SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

205

FROM: Community Health Agency Department of Public Health

SUBMITTAL DATE: March 7, 2012

SUBJECT: Approve the Agreement #11-186 between Community Health Agency Department of Public Health and Inland Empire Health Plan (IEHP) for specialty services

RECOMMENDED MOTION: That the Board of Supervisors:

1) Ratify the Agreement #11-186 between Community Health Agency Department of Public Health and Inland Empire Health Plan (IEHP) for the period of performance from date of execution and shall remain in effect for an initial term of five years unless terminated by either party; and

2) Authorize the Chairperson of the Board to sign three (3) original Agreements on behalf of the County.

BACKGROUND: (Continue on page 2)

LBK:td

Susan D. Harrington, Director of Public Health

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ -0-	In Current Year Budget:	Yes
	Current F.Y. Net County Cost:	$ -0-	Budget Adjustment:	No
	Annual Net County Cost:	$ -0-	For Fiscal Year:	11/12

SOURCE OF FUNDS: 100% funded by Medical/Medicare Managed Care Capitated and Fee for Service payments

Positions To Be Deleted Per A-30	☐
Requires 4/5 Vote	☐

C.E.O. RECOMMENDATION: APPROVE

County Executive Office Signature

BY: Debra Cournoyer

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS 3/1/12 DATE

Departmental Concurrence

Dep't Recomm.: ☐ Consent ☒ Policy

Per Exec. Ofc.: ☐ Consent ☒ Policy

Prev. Agn. Ref.: | **District:** All | **Agenda Number:** 3.13

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

SUBJECT: Approve the Agreement #11-186 between Community Health Agency Department of Public Health (DOPH) and Inland Empire Health Plan (IEHP) for specialty services

BACKGROUND: IEHP and Health Access are each public entities that operate a Health Maintenance Organization (HMO) that arrange for quality preventive, medical and hospital services to its enrolled members. IEHP and Health Access have requested a contract with Community Health Agency Department of Public Health for specialty care services.

DOPH services provided by this Agreement include coordination of specialty care in HIV/AIDS. IEHP will refer its members in need of specialty care in HIV/AIDS to Riverside Neighborhood Health Center. In addition to providing specialty services, the Agreement provides for IEHP to reimburse DOPH for specified services such as prevention and treatment of HIV/AIDS.

ORIGINAL

PARTICIPATING PROVIDER AGREEMENT
(ALL LINES OF BUSINESS)

BETWEEN

INLAND EMPIRE HEALTH PLAN
AND
IEHP HEALTH ACCESS

AND

COUNTY OF RIVERSIDE

FOR

SPECIALTY SERVICES

INLAND EMPIRE HEALTH PLAN
AND
IEHP HEALTH ACCESS
PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("Agreement") is made and entered into this First day of ______________, by and between (i) **INLAND EMPIRE HEALTH PLAN** ("IEHP"); (ii) **IEHP HEALTH ACCESS** ("Health Access"), known collectively as the ("IEHP Health Plan") and (iii) **COUNTY OF RIVERSIDE** ("PROVIDER"), with reference to the following facts:

WHEREAS, IEHP and Health Access are each public entities that are organized and licensed as health care service plans under the laws of the State of California; and

WHEREAS, IEHP and Health Access operates a Health Maintenance Organization (HMO) that arranges for quality preventive, medical and hospital services to be provided to persons who are enrolled as Members in the IEHP Health Plan in a manner consistent with the laws of the United States and the State of California; and

WHEREAS, the IEHP Health Plan is structured such that Members in Medi-Cal programs are assigned to IEHP and non-Medi-Cal Members are assigned to Health Access; and

WHEREAS, IEHP Health Plan has entered into Agreements with the California Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and the Centers for Medicare and Medicaid Services (CMS) through which IEHP Health Plan shall arrange for the provision of Health Care Services for San Bernardino and Riverside County residents who are eligible for health coverage and who enroll in the IEHP Plan; and

WHEREAS, IEHP Health Plan desires to provide a health care delivery system that utilizes methods to promote the efficient delivery of health care, and develops and implements health education and health maintenance for its Members; and

WHEREAS, PROVIDER has the requisite facilities, equipment and personnel necessary to deliver Health Care Services, all of which are appropriately licensed in the State of California; and

WHEREAS, IEHP Health Plan and PROVIDER mutually desire to preserve and provide quality cost-effective Health Care Services, compliant with the terms and conditions specified herein and to the extent permitted by law, to serve the needs of IEHP Health Plan Members.

NOW, THEREFORE, in consideration of their mutual agreements and promises, the parties hereto agree as follows:

1. DEFINITIONS

The following terms whenever used in this Agreement shall have the definitions contained in this Section 1. Unless otherwise indicated, all terms in any appropriate attachments, addendums and amendments hereto shall have the same meaning attributed to such terms in the body of this Agreement and references to Section numbers are to the appropriate Sections of this Agreement:

1.01 AGREEMENT – shall mean this Provider Agreement, dated as herein above stated, including all attachments, addendums and amendments hereto.

1.02 CAPITATION PAYMENTS –shall mean payments made to PROVIDER by IEHP Health Plan as a single, fixed, monthly amount. A fixed rate is paid per Member per month to cover a specified package of services, regardless of actual utilization as referenced in Attachment B, attached hereto.

1.03 FEE-FOR-SERVICE PAYMENTS – shall mean payments made to Provider by IEHP Health Plan on a Fee-For-Service basis for specific services performed in Attachment A, attached hereto. The specific payment rate is noted in the fee schedule in Attachment B, attached hereto.

1.04 COMMERCIAL PROGRAM - shall mean any product line in which the individuals eligible IEHP Health Plan are enrolled through Subscriber Agreement.

1.05 CO-PAYMENT – shall mean a nominal fee, approved by the applicable state and federal regulators that govern the IEHP Health Plan, that is charged to Members at the time of service for designated Health Care Services.

1.06 DHCS – is the Department of Health Care Services who finances and administers a number of California individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal). The DHCS works closely with health care professionals, county governments and health plans to provide health care safety net for California's low-income and persons with disabilities.

1.07 EMERGENCY MEDICAL CONDITION – shall mean a medical condition that is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part.

1.08 EMERGENCY SERVICES – shall mean those health services needed to evaluate or stabilize an Emergency Medical Condition.

1.09 ENCOUNTER DATA – shall mean the data submitted by PROVIDER regarding all Capitated Services rendered to assigned Members during each month.

1.10 HEALTH CARE SERVICES – shall mean all Medically Necessary services to which Members are entitled under the IEHP Plan, including Primary Care Services, medical, hospital, preventive, ancillary, emergency and health education services.

1.11 HEALTHY FAMILIES PROGRAM – is the federal and stated funded program authorized pursuant to Title XXI of the Social Security Act, Public Law 105-33, Section 12693 et.seq., Part 6.2, Division 2, California Insurance Code and Section 2699.6500 et. Seq., Title 10 , Chapter 5.8, California Code of Regulations, to make available subsidized health coverage through participating health plans for children under 19 years of age with family incomes above the level eligible for no cost Medi-Cal.

1.12 HEALTHY KIDS PROGRAM – shall mean the program, jointly subsidized by the Prop 10 Commission, IEHP, and other interest groups that provides insurance coverage for children of families living in Riverside or San Bernardino County earning less than a designated Federal poverty Level and are not eligible for any insurance.

1.13 IEHP-DIRECT – shall mean the department within IEHP Health Plan that administers direct contracting.

1.14 IEHP PLAN – shall mean any plan operated by IEHP Health Plan covering the provision of Health Care Services to Members.

1.15 MEDI-CAL – shall mean the California name for Medicaid, the federal and state program of medical assistance for needy and low-income people.

