Housing Transition Services Community Supports rendered to Members, Health Plan shall reimburse Provider in accordance with the applicable Claims Payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable rates set forth below:

Payment Rate.

1.2 Housing Transition Navigation Services $427PMPM**Housing Deposits Payment Terms**. For Clean Claims for Housing Deposits Community Supports rendered to Members, Health Plan shall reimburse Provider in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable rates set forth below:

Payment Rate.

Housing Deposits $5000

1.3 **Housing Tenancy and Sustaining Services Payment Terms**. For Clean Claims for Housing Tenancy and Sustaining Services Community Supports rendered to Members, Health Plan shall reimburse Provider in accordance with the applicable Claims Payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable rates set forth below:

Payment Rate.

Housing Tenancy and Sustaining Services $451PMPM

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 **Adequacy of Compensation**. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

EXHIBIT G-2

COMMUNITY SUPPORTS
PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Community Supports. The HCPCS code and modifier combined define the service as a Community Support. As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as an Community Supports.

HCPCS CODE	HCPCS DESCRIPTION	MODIFIER	MODIFIER DESCRIPTION
Housing Transition/Navigation Services			
H0043	Supported housing; per diem	U6	Used by Managed Care with HCPCS Code H0043 to indicate Community Supports Housing Transition Navigation Services
H2016	Comprehensive community support services; per diem	U6	Used by Managed Care with HCPCS Code H2016 to indicate Community Supports Housing Transition Navigation Services
Housing Deposits			
H0044	Supported housing, per month. Requires deposit amounts to be reported on the encounter. Modifier used to differentiate housing deposits from Short-Term Post-Hospitalization Housing.	U2	Used by Managed Care with HCPCS code H0044 to indicate Community Supports Housing Deposit
Housing Tenancy and Sustaining Services			
T2040	Financial management, self-directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services*

HCPCS CODE	HCPCS DESCRIPTION	MODIFIER	MODIFIER DESCRIPTION
TBD	Financial management, self-directed; per diem	U6	Used by Managed Care with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services
T2041	Support brokerage, self-directed; per 15 minutes	U6	Used by Managed Care with HCPCS code T2041 to indicate Community Supports Housing Tenancy and Sustaining Services*
TBD	Support brokerage, self-directed; per diem	U6	Used by Managed Care with HCPCS code T2040 to indicate Community Supports Housing Tenancy and Sustaining Services

* MCPs should process service encounters using this code. The modifier indicates to DHCS that this is the Housing Tenancy and Sustaining Services Community Supports. The use of this encounter code will signal the capturing of the service as alternative per diem codes are not available.

EXHIBIT H
RECUPERATIVE CARE (MEDICAL RESPITE) AND SHORT-TERM POST-HOSPITALIZATION HOUSING

1. DEFINITIONS

"Recuperative Care (Medical Respite)" is short-term residential care for Members who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Recuperative Care (Medical Respite) is primarily used for those Members who are Experiencing Homelessness or those with unstable living conditions who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment, but are not otherwise ill enough to be in a hospital. Recuperative Care (Medical Respite) services are described in this Exhibit H to Attachment C to the Agreement.

"Short-Term Post-Hospitalization Housing" is safe, supportive, post-hospital discharge transitional housing for Members who have high medical and/or behavioral health needs, allowing them to continue their medical, psychiatric, and/or substance use disorder recovery immediately after exiting an inpatient hospital or facility stay.

2. TERM

2.1 This Exhibit H shall be effective beginning on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for the period of one (1) year; thereafter, it shall automatically renew for additional one (1) year terms, unless earlier terminated by either party in accordance with the provisions of this Exhibit H.

2.2 This Exhibit H may be terminated without cause and for convenience by either party upon at least ninety (90) days written notice to the other party.

2.3 In the event of a breach of any material provision of Attachment C to the Agreement or this Exhibit H, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the provisions of Attachment C to this Agreement or Exhibit H. 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 Exhibit H unless such breach cannot be cured or remedied within thirty (30) days, in which case the period for remedy or cure

shall be extended for a reasonable time (not to exceed an additional sixty (60) days) provided the breaching party has made and continues to make a diligent effort to effect such remedy or cure.

