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

137

FROM: Riverside County Regional Medical Center

SUBMITTAL DATE: August 28, 2012

SUBJECT: Approval of the Ancillary Services Agreement with Borrego Independent Physician Association for hospital services

RECOMMENDED MOTION: Move that the Board of Supervisors:

1) Ratify the Ancillary Services Agreement with Borrego Independent Physician Association, effective July 1, 2012; and
2) Authorize the Chairperson to sign three (3) copies of the agreement; and
3) Direct the Clerk of the Board to return all three (3) copies of the signed originals to Riverside County Regional Medical Center Administration. Upon final execution of the agreement, a fully executed agreement will be returned to the Clerk of the Board.

BACKGROUND: The Borrego Independent Physician Association has approached Management at

(continued on Page 2)

Douglas D. Bagley, Hospital Director

FINANCIAL DATA				
Current F.Y. Total Cost:	$ 0	In Current Year Budget:	Yes
Current F.Y. Net County Cost:	$ N/A	Budget Adjustment:	No
Annual Net County Cost:	$ 0	For Fiscal Year:	2012/2013

SOURCE OF FUNDS: Revenue from payor for health care services provided

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

C.E.O. RECOMMENDATION: APPROVE

BY: Debra Cournoyer

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 8/6/12

Departmental Concurrence

☐ Consent ☒ Policy — Dep't Recomm.:

☐ Consent ☒ Policy — Per Exec. Ofc.:

Prev. Agn. Ref.: | **District:** All | **Agenda Number:** 3.82

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

SUBJECT: Approval of the Ancillary Services Agreement with Borrego Independent Physician Association for hospital services

BACKGROUND:

Riverside County Regional Medical Center (RCRMC) to negotiate an Agreement, as a result of the expansion of their medical network to Moreno Valley, This Agreement is applicable to Inland Empire Health Plan (IEHP) members enrolled with Borrego Independent Physician Association that are referred to RCRMC for medical services.

Completion of this agreement serves to advance the Hospital's objective to develop relationships that maintain the Hospital's managed care medi-cal enrollment base. IEHP members will be able to choose primary care providers affiliated with Borrego Independent Physician Association and designate RCRMC as their assigned Hospital. The rates provided in this agreement allow for the recovery of cost for services provided to IEHP members referred by the Borrego Independent Physician Association.

REVIEW/APPROVAL:

County Counsel has approved the agreement as to legal form.

DB:cg

ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement ("Agreement") is made and entered into as of the later of July 1, 2012, or the date this Agreement is fully executed by both parties ("Effective Date"), by and between Riverside County Regional Medical Center ("Hospital"), and Borrego Independent Physician Association ("Group"), with reference to the following facts:

A. Group has entered into Provider Agreements with certain Health Plans, which Provider Agreements require Group to provide or arrange for the provision of Ancillary Services to Members.

B. Group desires to engage Hospital to provide Ancillary Services to Members and Hospital is willing to provide Ancillary Services in accordance with the terms of this Agreement.

Based on the above facts, Group and Hospital agree as follows:

1. DEFINITIONS

1.1 Ancillary Services means those health care services (a) that are ancillary to the professional services provided by Group Physicians, (b) for which Group has accepted financial risk and (c) that Group has agreed to make available to Members. A list of Ancillary Services that Hospital is agreeing to provide to Members, including the Reimbursement Rates, is included in Exhibit A.

1.2 Group Physician means a physician who is employed by or contracted to Group for purposes of providing professional services to Members of Health Plans.

1.3 Health Plan means any of the Knox-Keene Act licensed health plans identified in Exhibit B.

1.4 Knox-Keene Act means the Knox-Keene Health Care Service Plan Act of 1975, as amended.

1.5 Member means an individual who (a) is entitled to receive health care services pursuant to an agreement with a Health Plan, and (b) has been assigned to Group (or a Group Physician) for care, pursuant to the terms of the applicable Provider Agreement.

1.6 Provider Agreement means each of those professional services agreements between Group and Health Plan.

1.7 Reimbursement Rate means the gross reimbursement rate at which Hospital has agreed to provide a particular Ancillary Service, as more particularly set forth in Exhibit A.

1.8 Emergency Services means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery of a Member by a physician necessary to relieve or eliminate the Emergency Medical Condition provided in accordance with the federal Emergency Medical Treatment and Active Labor Act. For purposes of this Agreement, Emergency Medical Condition shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, which may included severe pain or other acute symptoms, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (b) serious impairment to a bodily organ or part; or (c) serious

dysfunction of any bodily organ or part. With respect to pregnant women, an emergency medical condition exists when there is: (a) inadequate time to effect safe transfer to another facility prior to delivery; (b) transfer may pose a threat to the health or safety of the patient or fetus, or; (c) evidence of onset of uterine contractions or rupture of the membranes.

1.9 Billed Charges means the total charges for services rendered by Hospital as set forth in the Hospital's internally established chargemaster in effect on the date the services are rendered, considered Hospital's usual and customary charges; such charges are not dependent upon a governmental or payor fee schedule.

