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

FROM: Riverside County Regional Medical Center

SUBMITTAL DATE: May 1, 2013

SUBJECT: Approval of the Hospital Services Agreement with Alpha Care Medical Group, Inc.

RECOMMENDED MOTION:

1) Ratify the hospital services agreement with the Alpha Care Medical Group effective April 1, 2013; and
2) Direct the Clerk of the Board to hold this Agreement as a confidential document, not subject to the release under the Public Records Act and Health and Safety Code Section, 1457, (C)(1); and
3) Direct the Clerk of the Board to retain one (1) copy and return two (2) copies of the executed agreement to Riverside County Regional Medical Center for distribution.

BACKGROUND: Alpha Care Medical Group has contracted with Riverside County Regional Medical Center (RCRMC) for the expansion of their provider network to Moreno Valley.
(cont'd on page 2)

Douglas D. Bagley
Douglas B. Bagley, Hospital Director

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 4/11/13
Departmental Concurrence

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 FY:	$ 0	**For Fiscal Year:**	12/13

SOURCE OF FUNDS: Revenue from the Inland Empire Health Plan and IEHP Health Access

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

C.E.O. RECOMMENDATION: APPROVE

BY: Debra Cournoyer
Debra Cournoyer

County Executive Office Signature

Dep't Recomm.: ☒ Policy ☐ Consent
Per Exec. Ofc.: ☒ Policy ☐ Consent

Prev. Agn. Ref.: 6/4 3:02 | **District:** All | **Agenda Number:**

CLERK BOARD OF SUPERVISORS
RECEIVED RIVERSIDE COUNTY

3-40

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

BACKGROUND (Continued):

This agreement is applicable to health care services provided to enrollees of the Inland Empire Health Plan (IEHP) and Molina Healthcare of California (Molina) health care plans referred to RCRMC for health care and specialty care professional 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 and Molina members will be able to choose primary care providers affiliated with Alpha Care Medical Group and designate RCRMC as their assigned enrollment. The rates in the agreement allow for the recovery of cost for health care services referred by Alpha Care Medical Group, Inc.

The agreement has been approved as to form by County Counsel.

ALPHA CARE MEDICAL GROUP, INC.
HOSPITAL SERVICES AGREEMENT

This HOSPITAL SERVICES AGREEMENT (the "Agreement"), is entered into as of **APRIL 1, 2013** (the "Effective Date"), by and between **ALPHA CARE MEDICAL GROUP, INC.**, a California Hospital medical corporation ("IPA"), and the **COUNTY OF RIVERSIDE, ON BEHALF OF THE RIVERSIDE COUNTY REGIONAL MEDICAL CENTER** ("HOSPITAL").

RECITALS

WHEREAS, IPA is an individual practice association which contracts with physicians such as Hospital for the delivery of health care services; and

WHEREAS, HOSPITAL is a licensed hospital that desires to provide hospital services under the terms of this Agreement to members assigned to health plans that hospital has entered into an agreement;

WHEREAS, IPA enters into agreements ("Payor Agreements") with certain Health Care Service Plans, Non-Profit Hospital Service Plans, Health Maintenance Organizations, Medicare Advantage Organizations, and other third party payors and purchasers of Covered Services (collectively, "Payors"), for the provision of medical services to persons enrolled with such Payors;

WHEREAS, IPA and HOSPITAL desire to enter into this Agreement, whereby Hospital agrees to provide Covered Services on behalf of IPA to persons enrolled with such Payors.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties hereby agree as follows:

ARTICLE I
DEFINITIONS

1.1 "Authorization" means the prior approval by IPA or Payor for a Member to be referred for the performance of Covered Services.

1.2 "Board" means the IPA Board of Directors.

1.3 "Capitated Financial Alignment Demonstration" ("Duals Pilot") shall mean the pilot program developed by CMS and DHCS to provide comprehensive healthcare services to individuals eligible for both Medicare and no share cost of Medi-Cal.

1.4 "Capitation Fee" means the predetermined monthly payment to be made to Hospital for Covered Services to be provided to each Member assigned to Professional.

1.5 "Centers for Medicare and Medicaid Services ("CMS")" means the agency within the Department of Health and Human Services that administers the Medicare Program.

1.6 "Clean Claim" means claims that have been completed correctly, with no missing elements, and requiring no further information to determine Payor liability and process.

1.7 "Copayment" or "Deductible" means those charges for Hospital services that shall be collected directly by Hospital from Member as payment in addition to the Capitation Fee, in accordance with the Member's applicable

Evidence of Coverage.

1.8 "Covered Services" means those health care services and supplies that a Member is entitled to receive under a Payor's benefit program when rendered by a Participating Provider and that are described and defined in the Payor's Evidence of Coverage and disclosure forms, subscriber and group contracts, in a Payor's Provider Manual, and in accordance with the terms and conditions of this Agreement.

1.9 "CRVS" means the 1974 California Relative Value Studies published by the California Medical Association, as amended.

1.10 "Emergency" means, unless otherwise defined by applicable Payors, those health care services that are rendered by Participating Providers or by nonparticipating Providers after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, (b) danger of serious impairment of the individual's bodily functions, (c) serious dysfunction of any of the individual's bodily organs or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.11 "Encounter Data" means data elements to be provided by Professional. Encounter Data shall include all necessary Hospital and Member data including, Member name and identification number, date of visit, name of rendering provider(s), diagnosis, Health Plan, National Practitioner Identification ("NPI") number and treatment furnished.