3. GENERAL

3.1 Qualified Community Supports Providers. Qualified Community Supports Providers for Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing include but are not limited to the following:

3.1.1 Recuperative Care (Medical Respite)

3.1.1.1 Interim housing facilities with additional on-site support

3.1.1.2 Shelter beds with additional on-site support

3.1.1.3 Converted homes with additional on-site support

3.1.1.4 Provider directly operated or contracted recuperative care facilities

3.1.2 Short-Term Post-Hospitalization Housing

3.1.2.1 Interim housing facilities with additional on-site support

3.1.2.2 Shelter beds with additional on-site support

3.1.2.3 Converted homes with additional on-site support

3.1.2.4 Provider directly operated or contracted recuperative care facilities

3.1.2.5 Supportive housing providers

3.1.2.6 Provider agencies

3.1.2.7 Public hospital systems

3.1.2.8 Social service agencies

3.1.2.9 Providers of services for individuals Experiencing Homelessness

3.2 Minimum Qualifications. Provider must meet the following minimum qualifications:

3.2.1 Has experience in successfully providing recuperative, post-hospitalization housing and care to individuals Experiencing Homelessness with complex needs, including medical and behavioral health conditions;

3.2.2 Has expertise in coordinating the delivery of post-hospitalization recuperative in an integrated and coordinated fashion and is not excluded, barred, or under any sanctions in the Medi-Cal program;

3.2.3 Has expertise and experience in providing respite care and housing services to vulnerable, high-needs populations, including individuals Experiencing Homelessness;

3.2.4 Has defined processes, resources, and strategies to support patient-centered, housing-focused, and low-barrier approaches to service delivery;

3.2.5 Has current capacity and staff to provide appropriate, timely, and expedited care to Recipients throughout the Service Area;

3.2.6 Has an established facility for post-hospitalization recuperative services and housing that offers a clean and safe environment in a twenty-four (24) hour, seven (7) days a week, and three hundred and sixty-five (365) days a year shelter-based, residential care, or room and board environment and meets all applicable building, health and safety codes;

3.2.7 Offers facility maintenance services to ensure a clean, safe, and pest-free environment for Recipients, including but not limited to janitorial services and general repairs and upkeep services;

3.2.8 Offers facility security services to ensure a safe environment for Recipients and staff, including onsite security personnel, secured entrances, security lighting, security alarms, and cameras;

3.2.9 Has an established health policy with policies and procedures that include but are not limited: 1) possession of controlled substances; 2) security, use, and access of prescription medications; 3) Recipient use of over-the-counter medications; 4) Recipient access to emergency and medical care; 5) first aid equipment, supplies, and procedures; and 6) disease prevention;

3.2.10 Has an established food policy with policies and procedures that include but are not limited to: 1) provision of the nutritional needs of Recipients; 2) meeting health department standards; and 3) sanitary storage and preparation of food;

3.2.11 Has an established safety policy with policies and procedures that include but are not limited: 1) facility maintenance; 2) fire and earthquake safety; 3) fire prevention procedures; 4) fire drills and documentation; and 4) fire inspections and extinguishers;

3.2.12 Has an established security plan with policies and procedures that include but are not limited to: 1) eligibility screening; 2) secured entrances; 3) onsite security personnel; 4) security lightning, alarms, and cameras; 5) loitering/Good Neighbor Policy; 5) conflict de-escalation; 6) entrance and

exit procedures; 7) storage of Recipients' possessions; 8) possession of weapons onsite; 9) contacting law enforcement; and 10) and reporting adverse events;

3.2.13 Has an established Good Neighbor Policy to maintain a positive relationship with surrounding community and neighborhood and limit negative impact on surrounding areas, including a responsive team is available to address concerns;

3.2.14 Has strong, engaged organizational leadership and management who agree to and will participate in joint governance committees and regularly scheduled calls;

3.2.15 Maintains robust relationships and referral networks with local health systems, community clinics, Federally Qualified Health Centers, community-based organizations, first responders, medical groups, and specialty care providers;

3.2.16 Maintains robust relationships with local government agencies, shelters, Continuum of Care (CoC), housing providers and programs, landlords and rental management companies, and other housing providers, including, but not limited to, board and care, room and board, and senior housing facilities;

3.2.17 Has experience in participating on interdisciplinary teams and collaborating across disciplines;

3.2.18 Demonstrates experience in managing complex reporting requirements, including, but not limited to, HEDIS reporting;

3.2.19 Is able to produce reports on the services received and diagnoses of individual Recipients based on individual demographic data as specified by Health Plan;

3.2.20 Has data sharing agreements or arrangements with Health Plan, other county agencies, local health systems, primary care providers, and other providers as needed, to facilitate Community Supports coordination of care for Recipients; and

3.2.21 Demonstrates a willingness to participate in county-wide health information exchange and/or community information exchange through the execution of a Memorandum of Understanding.