1.10 Clean Claim means a paper or electronic billing instrument that consists of a complete UB-04 or CMS 1450, as applicable, data set or their respective successor forms, with entries stated as mandatory by the National Uniform Billing Committee and with respect to electronic claim forms, completed in the format and with the data content and data conditions specified in HIPAA.

2. HOSPITAL OBLIGATIONS

2.1 Ancillary Services. Hospital will provide Ancillary Services to Members on an "as needed basis" as directed by Group Physicians. Ancillary Services will be provided to the same extent, and subject to the same scheduled availability, as these services are generally available to all of Hospital's other patients.

2.2 Licensing. Hospital agrees to maintain its certifications, accreditations and all other licenses required by law during the term of this Agreement. Evidence of such licenses, certifications, and accreditations will be submitted to Group upon request. Hospital will promptly notify Group in writing of any material action against any of its licenses, its accreditation by JCAHO, any change of ownership, or any other situation that could materially impair the ability of Hospital to carry out its responsibilities under this Agreement.

2.3 Personnel. Hospital will provide all required licensed technicians and medical non-physician personnel necessary to perform Ancillary Services.

2.4 Non-Discrimination. Hospital agrees to provide Ancillary Services presently available at Hospital to Members in the same manner that Hospital provides such services to all of its other patients.

2.5 Billing. Hospital will bill Group for all Ancillary Services provided to Members, except for applicable co-payments and deductible payments that are required to be collected by Hospital. In a manner consistent with Hospital's customary billing practices, Hospital will complete a UB-92 form (or other form acceptable to both parties) for the Ancillary Services rendered. In all instances, Hospital will exercise reasonable efforts to transmit the initial invoice to Group promptly after completion of the Ancillary Services.

2.6 Verification of Eligibility. Hospital will attempt to obtain from Health Plan verification of the eligibility of all Members who receive Ancillary Services, in the manner set forth in Article 4 below.

2.7 Hospital Liability Insurance. Hospital, at its sole cost and expense, will procure and maintain policies of general liability and other insurance, or programs of self-insurance, necessary to insure Hospital and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with this Agreement. A copy of such insurance policies will be provided to Group upon its request.

2.8 No Restrictions on Establishment of Other Relationships. Hospital will not preclude or restrict in any way Group or Group Physicians from (a) establishing staff privileges at any non-EMC facility.

3. GROUP OBLIGATIONS

3.1 Compensation. Group will compensate Hospital for Ancillary Services provided to Members in accordance with Article 5 of this Agreement.

3.2 Authorization and Eligibility Verification. Group will provide and participate in a prospective authorization process as set forth in Article 4 below.

3.3 Use of Name. Group may use Hospital's name, mailing address, web mail address, telephone number, and any other relevant information in informational material distributed to Members in order to identify participating hospitals of health care services. Upon expiration or termination of this Agreement, Group agrees to remove Hospital's name from all its provider directories and correspondence with Members. Group is not authorized to use Hospital's name for advertising or any other purpose without Hospital's prior written consent.

3.4 Group Liability Insurance. Group, at its sole cost and expense, will procure and maintain policies of general liability and other insurance, or programs of self-insurance, necessary to insure Group and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with this Agreement. A copy of such insurance policies will be provided to Hospital upon its request.

3.5 Group Representation. Group represents to Hospital:

(a) Neither Group nor any Group Physician is bound by any agreement or arrangement which would preclude Group or any Group Physician from entering into, or from fully performing Group's obligations under this Agreement;

(b) No Group Physician's license to practice medicine in the State or in any other jurisdiction and no Group Physician's Drug Enforcement Agency number has ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or restricted in any way;

(c) No Group Physician's medical staff privileges at any health care facility has ever been denied, suspended, revoked, terminated, relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

(d) Group and each Group Physician shall perform Group's duties under this Agreement in accordance with: (1) all applicable federal, state, and local laws, rules and regulations; (2) all applicable standards of the Joint Commission on Accreditation of Healthcare Organizations and any other relevant accrediting organizations, and (3) all applicable bylaws, rules, regulations, procedures, and policies of Hospital and its medical staff;

(e) Neither Group nor any Group Physician has in the past conducted, and is not presently conducting, its or his/her medical practice in such a manner as to cause Group or nor any Group Physician to be suspended, excluded, debarred or sanctioned under the Medicare or Medicaid Programs or by any government licensing agency, and has never been charged with or convicted of an offense related to health care, or listed by a federal agency as debarred, excluded or otherwise ineligible for federal program participation;

(f) The compensation paid or to be paid by Group to any Group Physician is and will, at all times during the term of the Agreement, be fair market value for services actually provided by such Group Physician, not taking into account the value or volume of referrals or other business generated by such Group Physician for Hospital. Group represents to Hospital that Group has and will at all times maintain a written agreement with each Group Physician receiving compensation from Group that is not an employee of Group (e.g., each non-employed independent contractor), which written agreement is or will be signed by the parties, and does or

will specify the services covered by the arrangement. Group further represents that with respect to employees of Group with which Group does not have a written employment agreement, the employment arrangement is or will be for identifiable services and is or will be commercially reasonable even if no referrals are made to Group by the employee. Further, Group shall comply with all relevant claims submission and billing laws and regulations.