1.16 MEDICALLY NECESSARY – shall mean reasonable and necessary services to protect life, to prevent significant illness or significant disability, to alleviate severe pain and to diagnose or treat disease, illness or injury.

1.17 MEDICARE– A benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by IEHP Health Plan as outlined in Attachment E.

1.18 MEMBER – shall mean any eligible beneficiary who has enrolled in IEHP Plan.

1.19 MRMIB – is the California Managed Risk Medical Insurance Board, the administrative agency of the California Government responsible for administering the Healthy Families Program.

1.20 OPEN ACCESS PROGRAM – shall mean the program whereby designated Members are not formally assigned to a Primary Care Physician (PCP). This program allows for Members to be treated by any contracted PCP on a Fee For Service basis. PROVIDER shall treat any Member who is enrolled in the Open Access Program once eligibility is confirmed through IEHP Health Plan.

1.21 PARTICIPATING PROVIDER – shall mean any physician, licensed health care facility or other licensed health professional that is contracted with IEHP Health Plan to provide health care services to Members and identified in Attachment C, attached hereto and incorporated in full herein by reference.

1.22 PREPAID HEALTH PLAN – shall mean a Knox-Keene licensed health care plan holding a contract with the Department of Managed Health Care (DMHC) to provide services to beneficiaries.

1.23 PRIMARY CARE PHYSICIAN (PCP) – shall mean a physician who is responsible for supervising, coordinating and providing initial, primary and preventive care to Members, for initiating referrals, maintaining continuity of Member care, and providing health counseling and education. This means physicians who are practicing medicine in the areas of Family Practice, Pediatrics, Internal Medicine, Obstetrics-Gynecology, or General Practice.

1.24 PRIMARY CARE SERVICES – shall mean those covered services that Members are entitled to under the IEHP Health Plan, which PROVIDER is required to provide or to make available to Members. Primary Care Services shall include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses. Primary care is performed and managed by a the Member's assigned physician, utilizing consultation or referral as appropriate.

1.25 PRIMARY HOSPITAL – shall mean an acute care facility licensed under the laws of the State of California that is accredited by an IEHP Health Plan approved agency and is contracted with IEHP Health Plan at which PROVIDER is a member in good standing of the medical staff and to which Member has been assigned.

1.26 PRIOR AUTHORIZATION – shall mean a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

1.27 REFERRAL – shall mean the process where PROVIDER directs a Member to a participating provider to obtain Health Care Services.

1.28 STATE PROGRAM – shall mean Medi-Cal, Healthy Families, Healthy Kids, and Open Access product lines administered through IEHP Health Plan.

1.29 SURCHARGES – shall mean an additional fee, excluding any applicable Co-payment that is charged to a Member for covered services. Surcharges are prohibited under the IEHP Plan.

2. DUTIES OF PROVIDER

2.01 ACCESSIBILITY OF SERVICES – PROVIDER shall provide timely access to Health Care Services and provide for reasonable hours of operation in compliance with IEHP Health Plan established standards for access and availability, as these services are normally made available to the general public.

2.02 ADMINISTRATIVE GUIDELINES – PROVIDER agrees to perform his/her duties under this Agreement in a manner consistent with the administrative guidelines provided by IEHP Health Plan and comply with the policies and procedures outlined in the IEHP Provider Policy and Procedure Manual.

2.03 AVAILABILITY OF SERVICES – PROVIDER agrees to provide IEHP Health Plan with current information regarding Health Care Services available. PROVIDER shall notify and submit to IEHP Health Plan periodic reports that includes, but is not limited to, the identification of deletions and additions to Health Care Services provided by PROVIDER.

2.04 CHANGE IN PROVIDER INFORMATION – PROVIDER shall notify IEHP Health Plan in writing, ninety (90) days prior to any change in PROVIDER's office address, telephone number, office hours, tax identification number, or license status or number.

2.05 CITATIONS – PROVIDER shall notify IEHP Health Plan in writing within fifteen (15) days of each and every report of CMS, DHCS, The Joint Commission or any other accreditation agency, which contains any citation of PROVIDER for failure to meet any required standard; any legal or government action against any of its licenses, accreditations, or certifications; or any other situation that will materially impair the ability of PROVIDER to carry out the duties and obligations under this Agreement.

2.06 CONFORMANCE TO OTHER LAW – PROVIDER certifies compliance with the Americans with Disabilities Act of 1990 (42 USC, Section 12100 et. Seq.), the Drug Free Workplace Act of 1990 (Gov. Code Section 8355), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the U.S Pro-Children Act of 1994 (20 USC 6081 et seq.). PROVIDER certifies awareness of Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor, the derivative Cal/OSHA Standard and laws and regulations relating thereto and shall comply therewith as to all relative elements under the Agreement.

2.07 COVERING PROVIDER – If applicable, if PROVIDER is unable to provide Health Care Services when needed, PROVIDER may secure the services of a qualified covering provider. PROVIDER shall notify IEHP Health Plan as soon as reasonably possible of his/her intent to secure such services. PROVIDER may utilize only providers that have been credentialed or contracted by IEHP Health Plan. PROVIDER shall ensure that the covering provider: 1) looks solely to PROVIDER for compensation, 2) shall accept IEHP Health Plan's UM/QM and peer review processes, 3) shall not bill Members for Health Care Services rendered under any circumstances, excluding that of Section 4.03 and 4) shall comply with the terms of this Agreement.

2.08 CREDENTIALING – PROVIDER shall meet IEHP Health Plan's credentialing requirements and maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities. In addition, PROVIDER shall maintain, at all times, active privileges at Primary Hospital, have written arrangements in place with a covering admitting physician approved by IEHP Health Plan, or rely on a contracted admitting physician provided by IEHP Health Plan. PROVIDER agrees that only those medical professionals who are credentialed by IEHP Health Plan shall treat Members.

Hospital-based providers are not required to complete the IEHP Health Plan's credentialing requirements. PROVIDER shall maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities.

2.09 DATA REPORTING – If Capitated, PROVIDER shall submit to IEHP Health Plan, within ninety (90) days after each month of service and in a format acceptable to IEHP Health Plan, the Encounter Data as required by IEHP Health Plan, MRMIB and DHCS for the effective management of IEHP Health Plan's health care delivery system. PROVIDER shall ensure that Encounter data submitted to IEHP Health Plan is complete and accurate. IEHP Health Plan may withhold a portion of the monthly Capitation Payment for failure to submit complete, accurate and valid Encounter Data.

2.10 FACILITY TRANSFERS – If applicable, PROVIDER agrees to notify IEHP Health Plan or designee, immediately and to assist in facilitating the transfer of Members requiring Health Care Services that are not offered or available at PROVIDER'S facilities. PROVIDER agrees to cooperate and comply with IEHP Health Plan standards with respect to required referral systems for excluded (carve out) services to ensure continuity of care between IEHP Health Plan and the local health departments or other agencies to which the Member is referred.

2.11 HOSPITAL ADMISSION – PROVIDER, or IEHP Health Plan designee, shall admit all Members with acute conditions to the Members' Primary Hospital only, unless an appropriate bed or service is unavailable. PROVIDER agrees to secure an authorization from IEHP Health Plan prior to admitting a Member for an elective service.

2.12 HOURS OF OPERATION AND AVAILABILITY – If applicable, PROVIDER shall make arrangements to ensure the availability of physician services to Members twenty-four (24) hours per day, seven (7) days per week. PROVIDER agrees that scheduling of appointments shall be done in accordance with IEHP Health Plan standards and to maintain weekly appointment hours that are sufficient to serve Members. PROVIDER shall be available or have designated physician back-up available, telephonically to Members after regular business hours.