4. MEMBER ELIGIBILITY

4.1 Community Supports Eligibility Criteria. Member participation in Community Supports requires the Member to meet the following criteria defined and required by DHCS described in Sections 4.2 and 4.3 herein:

4.2 Recuperative Care (Medical) Respite Eligibility

4.2.1 Member is at risk of hospitalization or post-hospitalization, and (i) Member lives alone with no formal supports, or (ii) Member is facing housing insecurity or has housing that would jeopardize Member's health and safety without modification; or

4.2.2 Member is Homeless and receives Enhanced Care Management, or has one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder; or

4.2.3 Member is At Risk of Homelessness, and meets at least one of the following criteria: (i) has one or more serious chronic conditions, (ii) has a serious mental illness, (iii) is at risk of institutionalization or overdose or is requiring residential services as a result of a substance use disorder or has a serious emotional disturbance (children and adolescents), (iv) is receiving Enhanced Care Management, or (v) is a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or has a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or has been a victim of trafficking or domestic violence.

4.3 Short-Term Post-Hospitalization Eligibility

4.3.1 Member is exiting recuperative care; or

4.3.2 Member is exiting an inpatient hospital stay (either acute or psychiatric or chemical dependency and recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and meets any of the following criteria:

4.3.2.1 Member is Homeless; or

4.3.2.2 Member is At Risk of Homelessness, and meets at least one of the following criteria: (i) has one or more serious chronic conditions; (2) has a serious mental illness; (3) is at risk of institutionalization or overdose or are requiring residential services as a result of a substance use disorder or has a serious emotional disturbance (children and adolescents); (iv) is receiving Enhanced Care Management; or (v) is in transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or has a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or has been a victim of trafficking or domestic violence.

4.3.3 In addition to meeting one of the above criteria, Member must have medical/behavioral health needs such as Experiencing Homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

5. DELIVERY OF CS SERVICES

5.1 Restrictions/Limitations.

5.1.1 Recuperative Care Authorizations. Members are limited to no more than ninety (90) days of Recuperative Care (Medical Respite) in continuous duration. Health Plan reauthorizations for Recuperative Care (Medical Respite) shall limit Member to receiving no more than ninety (90) days of services in continuous duration.

5.1.2 Short-Term Post-Hospitalization Housing. This service is authorized by Health Plan on a monthly basis for a period of up to six (6) months. There is no continuous duration requirement for the six (6) months that a Member may be authorized for Short-Term Post-Hospitalizations Housing.

5.1.2.1 Health Plan authorizations for Short-Term Post-Hospitalization Housing are limited to once in a lifetime. For exceptions to the once in a lifetime limitation, Provider is responsible for submitting a special justification with the authorization request to Health Plan that should include a medical and cost justification for the requested exception to the once in a lifetime limitation. Health Plan review of the authorization request with the special justification submission will consider Member utilization patterns and trends to determine cost-effectiveness when making that determination.

5.2 Urgent Authorization Requests. For urgent authorization requests where a forty-eight (48) hour timeline would preclude the effective use of the service, Provider may directly authorize predefined Community Supports for no more than a forty-eight (48) hour time-period to allow Health Plan to follow its authorization process. Pre-authorization will be allowed only under specified circumstances when a delay would be harmful to the Member.

6. RECUPERATIVE CARE (MEDICAL RESPITE) SERVICES

6.1 Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing. Provider shall provide Recuperative Care (Medical Respite) to Members who no longer require hospitalization, but still need to recover from injury or illness. Provider shall provide Short-Term Post-Hospitalization Housing to Members who have medical and/or behavioral health needs, allowing them to continue their medical, psychiatric, and/or substance use disorder recovery

immediately after exiting an inpatient hospital or facility stay. Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization services include but are not limited to:

6.1.1 Onsite monitoring and medication oversight of Recipients during recuperation following significant medical treatment in a twenty-four (24) hour, seven (7) days a week, and three hundred and sixty-five (365) days a year lay-in respite, shelter-based environment.