(g) To the extent the Agreement includes payment for services rendered to Medicare Advantage Members, Group represents and warrants: (1) that Group has contracted directly with a Medicare Advantage Plan ("MA Plan") that receives a capitated payment from Medicare for all services that Group provides directly or indirectly, including services provided pursuant to this Agreement with Hospital; (2) that said MA Plan has provided assurances to Group that CMS approved its cost-sharing arrangements for Medicare beneficiaries; (3) that in establishing the terms of its contract with the MA Plan, neither party gave or received remuneration in exchange for, or to induce, the provision or acceptance of business for which payment may be made by a federal health care program on a fee-for-service basis; and (4) that Group's contract with said MA Plan (i) is in writing and signed and has a term of at least one year, (ii) specifies the items and services covered, (iii) prohibits Group from seeking payment in any form, directly or indirectly, from a Federal health care program for services provided under such contract; and (iv) prohibits Group from shifting the cost of such contract to other federal health care programs.

Each of the representations and warranties set forth herein shall be continuing and in the event any such representation or warranty fails to remain true and accurate during the term of this Agreement, Group shall immediately notify Hospital.

3.6 Exclusion List Screening. Group understands it is obligated to screen all of its current and prospective owners, legal entities, officers, directors, employees, contractors, and agents ("Screened Persons") against (a) the United States Department of Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities (available through the Internet at http://www.oig.hhs.gov of Parties Excluded from Federal Programs (available through the Internet at http://www.epls.gov) (collectively, the "Exclusion Lists"), to ensure that none of the Screened Persons are (1) currently excluded, debarred, suspended, or otherwise ineligible to participate in Federal healthcare programs, (2) in Federal procurement or nonprocurement programs, or (3) have been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but have not yet been excluded, debarred, suspended, or otherwise declared ineligible (each, an "Ineligible Person"). If, at any time during the term of this Agreement, any Screened Person becomes an Ineligible Person, or is proposed to be an Ineligible Person, Group shall immediately notify Hospital of the same.

4. ELIGIBILITY AND AUTHORIZATION

4.1 Group Information; Cooperation. Group agrees that the information provided on the attached Exhibit C is accurate and complete, including the phone number of the party responsible for verifying Member eligibility, and the address to which Hospital should submit its claims for payment. Group will contractual1y obligate or otherwise require its Group Physicians to confirm for Hospital in writing, upon request for authorization, the following: (a) a Member's affiliation with Group; (b) a Member's correct billing address; and (c) the authorization number and any other billing reference required for Group to process payment.

4.2 Verification of Eligibility; Authorization. Hospital will attempt to obtain from Group verification of the eligibility of all Members who receive Ancillary Services pursuant to this Agreement. If eligibility verification is not possible prior to the provision of Ancillary Services, Hospital wm request such verification at the earliest possible opportunity; provided however, that Hospital will not be required to obtain Group's approval prior to rendering emergency services to Members. Group is responsible for providing (a) verification that a Member is eligible to receive Ancillary Services, and (b) authorization for Hospital's provision of Ancillary Services to Member.

4.3 Guaranty of Eligibility and Authorization. Any verification or confirmation provided by Group relating to eligibility, scope of Ancillary Services authorized, or the amount of applicable co-payments and deductibles, will be conclusive. If Group determines that a Member previously verified as eligible was, in fact, not eligible for Ancillary Services, or Group withdraws its authorization for Ancil1ary Services that were medically necessary, Hospital has the right to continue to bill Group for the provision of the Ancil1ary Services so authorized, and Group must pay Hospital for the Ancillary Services under the terms of this Agreement. Group will not be relieved of its payment responsibility unless and until either (a) Hospital can make a medical1y appropriate transfer of Member to another facility or (b) payment arrangements are made with Member that are acceptable to Hospital. Group will be responsible for payment for any services provided by Hospital prior to such transfer.

4.4 No Denial of Payment.

Group may not deny payment for Ancillary Services that were provided without prior authorization if:

1) The Ancillary Services were provided in the case of an emergency;
2) Group's eligibility verification or authorization for services was not available in a timely manner; or
3) On respective review, the provision of such ancil1ary services is determined to have deemed medically appropriate

Group may not retroactively deny payment for Ancillary Services that were provided with prior authorization unless it can show that Hospital provided incorrect information or withheld pertinent information upon which authorization was granted.

5. COMPENSATION

5. 1 Payment and Late Payment.

A. All claims for Anci1lary Services rendered to Members under this Agreement will be paid directly to Hospital by Group at the Reimbursement Rates set forth on Exhibit A (less applicable copayments and deductibles that Hospital is required to collect). Payment is required within forty-five (45) calendar days of Group's receipt of a Clean Claim from Hospital at the address provided in Exhibit C. Group agrees to pay these Reimbursement Rates regardless of any other agreement between Group and any other parties or any agreement between Hospital and the Health Plan.