2.13 IDENTIFICATION OF OFFICERS, OWNERS, STOCKHOLDERS, CREDITORS - On an annual basis PROVIDER shall identify the names of the following persons by listing them on Attachment D of this Agreement, attached hereto and incorporated by this reference, as required by DHCS and MRMIB:

A. PROVIDER officers and owners who own greater than 10% of the PROVIDER;

B. Stockholders owning greater than 10% of any stock issued by PROVIDER

C. Major creditors holding more than 5% of any debts owed by PROVIDER;

PROVIDER shall notify IEHP Health Plan in writing within thirty (30) days of any changes in the information provided in Attachment D.

2.14 INSURANCE – PROVIDER agrees, throughout the term of this Agreement, to maintain medical malpractice insurance with a reputable carrier in the minimum amount of $1,000,000 per occurrence and $3,000,000 aggregate per year, plus extended reporting (tail coverage) endorsement, and to furnish IEHP Health Plan certificates evidencing such coverage.

2.15 INSURANCE – ANCILLARY PROVIDER – throughout the term of this Agreement PROVIDER agrees to maintain, at its sole cost and expense, professional general liability in the minimum amount of One Million Dollars ($1,000,000) combined single limited coverage; and One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) aggregate per year for professional liability for providing Health Care Services to Members on behalf of PROVIDER. PROVIDER employees may be covered by employer policies of insurance or by employer self-insurance programs. In the event PROVIDER procures a claims made policy as distinguished from an occurrence policy, PROVIDER shall procure and maintain prior to termination of such insurance, continuing "tail" coverage, unless successor policy coverage provides such "tail" protection. Evidence of insurance coverage for PROVIDER shall be provided to IEHP HEALTH PLAN each year. PROVIDER shall provide IEHP HEALTH PLAN with written notification thirty (30) days prior to any cancellation, reduction, or other material change in the amount or scope of any coverage required under this Section.

2.16 INSPECTION OF FACILITIES – Facilities used by PROVIDER to provide Health Care Services shall comply with provisions of Title 22, CCR, Section 53230 and Title 28, Section 1300.80. PROVIDER agrees to cooperate with inspections of PROVIDER facilities, as conducted by any state and federal regulatory agencies, or IEHP Health Plan staff, that are required to assure compliance with required facility standards.

2.17 LABORATORY SERVICES - PROVIDER shall utilize an IEHP Health Plan designated laboratory for all laboratory services as needed for Member care. PROVIDER shall get approval and an authorization number from IEHP Health Plan prior to utilizing another laboratory.

2.18 MEMBER GRIEVANCE RESOLUTION – PROVIDER shall notify IEHP Health Plan immediately, upon knowledge of a complaint by a Member. PROVIDER agrees to cooperate with IEHP Health Plan in resolving Member grievances and agrees to participate in the grievance review procedures of IEHP Health Plan. PROVIDER and PROVIDER's staff shall comply with all final determinations of IEHP Health Plan's grievance procedure, peer review and QM and UM Programs. At no time shall a Member's medical condition be permitted to deteriorate because of delay in provision of care that PROVIDER disputes. Fiscal and administrative concerns shall not influence the independence of the medical decision-making process to resolve any medical disputes between Member and provider of service.

2.19 NON-DISCRIMINATION – PROVIDER represents and assures that Health Care Services are provided to Members in the same manner and quality as such services are provided to PROVIDER's other patients. Members shall not be subject to any discrimination whatsoever by PROVIDER with regard to access to Health Care Services. PROVIDER may not impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of the PROVIDER. PROVIDER shall not request, demand, require or seek directly or indirectly the transfer, discharge or removal of any Member for reasons of Member's need for or utilization of Health Care Services.

PROVIDER shall not refuse or fail to provide Health Care Services to any Member. PROVIDER agrees to comply with the provisions of Title 2 CCR, Section 8107 et. seq., as may be amended from time to time, as incorporated by reference herein.

2.20 NON-SOLICITATION – PROVIDER shall not solicit Members on behalf of any other IPA, medical group, and HMO or insurance company. Solicitation shall mean conduct by PROVIDER, office staff, agent, or employee of PROVIDER, which may be reasonably interpreted as designed to persuade Members to discontinue their membership with IEHP Health Plan.

2.21 OTHER CONTRACTUAL COMMITMENTS – PROVIDER represents and assures IEHP Health Plan that contractual commitments to other HMOs, insurance companies, medical groups and other related entities do not restrict or impair PROVIDER from performing its duties under this Agreement and do not constitute a conflict of interest with the provision of Primary Care Services for Members.

2.22 OTHER REPORTING – If applicable, ROVIDER agrees to submit all information or reports, in a timely manner, as may be required to enable IEHP Health Plan to fulfill its reporting and other obligations under the Agreement, the Knox-Keene Act and the IEHP Health Plan.

2.23 PHARMACEUTICAL SERVICES –PROVIDER shall provide pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with Title 22, CCR, Section 53854.

2.24 PRIOR AUTHORIZATION – As applicable, PROVIDER shall obtain advance authorization from IEHP Health Plan, or designee, prior to any non-emergent Health Care Services provided to a Member. In the case of an emergency, PROVIDER agrees to notify IEHP Health Plan, or designee, either orally or in writing, no later than the first working day following the date of service.

2.25 PROVIDER ADVERTISING – Prior to listing or otherwise referencing IEHP Health Plan in any promotional or advertising brochures, media announcements or other advertising or marketing material, PROVIDER shall first obtain the prior written consent of IEHP Health Plan.

2.26 QUALITY MANAGEMENT (QM) AND UTILIZATION MANAGEMENT (UM) – PROVIDER shall comply with IEHP Health Plan's QM and UM Programs and any amendments to these programs as may be established or adopted by IEHP Health Plan from time to time. If a potential quality of care issue is identified based on Member complaints, or other information, IEHP Health Plan shall alert PROVIDER to initiate appropriate action. PROVIDER further agrees to assist IEHP Health Plan in the implementation of a corrective action plan.

2.27 REFERRAL PROCESS – PROVIDER understands and agrees that all specialty consultation or care must be obtained utilizing the procedures designated by IEHP Health Plan In addition PROVIDER shall not render Primary Care Services to unassigned Members nor provide Health Care Services that fall outside those listed in Attachment A, without prior authorization from IEHP Health Plan.

In the event that PROVIDER fails to comply with such procedures, IEHP Health Plan may, at its sole discretion, reimburse the provider of service and deduct such costs from any monies owed to PROVIDER.

2.28 SERVICES TO BE RENDERED – As applicable to Primary Care Providers, PROVIDER agrees to provide continuous and comprehensive Primary Care Services for all assigned Members with consideration of the physical, mental and psychosocial needs of the Members, including acute and chronic care. This includes coordinating specialty care and referrals, providing screening, counseling, preventive care services and periodic evaluation to ensure appropriate continuity of care, as outlined in Attachment A and E. As applicable to other Health Care Providers, PROVIDER shall provide to Members those Health Care Services that are Medically Necessary when such services are authorized by IEHP Health Plan, or designee, and in accordance with Attachment A and E of this Agreement. PROVIDER is responsible for coordinating the provision of Health Care Services with the Member's PCP, IPA, or IEHP Health Plan.

2.29 STANDARDS OF CARE – PROVIDER shall maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities. All Health Care Services shall be provided by professional personnel and at physical facilities in accordance with all applicable federal and state laws, licensing requirements and professional standards, and in conformity with the professional and technical standards adopted by IEHP Health Plan. Health Care Services shall be rendered by qualified providers unhindered by fiscal and administrative management.

3. DUTIES OF IEHP HEALTH PLAN

3.01 ADMINISTRATION – IEHP Health Plan shall perform all necessary administrative, accounting and reporting requirements and other functions to state and federal regulators consistent with the administration of IEHP Plan and this Agreement.