6.1.2 Provision of clinical services onsite, including medication management, nursing care, disease management, and post-acute medical care.

6.1.3 Coordination of medical appointments; referrals to physical health, mental health, and substance use disorder services; and support in accessing benefits and community resources.

6.1.4 Three (3) daily meals to Recipients, as well as snacks.

6.1.5 Limited or short-term assistance with Instrumental Activities of Daily Living ("ADL") and / or ADLs.

6.1.6 Provision of shelter and a clean environment to Recipients, including janitorial services, general repairs and upkeep, and maintenance of the full facility as a clean, safe, and pest-free environment per all applicable building, fire, and health codes.

6.1.7 Storage for Recipient possessions.

6.1.8 Accommodation of Recipient service animals.

6.1.9 Laundry services for Recipients.

6.1.10 Transportation and/or coordination of transportation benefits to medical, behavioral health, and social services appointments.

6.1.11 Monitor progress, improvement, and outcomes of Recipients at monthly intervals using standardized assessment tools. Use assessment results to support reauthorization submissions and/or to transition Members to lower intensity services.

6.1.12 Coordination with Recipient's Enhanced Care Management Lead Case Manager to ensure non-duplication of services, seamless care transitions, and provision of wrap-around care.

6.1.13 Participation in Ventura County Homeless Management Information Services ("HMIS") operated by the U.S. Department of Housing and Urban Development by obtaining access to HMIS and completing Ventura County HMIS training. Once authorized to participate in Ventura County HMIS,

complete and/or update Members' HMIS client profile and document housing services provided.

6.1.14 Coordination with the Area Housing Authority of the County of Ventura and the Ventura County Continuum of Care to assess and refer eligible Recipients for the Housing Choice Voucher, Public Housing, Shelter Plus Care, and other subsidized housing programs, or coordinate with the Recipient's Community Supports Housing Coordinator to ensure this coordination.

6.1.15 Provision of, or coordination with the Recipient's Community Supports Housing Coordinator to provide, housing location services based upon individualized needs and Recipient choice that include a range of permanent housing options as follows: apartments, senior housing, board and care, recovery housing, room and board, shared housing, family reunification, and other suitable options.

6.1.16 Assistance, or coordination with the Recipient's Community Supports Housing Coordinator to assist, with housing application documentation, including enrolling on and maintaining eligibility on subsidized housing waitlists, with affordable housing providers.

6.1.17 Provision of, or coordination with the Recipient's Community Supports Housing Coordinator to provide, support and transportation coordination for housing related appointments and viewings with landlords, and at housing determination and voucher issuance sessions with the Area Housing Authority of the County of Ventura.

6.1.18 Provision of, or coordination with the Recipient's Community Supports Housing Coordinator to provide, support to Recipients for appeals of denials from assisted housing, including preparation and documentation of mitigating circumstances.

6.1.19 Referrals to Housing Transition Navigation Services Community Supports to support Member access to housing navigation services.

6.1.20 Referrals to Housing Deposits Services Community Supports to support Member's access to funds for security deposits and utilities and work with Members on a housing budget.

6.1.21 Referrals to Housing Tenancy Sustaining Services Community Supports to support access to ongoing housing retention services following a successful housing placement.

6.1.22 Recipient education on tenant rights, responsibilities, and adherence to Good Neighbor policy, including, but not limited to, how to communicate effectively with housing entities, property management staff and other entities.

EXHIBIT H-1

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 and any applicable sub-attachments referenced hereto and incorporated herein.

ARTICLE I COMPENSATION TERMS

1.1 **Payment Terms**. For Clean Claims for Community Supports rendered to Members, Health Plan shall reimburse Provider in accordance with the applicable claims payment provisions of this Agreement, at the lesser of; (i) Provider's billed charges, or (ii) the applicable rates set forth below:

1.1.1 Payment Rate.

Location	Number of Beds	Rate
Ventura	4	$58,333 per bed per calendar year
Oxnard	10	$48,750 per bed per calendar year
Oxnard - Overflow	As needed	$225 per bed per diem

ARTICLE II REIMBURSEMENT TERMS

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) days following Health Plan's receipt of its capitation payment from DHCS for Members who received services from Provider if said Members are listed on the most current enrollment information as transmitted by DHCS.

2.2 **Adequacy of Compensation**. Provider shall accept payments as provided herein as payment in full for providing or arranging Community Supports under this Agreement. Provider shall not balance bill Members for any Community Supports.