B. If Group fails to pay Hospital within this period, the Reimbursement Rates set forth on Exhibit A will cease to be available to Group, and Group will be required to immediately reimburse Hospital 60% of Hospital's full Billed Charges. If Group does not immediately reimburse Hospital, then, in addition to any interest due to Hospital under state or federal law, a late payment fee will accrue at the rate of one and one-half percent (1.5%) per month (subject to a cap of the maximum rate permitted by law) on the claim amount, until the claim is paid.

C. Within twelve (12) months following receipt of payment of a claim, Hospital may contest the amount of the payment as being inconsistent with the terms of this Agreement and may recover any amounts underpaid by Group. If Hospital does not contest the amount of a claim payment within this time period, then the payment received wi1l be conclusively deemed appropriate.

5.2 Coordination of Benefits.

(a) If Group (or the applicable Health Plan) is primary under the applicable coordination of benefits

rules, Group will pay Hospital the full Reimbursement Rates required under this Agreement (less applicable co-payments and deductibles). If Hospital obtains any additional payments from secondary payors under the applicable coordination of benefits rules, Hospital will be entitled to keep those funds in addition to the fees paid by Group.

(b) If Group (or the applicable Health Plan) is not primary under the coordination of benefits rules, Group will pay Hospital only those amounts which, when added to amounts paid to Hospital from other sources, equal the Reimbursement Rates required under this Agreement.

(c) Nothing contained in this Agreement is intended to restrict or otherwise affect Hospital's right to seek to recover its full Billed Charges from a third-party payor other than Group. In addition, it is the intent of this provision that, when the coordinating payors determine their benefit payments on the basis of negotiated rates, the allowable expense billable by Hospital to the payors, in the aggregate, is the highest of the negotiated rates.

5.3 Financial Audits; No Offsets. Group does not have the right to offset any amount it believes that Hospital owes to Group against any of Hospital's other outstanding accounts, contracts, or claims. Group will have the right to audit any claims that it believes it may have overpaid, and may seek recovery of an overpayment by providing justification for the recovery to the reasonable satisfaction of Hospital. Group's right to seek recovery for overpayment will be limited to only those payments made within the six (6) months immediately prior to the date of the request for recovery.

5.4 Third Party Liability. If a third party other than Group is responsible for payment for the provision of Ancillary Services to a Member, Hospital reserves the right to obtain reimbursement from such third parties at Hospital's full Billed Charges. For example, this may occur if a Member is eligible to receive health care benefits from another benefit plan or if a Member has made a claim or filed an action to recover damages against a third party, including from a workers' compensation payor. If Hospital receives payment from a third party after it has received a payment from Group on the same account, Hospital will reimburse Group all appropriate amounts that Group had previously paid.

5.5 Hospital's Right to Bill Health Plans. If Group does not make a timely payment for Ancillary Services, Hospital may (without prejudice to its rights under this Agreement) bill the relevant Health Plan directly. If the Health Plan pays for the Ancillary Services on behalf of Group, and if Hospital and the Health Plan have entered into a separate agreement pursuant to which Hospital provides services to the Health Plans' members, the Health Plan must pay Hospital at the rates set forth in such separate agreement. The Reimbursement Rates identified in this Agreement are available only to Group and are not available to any Health Plan for any reason.

5.6 Conflict of Agreements. All oral and written agreements, contracts, understandings or arrangements related to the subject matter of this Agreement, including, but not limited to, Reimbursement Rates for Ancillary Services provided to Members, which may have been made or entered into between Hospital and Group, are terminated and replaced entirely with this Agreement. However, the parties agree that, in the event that the Reimbursement Rates set forth in this Agreement conflict with rates set forth in another enforceable agreement between the parties, the higher compensation rates will apply.

6. RECORDS

6.1 Maintenance. Hospital agrees to maintain its medical records in accordance with all applicable federal and state statutory and regulatory requirements for each Member in the same manner they are maintained for other Hospital patients.

6.2 Access. Hospital will provide Group with access, upon five (5) business days prior written notice and during customary business hours, to those claim and payment records relating to Ancillary Services

provided to Members.

6.3 Confidentiality. Hospital and Group agree that information concerning Members and the proprietary information and trade secrets of Hospital and of Group, including without limitation the Reimbursement Rates set forth in this Agreement, will be kept confidential and will not be disclosed to any person except as required by law.

6.4 Hospital Property. Group acknowledges that all financial records, corporate records, patient records, medical files, written procedures and other such items created by, compiled, or added to by Hospital or its employees in connection with the provision of Ancillary Services to Members will remain the property of Hospital and will not be removed or transferred from Hospital except in accordance with applicable laws and Hospital's policies.

7. TERM AND TERMINATION

7.1 Term. This Agreement will commence on the Effective Date and will remain in effect for an initial term of twelve (12) months. Thereafter, this Agreement will automatically renew for additional twelve (12) month terms, unless earlier terminated as provided herein.

7.2 Termination Without Cause. After the twelve (12) month initial term, either party may terminate this Agreement at any time, without cause, upon sixty (60) days' prior written notice delivered to the other party.