3.02 ADMINISTRATION OF PAYMENTS – IEHP Health Plan agrees to transmit Capitation Payments and other payments to PROVIDER in accordance with the terms and procedures set forth in this Agreement. All payments are subject to the availability of funds from payors to IEHP, including but not limited to, Federal congressional appropriation, State and/or other payor. The State of California operates on a fiscal year from July 1 through June 30. The DHCS' funding is based on the budget and appropriations, and subject to the availability of Federal congressional appropriation of funds.

3.03 AFTER-HOURS NURSE ADVICE LINE – IEHP Health Plan shall provide Members with access to after-hour medical advice and triage provided by licensed RNs, PAs and NPs. This service is provided Monday-Friday from 5:00pm - 8:00am and on weekends and holidays, through a toll-free telephone number.

3.04 AUTHORIZATIONS – IEHP Health Plan agrees to provide medical authorization access to PROVIDER for treatment and hospitalization of Members.

3.05 BENEFIT INFORMATION – IEHP Health Plan agrees to apprise all Members concerning the type, scope and duration of benefits and services to which such Members are entitled under the IEHP Plan. This includes, but is not limited to, written notification to Members of Health Care Services available and changes in the availability or location of Health Care Services being provided by PROVIDER, and issuance of an identification card to each Member upon enrollment.

3.06 CULTURAL AND LINGUISTIC SERVICES – IEHP Health Plan agrees to offer PROVIDER access to interpreter services for Members either through telephone language services or interpreters.

3.07 ELIGIBILITY INFORMATION – IEHP Health Plan shall maintain, update and distribute eligibility information to PROVIDER that contains those Members assigned to the PROVIDER within a specific month.

3.08 MARKETING ACTIVITIES – IEHP Health Plan agrees to provide marketing and public relations services, advertising and marketing to potential Members. IEHP Health Plan may use PROVIDER's name, office address, telephone number, and any other demographic information in any informational material distributed to Members and for other purposes related to the administration of the IEHP Health Plan.

3.09 MEDICAL MANAGEMENT – IEHP Health Plan shall provide appropriate services in support of PROVIDER for the medical care of Members, including but not limited to treatments and hospitalizations, case management and quality oversight. PROVIDER may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

3.10 MEMBER SERVICES – IEHP Health Plan shall provide customer service to Members, including, but not limited to, processing Member complaints and grievances, informing Members of IEHP Health Plan policies and procedures, providing Members with information about IEHP Health Plan and identifying contracted providers within IEHP Health Plan's network.

3.11 NOTIFICATION TO DHCS – IEHP Health Plan shall notify DHCS in the event of an amendment to or termination of this Agreement. Notice shall be given by properly addressed letter deposited in the U.S. Postal Service as first-class postage, prepaid registered mail.

3.12 PROVIDER ADVERTISING– IEHP Health Plan may use PROVIDER's name, office address, telephone number, and any other demographic information in any informational material distributed to Members and for other purposes related to the administration of the IEHP Plan.

3.13 PROVIDER EDUCATION AND TRAINING – IEHP Health Plan shall provide in-service training in the IEHP Provider Policy and Procedure Manual that contains IEHP Health Plan's policies and procedures.

IEHP Health Plan shall provide the necessary training on these policies and procedures when requested and in the development and initial implementation of procedures necessary to carry out the intent of this Agreement.

4. BILLING AND COMPENSATION

4.01 BILLING – In order to receive payment for Health Care Services rendered PROVIDER shall submit claims to IEHP Health Plan within one hundred and twenty (120) days from the date of service for authorized Health Care Services provided to Members. Capitated PROVIDER shall only submit claims to IEHP Health Plan for services not included in Attachment A. The claim must be submitted on a CMS 1500 or UB-04 claim form and shall include all information necessary to verify and substantiate the provision of and charges for Health Care Services, including providing the authorization number, as applicable. PROVIDER shall not seek payment for claims submitted after one hundred and twenty (120) days from the date of service.

4.02 CAPITATION PAYMENTS – If applicable, IEHP Health Plan shall make monthly Capitation Payments to PROVIDER as outlined in Attachment B for those Primary Care Services listed in Attachment A. Payments shall be post marked by the fifth (5th) day of each month following the month of service for all Members assigned to PROVIDER under the IEHP Direct PROVIDER number.

4.03 COLLECTION OF CHARGES FROM MEMBERS – PROVIDER agrees that the only charges for which a Member may be liable and be charged by PROVIDER shall be for applicable Co-payments, coinsurance and/or deductibles or for medical services not covered under the IEHP Plan. PROVIDER shall advise Member of their payment responsibility, if any, prior to rendering services that require Co-payments, coinsurance and/or deductibles. PROVIDER shall obtain a written waiver from Member prior to rendering non-covered medical services to Member. The waiver must be obtained in advance of rendering services and shall specify those non-covered services or services IEHP Health Plan has denied as not being Medically Necessary and shall clearly state that the Member is responsible for payment of those services.

4.04 COORDINATION OF BENEFITS –PROVIDER agrees to coordinate benefits with other programs or entitlement, excluding tort liability of a third party, and estates from deceased Members, and recognizes the other coverage as primary and IEHP Health Plan as the payor of last resort. In the case in which IEHP Health Plan is other than primary, IEHP Health Plan shall pay the lesser of the amounts which when added to the amounts received by PROVIDER from other sources equals one hundred percent of the amount required under this Agreement as specified in Attachment B. Unless Member has other health insurance coverage, PROVIDER accepts payment from IEHP Health Plan for Health Care Services as provided herein as full payment for such Health Care Services and shall at no time seek compensation from Members, excluding applicable Copayments for Medi-Cal, Healthy Family Members, Healthy Kids Members or the State.

4.05 FULL COMPENSATION – PROVIDER shall accept the payments specified in Attachment B of this Agreement as payment in full for all Health Care Services provided to Members and for all administrative costs incurred for providing such services.

In the event IEHP Health Plan fails to make any payments to PROVIDER as provided herein, whether from IEHP Health Plan's insolvency or otherwise, Members shall not be liable for payment to PROVIDER, under any circumstances, for Health Care Services.

4.06 HOLD HARMLESS – In the event IEHP Health Plan fails to make any payments to PROVIDER as provided herein, whether from IEHP Health Plan's insolvency or otherwise, Members shall not be liable to PROVIDER, under any circumstances, for Health Care Services. PROVIDER further agrees to hold harmless the State of California in the event of non-payment by IEHP Health Plan.

4.07 POTENTIAL TORT LIABILITY – To the extent permitted by the Healthy Families, Healthy Kids or Medicare programs, as applicable, in the event PROVIDER recovers any amount from a third party, PROVIDER shall notify IEHP Health Plan of any such recovery and shall provide IEHP Health Plan with an accounting of all such sums recovered. In the event IEHP Health Plan has compensated PROVIDER for such Covered Services and PROVIDER has recovered sums from a third party, PROVIDER agrees to pay such recovered sums to IEHP Health Plan up to the amounts that IEHP Health Plan paid to PROVIDER, to the extent that IEHP Health Plan has not recovered such amounts from its own third party recovery efforts. PROVIDER shall pay these amounts to IEHP Health Plan within thirty (30) days of IEHP Health Plan informing PROVIDER of the amounts IEHP Health Plan recovered from its own third party recovery efforts, if any. This section does not obligate, nor does it prohibit, either IEHP Health Plan or PROVIDER to undertake such third party recovery efforts.