2.3 **Use of Beds and Rates**. The beds identified in Section 1.1 may be used for either Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization interchangeably as authorized. The rates per bed per calendar year, and the per bed per diem rates for Oxnard Overflow shall apply to both Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing.

EXHIBIT H-2

COMMUNITY SUPPORTS
PROCEDURE CODES

The following Healthcare Common Procedure Coding System ("HCPCS") codes must be used for Recuperative Care (Medical Respite). The HCPCS code and modifier combined define the service as a Community Support As an example, HCPCS code H0043 by itself does not define the service as a Community Support. HCPCS code H0043 must be reported with modifier U6 for the service to be defined and categorized as an Community Supports.

HCPCS CODE	HCPCS DESCRIPTION	MODIFIER	MODIFIER DESCRIPTION
Recuperative Care (Medical Respite)			
T2033	Residential care, not otherwise specified (NOS), waiver; per diem	U6	Used by Managed Care with HCPCS Code T2033 to indicate Community Supports Recuperative Care (Medical Respite)

ATTACHMENT D
Medi-Cal Managed Care Program Provisions

The below provisions apply exclusively to Community Supports 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 Community Supports 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 C.F.R. § 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 C.F.R..§ 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 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 the 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 C.F.R. § 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 the Provider. (42 C.F.R. § 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, 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 the Provider from participation in the Medi-Cal Managed Care Program; seek recovery of payments made to the 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 Community Supports 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 the Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use as they are able for the purpose of Member care coordination. (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 comply with language assistance standards developed pursuant to Health & Safety Code §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;

1) Quality improvement responsibilities, and specific delegated functions and activities of Health Plan and provider.
2) Health Plan's oversight, monitoring, and evaluation processes and Provider's agreement to such processes.
3) 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.
4) Health Plan's actions/remedies if Provider's obligations are not met. (Medi-Cal 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 C.F.R. 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. § 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 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 C.F.R. 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 § 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 § 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 § 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 § 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 § 14454 and, Title 22 CCR,§ 53620 et. seq., except § 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 §§ 14454(c) and 14115.5, and California Code of Regulations, Title 22 CCR, § 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 C.F.R. § 438. 3(h).)

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

a. Provide written disclosure of any prohibited affiliation under 42 C.F.R. § 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. § 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. 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 the 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 Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Agreement, 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 Penal Code 422.56 or physical or mental handicap include, but are not limited to, the following:

- Denying any Member any Community Supports or availability of a Facility;
- 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;
- Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;
- 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;
- The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, of the Recipients to be served.

Provider shall take affirmative action to ensure that Members are provided Community Supports 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 Penal Code 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 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. § 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. § 438.608, the Federal False Claims Act (31 .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. §§ 438.608(a)(8) and 438.610. Additionally, Provider is prohibited from employing, contracting or maintaining a contract with persons or entities for the provision of services related to this Agreement that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. Provider shall notify Health Plan immediately upon discovery of employment or contract with a person or entity that is excluded, suspended, or terminated. A list of suspended and ineligible providers is updated monthly and available on line and in print at the DHCS Medi-Cal website (http://medi-cal.ca.gov). Lists of excluded individuals and entities are also available through the DHHS, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov), and the Federal System of Award Management (http://www.sam.gov). Provider is deemed to have knowledge of any persons or entities on these lists. Provider must notify Health Plan within ten (10) working days of removing a suspended, excluded, or terminated provider from its employment or subcontract and confirm that the individual or entity is no longer

receiving payments in connection with the Medicaid program. 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 Cal. Health & Safety Code §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:

No visitors are allowed.

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.

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 Section 297 of the Cal. Family Code.

ATTACHMENT E

ATTESTATION OF NON-DUPLICATION AND NON-SUPPLANTATION OF MEDI-CAL SERVICES

Provider hereby attests that Community Supports provided to Members under the Agreement do not supplant services received by a Medi-Cal beneficiary from other State, local, or federally-funded programs and are in accordance with the CalAIM Standard Terms and Conditions and federal and DHCS requirements.

Date of Receipt: _____

Initials of Authorized

Representative of Provider: _____

ATTACHMENT F
ACKNOWLEDGMENT 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 G
DISCLOSURE FORM

(Welfare and Institutions Code Section 14452(a). 42 C.F.R. § 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.