7.3 Termination With Cause. Either party may terminate this Agreement with cause upon thirty (30) calendar days' prior written notice delivered to the other party, if the other party breaches any material provision of this Agreement and such breach is not cured to the satisfaction of the non-breaching party within this thirty (30) calendar day period.

7.4 Immediate Termination by Hospital. Upon occurrence of any of the following events, Hospital may immediately terminate this Agreement by written notice to Group, if:

(a) Group fails to make any monetary payment to Hospital within the applicable time frame set forth in this Agreement.

(b) Group fails to maintain adequate professional and general liability insurance coverage, or to immediately replace coverage that is canceled or otherwise terminated.

(c) Group or any Group Physician is convicted of a criminal offense related to health care; or Group or any Group Physician is listed by a federal agency as being debarred, excluded, or otherwise ineligible for federal program participation.

(d) A petition is filed to declare Group bankrupt or for reorganization under the bankruptcy laws of the United States; a receiver is appointed over all or any portion of Group's assets; or Group fails to meet and maintain any state or federal required solvency standards, if any.

(e) Closure of Hospital, cessation of the patient care operations or sale of Hospital or of all, or substantially all, of Hospital's assets.

(f) Failure to amend this Agreement within the time frame set forth in Subsection 5.1 (d) to include Reimbursement Rates consistent with a Fair Market Value Report obtained in accordance with Subsection 5 .1 (d).

8. COMPLIANCE WITH LAW; KNOX-KEENE ACT REQUIREMENTS

8.1 Compliance with Applicable Law. The parties will comply with relevant Federal, state and local laws, statutes, ordinances, orders and regulations that are applicable to the terms and conditions of this Agreement, including,

but not limited to, all applicable Medicare Advantage laws and regulations, including those provisions required by the Centers for Medicare and Medicaid Services ("CMS," formerly known as "HCF A") to comply with the Balanced Budget Act of 1997 as detailed in Exhibit D.

8.2 Changes in Law. Each party will have the right to request an amendment to this Agreement in the event that there is any change or modification in the laws, regulations or rules of Medicare or Medicaid in a manner that materially affects any of the provisions of this Agreement or in the event that any other governmental or nongovernmental agency, or any court or administrative tribunal, publishes or issues any law, regulation, rule, judgment or other communication that materially affects any of the provisions of this Agreement. In the event one party provides notice of request to amend, the parties will negotiate in good faith to attempt to amend those terms of the Agreement that are affected by the change or modification. If the parties cannot agree on an amendment, the party providing notice of request may terminate this Agreement for cause.

8.3 **Knox-Keene Act Requirements.**

(a) No Surcharges.

(1) In no event, including but not limited to nonpayment by Group, Group's insolvency or breach of this Agreement will any Member be liable for any sums owed to Hospital by Group, and Hospital will not bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any recourse against, or make any surcharge upon, a Member or other person acting on a Member's behalf. This provision will not prohibit collection of co-payments, payment for non-covered services or coordination of benefit revenues from secondary carriers by which Member is covered. If Group receives notice of any surcharge upon a Member, it will be empowered to take appropriate action.

(2) The obligations set forth in this Section 8.3 will survive the termination of this Agreement regardless of the cause giving rise to such termination and will be construed for the benefit of Member, and the provisions of this Section 8.3 will supersede any oral or written agreement to the contrary now existing or later entered into between Hospital and Member or persons acting on behalf of either of them.

(b) Obligations Following Termination.

(1) Obligations Following Termination. Upon expiration or termination of this Agreement, Hospital agrees to continue to provide Ancillary Services to any Member who is under the care of Hospital on the expiration or termination date until the services being rendered are completed or until such Member is transferred to another facility. Group agrees to compensate Hospital during this continuation of care period at the Reimbursement Rates set forth in this Agreement.

(2) Records. Hospital will maintain such records and provide such information to Group, the applicable Health Plan, or to the Commissioner of the Department of Managed Health Care ("Commissioner"), as may be necessary for compliance with the provisions of the Knox-Keene Act, and the applicable rules and regulations, and will retain all such records for the time required by law. Hospital's obligations to retain records and provide information will not terminate upon the termination of this Agreement, whether by rescission or otherwise.

(c) Access to Information.

(1) Group, the Commissioner and any Health Plan contracting with Group will have access at reasonable times, upon five (5) business days advance written notice, to the books,

records and papers of Hospital relating to Ancillary Services provided to Members.

(2) Group will warrant that prior to requesting a Member's medical records, it will obtain a valid written release from Member (or his or her legal representative) authorizing Group to obtain his or her medical records and will hold harmless, indemnify, and defend Hospital from any liability incurred by Hospital as a result of such medical record release. In addition, Group will pay Hospital its usual fees for copying services.

9. GENERAL PROVISIONS

9.1 Notice. Any notice required to be given under this Agreement will be in writing and must be sent by certified mail, return receipt requested to the addresses listed below or such other address as may be later designated in writing by either party. Any correspondence sent to an address other than the ones listed below will not be adequate notice under this Section 9.1.