4.08 REIMBURSEMENT – IEHP Health Plan shall pay PROVIDER for authorized Health Care Services in accordance with California Health and Safety Code, § 1371 et. seq. and Attachment B of this Agreement, within forty-five (45) working days of receipt of an uncontested claim which is accurate, complete and otherwise in accordance with IEHP Health Plan standards. IEHP Health Plan shall notify PROVIDER at least forty-five (45) days prior to any material modification to IEHP Health Plan's proprietary fee schedules, claims and dispute filing guidelines. or other reimbursement guidelines. IEHP Health Plan shall not be obligated to pay PROVIDER on any claim not submitted within one hundred and twenty (120) days from the date of service. If for any reason it is determined that IEHP Health Plan overpaid PROVIDER, IEHP Health Plan may deduct monies in the amount equal to the overpayment from any future payments to PROVIDER after thirty (30) days written notice. Notwithstanding anything to the contrary set forth in this Agreement, IEHP Health Plan may reduce the rates or other compensation payable to PROVIDER at any time or from time-to-time during the term of this Agreement as determined by IEHP Health Plan to reflect implementation of State or federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Covered Services, or changes in rates implemented by the DHCS, CMS or any other governmental agency providing revenue to IEHP Health Plan, or any other change that results in decreases to the rates or level of funding paid to IEHP Health Plan. The amount of such adjustment shall reasonably be determined by IEHP and may not be in direct proportion to or in the same amount as the decrease to the rates or level of funding paid to IEHP Health Plan. All other rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same.

Notwithstanding anything to the contrary set forth in this Agreement, IEHP Health Plan's obligation to pay PROVIDER any payment amount hereunder shall be subject to IEHP Health Plan's corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to IEHP Health Plan, as applicable.

4.09 REIMBURSEMENT DISPUTES - In the event PROVIDER disagrees with any payment, denial, adjustment or contest made by IEHP Health Plan, PROVIDER has 365 calendar days to submit a written dispute to IEHP Health Plan. Said dispute shall include all information necessary to verify and substantiate the dispute. IEHP Health Plan shall handle all written disputes in accordance with Health and Safety Code, § 1371 et. seq. (AB1455).

4.10 SERVICE WAIVER – In the event Health Care Services are not covered under the IEHP Health Plan or are denied by IEHP Health Plan as not being Medically Necessary, PROVIDER shall not charge Members unless PROVIDER has obtained a written waiver from Member. The waiver must be obtained in advance of rendering services and shall specify those non-covered services or services IEHP HEALTH PLAN has denied as not being Medically Necessary and shall clearly state that the Member is responsible for payment of those services.

4.11 SURCHARGES PROHIBITED – Notwithstanding Section 4.03, PROVIDER shall in no event, including, without limitation, non-payment by IEHP Health Plan, insolvency of IEHP Health Plan, or breach of the Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive any form of payment from any Member, the State, or County, for Health Care Services provided pursuant to this Agreement. PROVIDER also agrees it shall not maintain any action at law or equity against a Member to collect sums owed by IEHP Health Plan to PROVIDER. Upon receipt, by IEHP Health Plan, of notice of any Surcharge being made by PROVIDER for Health Care Services, IEHP Health Plan shall take appropriate action consistent with the terms of this Agreement. PROVIDER's obligations regarding the collection of surcharges from Members shall survive the termination of this Agreement.

5. RECORDS AND CONFIDENTIALITY

5.01 ACCESS TO RECORDS – PROVIDER shall provide access at reasonable times upon demand by IEHP Health Plan, the U.S. Department of Health and Human Services, the Department of Corporations, DMHC, DHCS or any governmental regulatory agency responsible for the administration of the IEHP Health Plan, to inspect, exam or copy any books, papers and records, including but not limited to Member medical records, relating to Health Care Services provided pursuant to this Agreement. Such records shall be made available at all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California.

5.02 CONFIDENTIALITY OF RECORDS – PROVIDER shall request from Member, or Member's legal representative, authorization for the release of the Member's medical records. Provider shall safeguard the confidentiality of Member medical records and treatments in accordance with all state and federal laws, including, without limitation, Title 42, Code of Federal Regulations, Section 431.300 et seq., and Section 14100.2, California Welfare and Institutions Code, the Health Insurance Portability and Accountability Act (HIPAA) and regulations adopted thereunder.

5.03 RECORDS MAINTENANCE – PROVIDER shall prepare and maintain adequate records related to Health Care Services provided to each Member, in such form and containing such information as reasonably necessary for IEHP Health Plan to properly administer the IEHP Plan, consistent with state and federal law. PROVIDER shall maintain its books and records in accordance with general standards for books and record keeping. PROVIDER shall retain such records and encounter data for at least ten (10) years from the close of DHCS' fiscal year in which this Agreement is in effect. This obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

5.04 RECORDS RELATED TO RECOVERY FOR LITIGATION – Upon request by DHCS and IEHP Health Plan, PROVIDER shall timely gather, preserve and provide to IEHP Health Plan, in the form and manner specified by DHCS, any information specified by DHCS subject to any lawful privileges, in PROVIDER's possession, relating to threatened or pending litigation by or against DHCS. PROVIDER shall use all reasonable efforts to immediately notify IEHP Health Plan of any subpoenas, documentation production requests, or requests for records, received by PROVIDER related to this Agreement.

6. DISPUTE RESOLUTION

6.01 DISPUTE RESOLUTION – For disputes unresolved by the IEHP Health Plan provider appeals process, IEHP 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 be required to 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").

6.02 JUDICIAL REFERENCE – At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (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 California 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 638 for appointment of a referee before the appropriate judge of the San Bernardino Superior Court. 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 agree that the only proper venue for the submission of claims to judicial reference shall be the County of San Bernardino, California, and that the hearing before the referee shall be concluded within nine (9) months of the filing and service of the complaint. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

6.03 LIMITATIONS – 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 the 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.

6.04 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 counties of San Bernardino or Riverside, State of California.

7. TERM AND TERMINATION

7.01 TERM – The term of this Agreement shall become effective on ____________ and shall remain in effect for an initial term of five year[s] unless earlier terminated by either party as set forth below. Thereafter, this Agreement shall renew automatically, upon formal approval by the Inland Empire Health Plan/IEHP Health Access Governing Board, on the same terms and subject to the same conditions.

7.02 DISSOLUTION OF IEHP HEALTH PLAN – This Agreement shall be terminated upon the dissolution of IEHP Health Plan by mutual action of the Riverside County and San Bernardino County Board of Supervisors. If IEHP Health Plan has incurred no obligations, either County Board of Supervisors may terminate the JPA and IEHP Health Plan by giving not less than sixty (60) days written notice thereof to the other party. Also, either County Board of Supervisors may terminate the JPA by written mutual consent, by giving twelve (12) months' written notice thereof to the other party given that the JPA cannot be terminated until all forms of indebtedness incurred by IEHP Health Plan have been paid, or adequate provision for such payment shall have been made. Upon dissolution of IEHP Health Plan by Riverside County and San Bernardino County Board of Supervisors, this Agreement is rendered null and void. The debts, liabilities, and/or obligations of IEHP Health Plan are those of IEHP Health Plan alone. Neither Riverside County nor San Bernardino County assumes any of the debts, liabilities and/or obligations of IEHP Health Plan.

7.03 TERMINATION WITHOUT CAUSE – Either party may terminate this Agreement without cause upon providing the other party with ninety (90) days prior written notice of termination. Termination shall take effect automatically upon expiration of the ninety (90) day notice period.

7.04 TERMINATION FOR CAUSE – This Agreement shall terminate immediately, upon IEHP Health Plan's written notice, in the event of the occurrence of any of the following:

7.04.01 FAILURE TO PROVIDE QUALITY SERVICES – PROVIDER's failure to maintain the standards as provided herein.

7.04.02 FAILURE TO RENDER SERVICES – PROVIDER's failure to provide Health Care Services to Members as provided herein.

7.04.03 BREACH OF MATERIAL TERM – PROVIDER's breach of any material term, covenant or condition of the Agreement.

7.04.04 LICENSING – Revocation, suspension, or restriction of PROVIDER's licenses, accreditation or certification required for the performance of the duties hereunder.