To Group:
Borrego IP A
955 Harbor Island Drive, Suite
155
San Diego, CA 92101
Attention: Alfredo Ratniewski, M.D.

To Hospital:
Riverside County Regional Medical
Center 26520 Cactus A venue
Moreno Valley, CA 92555
Attention: Douglas D. Bagley, CEO

Copy: Contracts Administration

Any party may change their address by giving the other party written notice of the new address in the manner set forth above.

9.2 Non-Exclusive. Nothing in this Agreement will preclude Hospital from participating in or contracting with any other medical Group, preferred provider organization, health maintenance organization, insurer or otherwise, whether before, during or subsequent to this Agreement.

9.3 Dispute Resolution. In the event a dispute arises out of the interpretation, performance or breach of this Agreement, the parties will meet and negotiate in good faith to resolve the dispute.

9.4 Unforeseeable Events. If the operations of Hospital are substantially interrupted by an act of war, fire, insurrection, strike, riots, earthquakes or other acts of nature of any cause that is not the fault of Hospital or is beyond the reasonable control of Hospital, Hospital will be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

9.5 No Third Party Beneficiaries. The parties agree that this Agreement is not intended to be a "third party beneficiary" contract and will not, in any manner whatsoever, establish rights in any third parties, increase the rights of any Member with respect to Group, or the duties of Group to any Member, or create any rights on behalf of Members with respect to Hospital. Additionally, the Reimbursement Rates in this Agreement are available only to Group, and no third party will be entitled to access such rates through Group without

the written consent of Hospital.

9.6 Assignment. Group may not assign any of its rights or delegate any of its duties under this Agreement to any person or entity without first obtaining the written consent of Hospital. Specifically, under no circumstances will Group be permitted to assign or otherwise make available to any third party, the Reimbursement Rates set forth in this Agreement. Hospital may grant or withhold such consent to Group's assignment of rights or delegation of duties in Hospital's sole and absolute discretion. Any attempted assignment that does not comply with the provisions of this Section will be void and of no effect. Notwithstanding the above, Hospital may assign this Agreement to its affiliates without prior written consent of Group.

9.7 Governing Law. This Agreement will be governed in all respects by the laws of the state of California.

9.8 Severability. If any provision of this Agreement is held illegal, invalid or unenforceable under present or future laws effective during the term of this Agreement, such provision will be fully severable. This Agreement should be construed and enforced as if such illegal, invalid or unenforceable provision had never existed and the remaining provisions will remain in full force and effect, unaffected by such severance, provided that the invalid provision is not material to the overall purpose and operations of this Agreement.

9.9 Waiver. A waiver of any of the provisions of this Agreement should not be construed as a waiver of any other provision, nor will any waiver constitute a continuing waiver. No waiver will be binding on Hospital unless executed in writing by an authorized representative of Hospital. All rights and remedies provided in this Agreement are cumulative and not exclusive.

9.10 Amendment. Revisions, modifications, or amendments to any of the terms of this Agreement will not be effective except by a written amendment signed by an authorized representative of Group and Hospital.

9.11 Referrals. The parties acknowledge none of the benefits granted to Group is conditioned on any requirement that Group make referrals to, be in a position to make or influence referrals to, or otherwise generate business for Hospital. The parties further acknowledge that Group Physicians are not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other facility of Group's choosing.

9.12 Indemnification. In connection with the obligations imposed by this Agreement, GROUP agrees to indemnify and hold harmless Hospital, its respective directors, officers, Board of Supervisors, agents, employees, and independent contractors from any and all liability whatsoever, based or asserted upon any act, omission of GROUP, its directors, officers, agents, employees, independent contractors, or subcontractors arising out of or in any way relating to this Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the actions of GROUP its officers, agents, employees, subcontractors, agents or representatives from this Agreement. Hospital agrees to indemnify and hold harmless Group, its respective directors, officers, Board of Directors, agents, employees, and independent contractors from any and all liability whatsoever, based or asserted upon any act, omission of Hospital, its directors, officers, agents, employees, independent contractors, or subcontractors arising out of or in any way relating to this Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the actions of Hospital, its officers, agents, employees, subcontractors, agents or representatives from this Agreement.

9.13 Entire Agreement. This Agreement constitutes the entire agreement between the parties for the provision of Ancillary Services to Members by Hospital and supersedes any and all oral or written communications or proposals not expressly included in this Agreement.

9.14 Representation by Counsel; Interpretation. Each of Group and Hospital acknowledges that it has been

represented or has been given the opportunity to be represented by counsel in connection with this Agreement. Accordingly, any rule of law that would require interpretation of any claimed ambiguities in this Agreement against the party that drafted it has no application and is expressly waived. The provisions of this Agreement will be interpreted in a reasonable manner to affect the intent of Group and Hospital. Group and Hospital further acknowledge that the pricing and price related terms of this Agreement have been negotiated on an arms' length basis, without consideration of any referral or potential referral of patients by Group or Group Physicians to Hospital outside this Agreement.

9.15 The Parties shall observe all Federal, State, and COUNTY laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and any subsequent revisions thereto, concerning the security and privacy of patient records and information.