7.04.05 LOSS OF INSURANCE COVERAGE – Failure by PROVIDER to maintain adequate professional liability insurance coverage, as provided herein.

7.04.06 FRAUD – Upon IEHP Health Plan's determination that PROVIDER has engaged in a fraudulent activity against the Plan or its Members

7.05 NOTICE OF BANKRUPTCY – Notice shall be given within ten (10) working days to the other party of any filing for bankruptcy, insolvency or for reorganization, or the appointment of a receiver, trustee or conservator, or assignment to creditors. In the event PROVIDER files for bankruptcy protection in any form, this Agreement may terminate immediately.

7.06 CONTINUING CARE RESPONSIBILITIES – In the event of termination of this Agreement, IEHP Health Plan shall be responsible to notify all Members under care prior to termination. PROVIDER shall continue to provide or arrange for Health Care Services to Members until the effective date of transfer of such Members for further treatment and written notice of such transfer has been provided by IEHP Health Plan to PROVIDER. If a Member's care cannot be transferred for medical reasons, PROVIDER shall continue to provide or arrange for treatment for the Member until IEHP Health Plan notifies PROVIDER of such transfer in writing. PROVIDER shall be compensated as set forth in Attachment B for services rendered pursuant to this Agreement.

7.07 CONTINUING CARE RESPONSIBILITIES – PRIMARY CARE PHYSICIAN – In the event of termination of this Agreement, PROVIDER shall continue to provide or arrange for Primary Care Services to Members until the effective date of transfer of such Members for further treatment and written notice of such transfer has been provided by IEHP Health Plan to PROVIDER. If a Member's care cannot be transferred for medical reasons, PROVIDER shall continue to provide or arrange for treatment for the Member until IEHP Health Plan notifies PROVIDER of such transfer in writing. PROVIDER shall be compensated as set forth in Attachment B for services rendered pursuant to this Agreement.

7.08 CONTINUING CARE RESPONSIBILTIES – SKILLED NURSING AND REHABILITATION FACILTIES – In the event of termination of this Agreement, PROVIDER shall continue to provide and be compensated for Health Care Services under the terms of this Agreement to Members who are admitted on the date of termination until the effective date of discharge or the safe transfer of such Members to another health care facility.

7.09 MEMBER RECORDS – Upon termination of this Agreement, PROVIDER agrees to assist IEHP Health Plan in the transfer of Member medical care by making available copies of medical records, patient files and other pertinent information necessary for efficient case management of Members.

7.10 NON-PAYMENT POLICY – Notwithstanding the above, or any other provisions to the contrary, PROVIDER agrees that in the event IEHP Health Plan ceases operations for any reason, including insolvency, PROVIDER shall continue to provide Health Care Services for those Members who are hospitalized on an inpatient basis. PROVIDER shall not bill, charge, collect or receive any form of payment from any such Member or have any recourse against Member for Health Care Services provided after IEHP Health Plan ceases operation. This continuation of Health Care Services obligation shall continue until Member is discharged from PROVIDER.

8. RELATIONSHIP OF PARTIES

8.01 CONFLICT OF INTEREST – The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

8.02 NON-LIABILITY OF COUNTIES – Neither Riverside County nor San Bernardino County assumes any responsibility for any of the obligations under this Agreement.

8.03 INDEMNIFICATION – PROVIDER shall indemnify and hold harmless IEHP Health Plan its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of PROVIDER's officers, directors, agents, employees, Providers, agents and shareholders acting alone or in collusion with others. PROVIDER also agrees to hold harmless both the State and Members in the event that IEHP Health Plan cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.

8.04 INDEPENDENT PROVIDER – It is understood and agreed that PROVIDER is an independent contractor in the business of providing Health Care Services to Members and that no relationship of employer-employee exists between the parties hereto. Neither of the parties nor any of their respective officers, directors or employees shall act as, nor be construed to be, an agent, employee or representative of the other.

8.05 LIABILITY FOR OBLIGATIONS – Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party or any third party, unless liability is found against either party based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law basis for liability. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any obligation for the payment of wages, salaries or other compensation (including all state, federal and local taxes and mandatory employee benefits), insurance and voluntary employment-related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of such party's employees, agents and representatives.

8.06 PROVIDER PARTICIPATION – The execution of this Agreement shall qualify PROVIDER as a Participating Provider in the rendition of Health Care Services to Members pursuant to the terms of the IEHP Health Plan, as amended from time to time.

9. GENERAL PROVISIONS

9.01 AMENDMENT – This Agreement may be amended or modified only by mutual written consent of the parties. Amendments required due to legislative, regulatory or other legal authority do not require the prior approval of PROVIDER and shall be deemed effective immediately upon PROVIDER's receipt of notice.

9.02 ASSIGNMENT – PROVIDER shall not assign or delegate any duties, rights and obligations under this Agreement to any person or entity without first obtaining the written consent of IEHP Health Plan and DHCS. IEHP Health Plan and DHCS must approve all subcontracts between PROVIDER and other providers prior to use.

9.03 ATTORNEYS' FEES – If any action at law or in equity is necessary to enforce the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees and reasonable costs, in addition to any other relief to which such party may be entitled.

9.04 CAPTIONS – Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

9.05 CERTIFICATION OF AUTHORITY TO EXECUTE THIS AGREEMENT – PROVIDER certifies that the individual signing herein has authority to execute this Agreement on behalf of PROVIDER, and may legally bind PROVIDER, and his/her contracted physicians as listed on Attachment C, to the terms and conditions of this Agreement, and any attachments hereto.

9.06 CONTRACT REQUIREMENTS – IEHP Health Plan is subject to the provisions of sections 1340 et. seq. of the Health and Safety Code, sections 1300.43 of Title 28 of the California Code of Regulations and sections 2698.100 et. seq, of Title 10 of the California Code of Regulations, as may be amended from time to time.

9.07 CONFIDENTIALITY OF THIS AGREEMENT – To the extent reasonably possible, each party agrees to maintain this Agreement as a confidential document and not to disclose the Agreement or any of its terms or reports without the approval of the other party, subject to the limitation of the Public Records Act and the Brown Act.

9.08 ENTIRE AGREEMENT – This Agreement, including all attachments and manuals, which are hereby incorporated in this Agreement, supersedes any and all other agreements, promises, negotiations or representations, either oral or written, between the parties with respect to the subject matter and period governed by this Agreement and no other agreement, statement or promise relating to this Agreement shall be binding or valid.

9.09 GOVERNING LAW – IEHP Health Plan, PROVIDER and this Agreement are subject, and must comply with, the applicable laws of the State of California and the United States of America including, but not limited to: the California Knox-Keene Act and the regulations promulgated thereunder by the California Department of Managed Health Care, the Health Maintenance Organization Act of 1973 and the regulations and CMS instructions promulgated thereunder by the United States Centers for Medicare and Medicaid Services (CMS), and the Waxman-Duffy Prepaid Health Plan Act and the regulations promulgated by DHCS, and the Healthy Families Act and the State Children's Health Insurance Program (found in Title 21 of the Social Security Act). Any provision required to be in this Agreement by any of the above Acts, CMS instructions and regulations shall bind IEHP Health Plan and PROVIDER, whether or not expressly provided in this Agreement.

9.10 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – IEHP PLAN and PROVIDER are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, enacted August 21, 1996, and the laws and regulations promulgated subsequent hereto, for purposes of services rendered pursuant to the Agreement. Both parties agree to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under this Law. Both parties further agree that it shall be in compliance with the requirements of HIPAA, and the laws and regulations promulgated subsequent hereto.

9.11 INVALIDITY AND SEVERABILITY – In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

9.12 NOTICES – Any notices required to be given hereunder shall be in writing to either IEHP Health Plan or PROVIDER at the address listed below, or at such other addresses as either IEHP Health Plan or PROVIDER may hereafter designate to the other:

IEHP HEALTH PLAN:
Inland Empire Health Plan
P. O. Box 19026
San Bernardino, CA 92423
(909) 890-2000
Attn: Director of Contracts

PROVIDER:
County of Riverside
4065 County Circle Drive #306
Riverside, CA 92503
(951) 358-5077
Attn: Medical Services/Clinic Management

All notices shall be deemed given on the date of delivery if delivered personally or on the third business day after such notice is deposited in the United States mail, addressed and sent as provided above.

9.13 IEHP PROVIDER POLICY AND PROCEDURE MANUALS – IEHP Health Plan shall develop and provide to PROVIDER and PROVIDER shall comply with IEHP Policy and Procedure Manuals that shall set forth IEHP Health Plan's administrative requirements. IEHP Health Plan may modify the Manuals from time to time by written notice to the PROVIDER. The IEHP Provider Policy and Procedure Manuals are hereby incorporated in full by reference.

9.14 TERMS – Unless otherwise indicated, all terms in any appropriate attachments, addendums and amendments hereto shall have the same meaning attributed to such terms in the body of this Agreement and references to Section numbers are to the appropriate Sections of this Agreement.

9.15 TIME OF THE ESSENCE – Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

9.16 WAIVERS – No obligation under this Agreement or an Attachment hereto may be waived by any party hereto except by an instrument in writing, duly executed by the party waiving such obligations. All matters shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the extension of the waiver to other provisions of this Agreement unless so specified in writing.

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ORIGINAL

IN WITNESS WHEREOF, the parties hereto have signed this Participating Provider Agreement as set forth below.

PROVIDER

By:______________________________

Print Name and
Title:______________________________

____

Date:______________________________

TIN: 95-6000930

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS 3/12/12
DATE

IEHP HEALTH ACCESS

By: ______________________________
Bradley P. Gilbert, M.D.
Chief Executive Officer

Date: ______________________________

By: ______________________________
Chairperson
IEHP Health Access
Governing Board

Date: ______________________________

Attest: ______________________________
Secretary
Inland Empire Health Plan for IEHP Health Access

Date: ______________________________

Approved as to Form and Content

By: ______________________________
Jinny R. Yang
Staff Counsel for IEHP Health Access

Date: ______________________________

INLAND EMPIRE HEALTH PLAN

By: ______________________________
Bradley P. Gilbert, M.D.
Chief Executive Officer

Date:______________________________

By: ______________________________
Chairperson
Inland Empire Health Plan
Governing Board

Date: ______________________________

Attest: ______________________________
Secretary
Inland Empire Health Plan

Date: ______________________________

Approved as to Form and Content

By: ______________________________
Jinny R. Yang
Staff Counsel for Inland Empire Health Plan

Date: ______________________________

ATTACHMENT A

HEALTH CARE SERVICES

COUNTY OF RIVERSIDE

The list below outlines Health Care Services to be provided by PROVIDER under this agreement and require prior authorization.

HIV/AIDS Services

ATTACHMENT B

COMPENSATION

PARTICIPATING PROVIDER (SPECIALIST)

COUNTY OF RIVERSIDE

Reimbursement shall be according to following fee schedules:

A. STATE PROGRAMS

Reimbursement for authorized Health Care Services rendered shall be atOne Hundred Percent (100%) of the most current Medi-Cal rates, as published quarterly by DHCS.

B. COMMERCIAL PROGRAMS

Reimbursement for authorized Health Care Services rendered shall be at One Hundred Percent (100%) of the most current Medicare allowable as listed in the Medicare Physician Fee Schedule, published annually by CMS (centers for Medicare and Medicaid Services).

C. MEDICARE

Reimbursement for authorized Health Care Services rendered shall be at Eighty Percent (80%) of the most current Medicare allowable as listed in the Medicare Physician Fee Schedule, published annually by CMS (centers for Medicare and Medicaid Services).

D. PHARMACEUTICALS

Reimbursement for authorized injectables shall be at 100% of the most current Medicare allowable as listed in the Medicare Drug Average Sales Prices ("ASP") Information Resources pricing file published quarterly by CMS ("Centers for Medicare and Medicaid Services").

Reimbursement for miscellaneous injectables, J3490, will be at Wholesale Acquisition Cost (WAC) + 5% (Published by First Data Bank) and require submission of National Drug Code (NDC) and the quantity.

By report and RNE procedures without established unit values shall be paid at thirty five percent (35%) of billed charges.

ATTACHMENT B
(Continued)

<u>COMPENSATION</u>

PARTICIPATING PROVIDER (SPECIALIST)

COUNTY OF RIVERSIDE

PROVIDER shall accept such reimbursement as payment in full for those authorized Health Care Services provided to Members. Reimbursement shall not exceed billed charges:

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department – IEHP PLAN Direct
P.O. Box 10129
San Bernardino, CA 92423-0129

ATTACHMENT C

PARTICIPATING PROVIDERS

COUNTY OF RIVERSIDE

The following list shall set forth the name, address, telephone number, and office hours of PROVIDER's facilities and the name, type and license of those providers who shall provide Health Care Services under this agreement. PROVIDER shall provide IEHP Health Plan written notification ninety (90) days prior to any changes in this Attachment C.

FACILITY NAME	ADDRESS	GROUP NPI	OFFICE HOURS
Riverside Neighborhood Health Center	7140 Indiana Avenue Riverside, CA 92504		M-F 7:30 am – 5:00 pm

Provider Name	License# and NPI	Phone/Fax	Type
1.Daniel D. Pearce, D.O.	20A5464/1376635383	951-358-6000 951-358-6044	Internal Medicine HIV/AIDS

ATTACHMENT D

OFFICERS, OWNERS, STOCKHOLDERS AND CREDITORS

COUNTY OF RIVERSIDE

List, by category, all of the above:

Name	Title	*Ownership % (as applicable)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

* If corporation is publicly traded on a US stock market, indicate "Publicly Traded Corp."
Please indicate how your organization is legally organized (circle one):

Corporation Partnership Sole Proprietorship

Other (please describe):

ATTACHMENT E

MEDICARE

COUNTY OF RIVERSIDE

I. DEFINITIONS

1.1. Downstream Entity means all entities or individuals below the level of the First Tier Entity (e.g., individual providers that contract with an IPA or Administrative Service Entities), typically referred to as subcontractors, related entities, and management companies. Downstream Entity shall also be referred to a Provider for the purposes of this Addendum.
1.2. End Stage Renal Disease (ESRD) – means members who require kidney dialysis for the remainder of life.
1.3. First Tier Entity means the contracted provider, which is the first level of contractor with the Health Plan (e.g., Individual Practice Association (IPA), Hospital, Physician, Specialist, Ancillary Provider or Physician Hospital Association (PHO) who or which has a direct contract with Health Plan.
1.4. Centers for Medicare and Medicaid Services (CMS) means the agency within the Department of Health and Human Services that administers the Medicare Program.
1.5 CMS Agreement means the Medicare Advantage contract between CMS and the MAO.
1.6 Medicare Advantage Organization means a Health Plan or Provider Sponsored Organization who has entered into an agreement with the CMS to provide Medicare beneficiaries with health care options.
1.7 Member means an individual who has enrolled in or elected coverage through a MAO.
1.8 Provider means a First Tier Entity for the purposes of this Addendum.

II. ACCESS: RECORDS AND FACILITIES

Provider agrees:

2.1. To give the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and the General Accounting Office (GAO) or their designees the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of subcontractors, or related entities for the later of ten (10) years, or for periods exceeding ten (10) years, for reasons specified in the federal regulation. (422.504(e)(2),(3)(4)); (422.504(i)(2)(ii)
2.2. To safeguard the privacy and confidentiality of any information that identifies a particular Member and to maintain and ensure that accuracy of such records in an accurate and timely manner. (422.118)
2.3 To comply with MAO's standards for timeliness for appointments and waiting times for each type of service.