9.16 Authorized Representative of Hospital. For the purposes of this Agreement, Hospital's Chief Executive Officer and Chief Operations Officer are the only individuals authorized to act on behalf of Hospital in executing any written supplement, amendment or modification to this Agreement, or in granting any written consent, approval or waiver required under this Agreement.

By their signature below, each party agrees to be bound by the terms of this Agreement, including the attached Exhibits.

Hospital:
By: [signature]
Douglas D. Bagley
Title: Chief Executive Officer
Date: 7/24/12

Group:
By: ______________________
Name: Alfredo Ratniewski, M.D.
Title: President
Date: ______________________

APPROVED

County of Riverside

By: ______________________
John Tavaglione
Chairman, Board of Supervisors

Date: ______________

FORM APPROVED COUNTY COUNSEL
BY: [signature] NEAL R. KIPNIS 8/2/12 DATE

EXHIBITS TO THE AGREEMENT

The following Exhibits are attached and are a material part of this Agreement. Exhibit A Ancillary Services;

Reimbursement Rates

Exhibit B Health Plan Provider Agreements

Exhibit C General Information

Exhibit D Medicare Advantage (MA) Downstream Entity Contract

EXHIBIT A
Ancillary Services
Reimbursement Schedule

1. The following Reimbursement Rates apply to technical services and supplies that are strictly identified as the Group's financial responsibility in a Provider Agreement, and where the Group is the payor of record. Services which are the financial responsibility of any other entity, including, but not limited to, a Health Plan, a hospital other than Hospital, or another medical group / IPA, are outside of the scope of this Agreement, and the contracted rates set forth herein do not apply for such services. The Reimbursement Rates include reimbursement for all technical services and supplies provided by Hospital, but these rates do not include compensation for physician professional services, which will be billed separately by the applicable physicians.

2. Under no circumstances will the Reimbursement Rates set forth in this Schedule be assigned or otherwise made available to any entity other than Group (including, without limitation, any Health Plan or any participating provider of Health Plan).

3. The Reimbursement Rates set forth below are inclusive of any co-payments and deductibles that are applicable pursuant to Members' benefit programs with the Health Plans.

4. This list of Ancillary Services may be modified from time to time only by the written consent of both parties.

5. Any changes to this Exhibit requires a written amendment executed by an authorized representative of both Group and Hospital.

Reimbursement Schedule	**Medi-Cal**	**Healthy Kids, Healthy Families**	**Medicare**
Outpatient Diagnostic and Therapeutic Services	100% Medi-Cal Fee Schedule for Hospitals	125% Medicare Allowable	N/A
Emergency Room	Health Plan Responsibility	Health Plan Responsibility	N/A
Ambulatory Surgery	100% Medi-Cal Fee Schedule for Hospitals	100% Ambulatory Payment Classification	N/A
Outpatient Clinics (Z7500)	100% Medi-Cal Fee Schedule	100% Medi-Cal Fee Schedule	N/A
Outpatient Observation	100% Medi-Cal Fee Schedule for Hospitals	125% Medicare Allowable	N/A
All other Outpatient Services (Including Pharmaceuticals)	100% Medi-Cal Fee Schedule for Hospitals	125% Medicare Allowable	N/A
Implants and Prosthetics over $500.00	35% of Hospital Billed	35% of Hospital Billed	N/A

EXHIBIT B
Health Plan Provider Agreements

1.
The following list of Health Plans and Products represents those Health Plans and products where Group has entered into a Provider Agreement and is responsible for services listed as Group's financial responsibility on the DOFR.

2.
Group will be responsible to meet and confer with Hospital if there are any additions or deletions to the Health Plans or products listed herein this Exhibit B to determine if Hospital participates with the added Health Plans.

Inland Empire Health Plan

EXHIBIT C

General Information

Claims or Billing Inquiries
Name: Borrego IPA
Address: 955 Harbor Island Drive Suite 162
City: San Diego
State: CA Zip: 92101
Attn: Claims
Phone: (619) 704-3770

Medical Appeals:
Name: Borrego IPA
Address: 955 Harbor Island Drive Suite 162
State: CA Zip: 92101
Attn: Appeals
Phone: (619) 704-3770

Other Phone Numbers
Provider Relations: (619) 704-3770
Authorization: Same
Benefit Eligibility: Same

EXHIBIT D
MEDICARE ADVANTAGE DOWNSTREAM ENTITY CONTRACT ADDENDUM

The Provider Agreement is a Downstream Entity Contract, and this Exhibit D is intended to and will add contractual language required by CMS for participation as a Medicare Advantage contracted provider or organization. For purposes of this Exhibit D, Group is referred to as "First Tier Entity" and Hospital is referred to as "Provider", in addition to the following facts:

Whereas, CMS requires specific contract language be incorporated into contracts and subcontracts with downstream entities to comply with the provisions of the Balanced Budget Act of 1997;

Whereas, First Tier Entity has contracted with various Medicare Advantage Organizations to provide hospital and other medical services to Medicare beneficiaries who have elected to enroll in such Medicare Advantage organizations;

Whereas, Provider is a subcontractor of First Tier Entity and has agreed to provide services to such Medicare beneficiaries.

Whereas, Provider and First Tier Entity agree to the addition of the following language as specified by CMS, which shall be incorporated into the agreement between Provider and First Tier Entity ("Agreement") provided, however, this Addendum shall apply only to services rendered to First Tier Entity's Medicare Advantage Members.

I. DEFINITIONS

1.1 **Downstream Entity** means all entities or individuals who are contracted 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 Provider in this Addendum.

1.2 **First Tier Entity** means the first level of contractor with the Medicare Advantage (e.g., individual Practice Association (IP A) or Physician Hospital Association (PHO)) who or which bas a direct contract with the Medicare Advantage.

1.3 **Centers for Medicare and Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA)** means the agency within the Department of Health and Human Services that administers the Medicare Program.

1.4 **Medicare Advantage Organization** means a health plan or provider sponsored organization that has entered into an agreement with CMS to provide Medicare beneficiaries with health care options.

1.5 **Member** means an individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

1.6 **Provider** means a Downstream 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 (RRS), 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. The obligations herein stated shall survive termination and/or expiration of the Agreement.

2.2 To safeguard the privacy of any information that identifies a particular Member and to maintain such records in an accurate and timely manner.

III. ACCESS: BENEFITS & COVERAGE

Provider agrees:

3.1 To not discriminate against Members based on health status.

3.2 To pay for emergency and urgently needed services consistent with federal regulations, if such services are Provider's ability under the terms of the Agreement with First Tier Entity.

3.3 To pay for renal dialysis services for Members temporarily outside the service area, if such services are Provider's liability under the terms of the Agreement with First Tier Entity.

3.4 To provide access to benefits in a manner described by CMS.

IV. MEMBER PROTECTIONS

Provider agrees:

4.1 To provide all covered benefits to Members in a manner consistent with professionally recognized standards of health care.

4.2 To comply with all confidentiality and Member record accuracy requirements.

4.3 To hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the Medicare Advantage or First Tier Entity. In no event, including but not limited to, nonpayment or breach of an agreement by the Medicare Advantage, First Tier Entity, or any 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 a Member, or a person acting on behalf of a Member, for covered services provided. This provision does not prohibit (i) collection of applicable coinsurance, deductibles, or co-payments, as specified in the Evidence of Coverage, or (ii) collection of fees for non-covered services provided the Member was informed in advance of cost and elected to have non-covered services rendered.

4.4 To allow Members who are hospitalized on an inpatient basis at the time of termination of an agreement between Medicare Advantage and First Tier Entity, to remain under the care of Provider until discharged from the hospital or through the time period for which Member's CMS premium has been paid. During such time, First Tier Entity shall continue to compensate Provider for Covered Services rendered to such Members pursuant to the terms and conditions of this Agreement.

V. DELEGATION

Provider agrees:

5.1 To maintain delegated functions consistent with Medicare Advantage requirements and compliant with

Medicare Advantage regulations.

5.2 To comply with any applicable delegation requirements between the Medicare Advantage and First Tier Entity.

VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

6.1 To include specific physician payment and incentive arrangements, if any, in agreements with other downstream entities.

6.2 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.

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 First Tier Entity and/or Medicare Advantage all data, including medical records, necessary to characterize the content and purpose of each encounter with Member.

7.2 To submit and certify the completeness and truthfulness of all encounter data.

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.

8.2 To comply with Medicare Advantage's medical policy, quality assurance program, and medical management program.

IX. COMPLIANCE

Provider agrees:

9.1 To provide First Tier Entity with at least sixty (60) days written notice before terminating the Agreement between Provider and First Tier Entity without cause.

9.2 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.

9.3 To comply with all applicable Medicare Advantage and First Tier Entity procedures and manuals to the extent such procedures and manuals implement Medicare Advantage requirement applicable to Provider.

9.4 To comply and require all downstream entities contracting with Provider to comply with applicable state and Federal laws and regulations, including Medicare laws and regulations and CMS instructions.

9.5 To not employ or contract with individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act.

9.6 To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Medicare Advantage Members which procedures Medicare Advantage undertakes to provide to First Tier Entity and Provider, including gathering and forwarding information on appeals to Medicare Advantage, as necessary.

X. PRIVATE FEE FOR SERVICE

If Medicare Advantage offers a private fee-for-service plan, Provider agrees:

10.1 Those agreements with contracting providers must specify uniform fee-for-service payment rates.

XI. ADOPTION OF MEDICARE RISK PROGRAM CONTRACT REQUIREMENTS

Provider agrees:

11.1 That all contracts must be signed and dated.

11.2 To serve Members during the term of this Addendum.

11.3 To comply with the regulatory requirements and Medicare Advantage guidelines promulgated by CMS, which are more fully documented in Medicare Advantage's policies, procedures and manuals. Except as provided in this Addendum, all other provisions of the Agreement between Provider and First Tier Entity not inconsistent herein shall remain in full force and effect. This Addendum 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.