III. ACCESS: BENEFITS & COVERAGE

Provider agrees:

3.1. To not discriminate based on health status. (422.110(a)
3.2. To pay for emergency and urgently needed services consistent with federal regulations, if such services are Provider's liability. (422.100(b)

3.3 To pay for emergency and urgently needed services and renal dialysis services for Members temporarily outside the service area consistent with federal regulations, if such services are Provider's liability. (422.100(b)(1)(iv)

3.4. To direct access to mammography screening and influenza vaccinations. (422.100(g)(1)

3.5. To not collect any co-payment or other cost sharing for influenza vaccine and pneumoccal vaccines. (422.100(g)(2)

3.6. To direct access to in-network women's health provider for women for routine and preventative services. (422.112(a)(3)

3.7. To have approved procedures to identify assess and establish a treatment plan for Members with complex or serious medical conditions. (422.112(a)

3.8 To provide access to benefits in a manner described by CMS. (422.112(a)(8)

3.9 To maintain procedures to inform and educate Subscribers Member of follow-up care requirements or provide training in self care as deemed medically necessary by Provider.

IV. MEMBER PROTECTIONS

Provider agrees:

4.1. To work with the MAO regarding conducting a health assessment of all new Members within ninety (90) days of the effective date of enrollment. (422.112(b)(5)

4.2. To provide all covered benefits in a manner consistent with professionally recognized standards of health care. (422.504(a) (3)(iii)

4.3 To comply with all confidentiality and Member record accuracy requirements. (422.504(a)(13); 422.118))

4.4 To document in a prominent place in the medical record whether or not an individual has executed an advance directive. (422.128(b) (1)(ii)(E)

4.5 To hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or capitated provider organization. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or intermediary, shall Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision also does not prohibit collection of applicable coinsurance, deductibles, or copayments, as specified in the Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. (422.504(g)(1)(i); (422.504(i)(3)(i)

4.6 If the CMS Agreement is terminated or is not renewed or the MAO becomes insolvent, to protect Members who are hospitalized from loss of benefits through the discharge date and through the period of time CMS premiums are paid. (422.504(g)(2)(i); 422.504(g)(2)(ii) and 422.504(g)(3).

4.7 Provider shall address the special needs of Members who are members of specific ethnic and cultural populations such as, but not limited to, the Vietnamese and Latino populations.
Provider shall in its policies, administration, and services practice the values of (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive environment where difference are valued, respected and managed; (d) through cultural diversity training, foster in staff and/or providers' attitudes and interpersonal communication styles which respect Member's cultural backgrounds; and (e) referring members to culturally and linguistically appropriate community services program. In addition, Provider shall provide translation of written materials in the languages served.

Written materials to be translated include, but are not limited to, signage, the member service guide, enrollee information, notices, marketing information and welcome packages. (422.112(a)(8)

4.8 To educate patients regarding their health needs; share findings of the members' medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms; recognize that the member has the final say in the course of action to take among clinically acceptable choices.

4.9 To not encourage disenrollment of a member because of the onslaught of ESRD.

V. DELEGATION

Provider agrees:

5.1. To perform and maintain delegated functions consistent with MAO's contractual obligations under the CMS Agreement. (422.504(i)(3)(iii)

5.2 To comply with MAO's policies and procedures as set forth in the Medicare Advantage Participating Provider Operations Manual, including, without limitation, provisions that (i) provide for revocation of the delegated activities or other remedies in instances where MAO determines that Provider and/or delegated parties have not performed satisfactorily, (ii) specify that the performance of Provider and/or delegated parties shall be monitored by MAO on an ongoing basis, (iii) specify that the credentials of medical professionals affiliated with Provider and/or delegated parties will be either reviewed by MAO or the credentialing process will be reviewed and approved by MAO and MAO shall audit the credentialing process on an ongoing basis, and (iv) specify that Provider and/or delegated parties, in the performance of such delegated activities, shall comply with all applicable Medicare laws, regulations, and CMS instructions. (422.504(i)(4)

VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

6.1. To include, when applicable, specific payment and incentive arrangements in agreement with all Downstream Entities. (422.208)

6.2. To pay claims promptly according to CMS standards and comply with all payment provisions of state and federal law. CMS requires non-contracted Provider claims to be paid within thirty (30) days of receipt and contracted Provider claims to be paid within sixty (60) days of receipt. (422.520(b).

6.3. That Members health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.

VII. REPORTING AND DISCLOSURE

Provider agrees:

7.1. To submit to MAO all data, including medical records, necessary to characterize the content and purpose of each encounter with Member. (422.310(b)

7.2 To submit and certify the completeness and truthfulness of all encounter data. (422.504(a)(8)

7.3 To adhere to and comply with all reporting requirements as set forth in 42 C.F.R. 422.516 and the requirements in 42 C.F.R. 422.310. (422.504(a)(8)

VIII. QUALITY ASSURANCE / QUALITY IMPROVEMENT

Provider Agrees:

8.1. To cooperate with an independent quality review and improvement organization's activities pertaining to provision of services for Members. (422.152(a)

8.2 To comply with MAO's medical policy, Quality Assurance program, and Medical Management program. (422.152)

IX. COMPLIANCE

Provider agrees:

9.1. That the MAO or First Tier Entity must notify any Provider, in writing, of the reason(s) for denial, suspension or termination determinations that affect health care professionals. (422.202(d)(1)

9.2. To provide both the First Tier Entity and the MAO at least 60 days written notice before terminating a contract without cause. (422.202(d)(4)

9.3. To meet the requirements of all other laws and regulation, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds. (422.504(h)(1)

9.4. To comply with (and require that all Downstream Entities comply with) all applicable MAO procedures and IEHP Health Advantage Participating Provider Operations Manual including, but not limited to, the accountability provisions. (422.504(i)(3)(ii).

9.5. To comply with and require that all Downstream Entities comply with applicable state and Federal laws and regulations, including Medicare laws and regulations and CMS instructions. (422.504(i)(4)(v)

9.6. To not employ or contract with (and require that all Downstream Entities not employ or contract with) individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. (422.752(a)(8)

9.7 To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Members, including gathering and forwarding information on appeals to MAO, as necessary. (422.562(a)

9.8 To adhere to all guidelines and requirements for marketing as set forth by CMS. This includes, but is not limited to, discouraging Providers from (423.2268):

- 9.8.1. Attempting to explain MCO membership and costs;
- 9.8.2. Being the exclusive source of membership information;
- 9.8.3. Acting as Agents of the Plan;
- 9.8.4 Acting outside their role as medical providers of care;
- 9.8.5 Discriminating in favor of "healthy" patients.

9.9 Providers may do the following:

- 9.9.1 Display plan-marketing materials for all plans with which the Provider participates, or display materials for those plans that provide them;
- 9.9.2 Cooperatively advertise and market with Plan.

X. ADOPTION OF MEDICARE CONTRACT REQUIREMENTS

Provider agrees:

10.1. That all contracts must be signed and dated.

10.2. To serve Members during the term of this Addendum.

10.3. To comply with the regulatory requirements and MAO's guidelines promulgated by Medicare, which are more fully documented in MAO's policies, procedures, and manuals (422.202(b) or comply with Medicare laws, regulations and CMS instructions which are more fully documented in MAO's policies, procedures and manuals. (422.202(b) (422.504(i)(4)(v)

Except as provided in this Addendum, all other provisions of the Agreement between MAO and First Tier Entity not inconsistent herein shall remain in full force and effect. This Attachment shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall terminate upon the termination of such Agreement.

XI. For purposes of Medicare Members, the provisions of this Attachment E and Federal Law shall prevail.