1.12 "Evidence of Coverage" means the document issued by a Payor to a Member that describes the Covered Services for which a Member is eligible and the conditions and circumstances under which the Payor is obligated to pay for such services on behalf of the Member.

1.13 "Fee-for-Service ("FFS")" means Hospital will be paid according to a determined payment schedule for all authorized services rendered.

1.14 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 (Public Law No. 104-191) and the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and Part 164, Subparts A and E and any subsequent amendment thereto.

1.15 "HITECH" means the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, regulations promulgated thereunder, and any subsequent amendment thereto.

1.16 "IPA Provider Manual" means a compilation of IPA's policies and procedures that set forth conditions with which Participating Providers must comply, as amended from time to time. The IPA Provider Manual is not intended to be the sole and exclusive source of IPA's policies and procedures.

1.17 "Medical Director" means a physician who is authorized by IPA to be responsible for (a) administering IPA medical affairs, (b) serving as IPA's director of medical affairs, and (c) serving as IPA's medical liaison to Payors and Participating Providers.

1.18 "Medically Necessary" means, unless otherwise defined by applicable Payors, those services that are provided, ordered, directed, authorized or approved by a Participating Provider and that: (a) are appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; (b) provide for the diagnosis and treatment of a medical condition; (c) are not primarily for the convenience of the Member, the Member's attending or consulting physician or another Participating Provider or nonparticipating Provider; (d) are rendered in accordance with accepted medical

practices and community standards; and (e) conform with the Hospital and technical standards adopted by IPA and by applicable Payors.

1.19 "Medicare Advantage Organization ("MAO")" means a health plan or provider sponsored organization, which has entered into an agreement with CMS to provide Medicare beneficiaries within a particular geographic area with a specific set of health care benefits.

1.20 "Member" means a person who is enrolled in the benefit program of any Payor which contracts with IPA, including his/her enrolled dependents, who is entitled to receive Covered Services.

1.21 "NCQA" means the National Committee for Quality Assurance.

1.22 "Non-Covered Services" means those health care services which are not benefits under applicable Evidences of Coverage.

1.23 "Participating Provider" means any physician, hospital or other licensed health facility or licensed health professional, ancillary or allied health provider that or who has entered into an agreement with IPA or with any applicable Payor to provide Covered Services to Members. A Participating Provider is also considered a "Downstream Provider" for purposes of this Agreement.

1.24 "Payor(s)" means Health Care Service Plans, Non-Profit Hospital Service Plans, Health Maintenance Organizations, and Medicare Advantage Organizations.

1.25 "Policies and Procedures" means the policies and procedures or rules and regulations developed and adopted by Payors and IPA applicable to the provision of Covered Services and communicated to Hospital pursuant to this Agreement.

1.26 "Primary Hospital" means the primary hospital contracting with IPA or Payor from time to time, as determined in the sole discretion of IPA.

1.27 "Primary Care Physician ("PCP")" means the physician who is selected by a Member, or who is otherwise assigned a Member by IPA or by applicable Payors, to manage the overall preventive and ongoing health care of the Member, to render first contact medical care and to provide Primary Care Services, including referrals to other Participating Providers, according to the terms of the Payor and IPA's Provider Manual. This definition of PCP shall include all physicians who are general internists, pediatricians, family practitioners and general practitioners, or any other physicians who have been approved by the IPA Board to be designated as a PCP.

1.28 "Primary Care Services" mean those Covered Services described and defined in the Payor's Evidence of Coverage and disclosure forms, subscriber and group contracts, and in Payor's Provider Manual as being Primary Care Services.

1.29 "Referral" means the process by which a PCP directs a Member to seek and obtain Covered Services from another health professional, hospital or other provider of Covered Services.

1.30 "Service Area" means the geographical area that is IPA's service area as defined by the IPA and approved by Payors.

1.31 "Specialist Physician" means a physician who is professionally qualified to practice his/her designated specialty and whose agreement with IPA includes responsibility for providing Covered Services in his/her designated specialty.

1.32 "Subcontract" means an agreement between Hospital and a Subcontractor for provision of services to Members under this Agreement.

1.33 "Subcontractor" means an individual Participating Provider or any other entity who provides Covered Services to Members pursuant to a direct or indirect contract or other arrangement with Professional.

1.34 "Utilization Management/Quality Improvement (UM/QI) Program" means the programs, processes and standards established and carried out by IPA to authorize and monitor the utilization and quality of Covered Services provided to Members in conformance with regulatory requirements and Payor policies and procedures.

ARTICLE II
SERVICES TO BE PERFORMED BY THE PROFESSIONAL

2.1 Covered Services. Hospital agrees to provide all available Covered Services to all Members referred to Participating Provider. Hospital agrees to provide such Covered Services in accordance with the terms and conditions of (i) this Agreement, and (ii) all Substantial Shared Risk Agreements in each Payor's product line for which IPA contracts to provide Covered Services. Hospital shall provide non-emergency Covered Services (including diagnostic services) to a member only upon receiving prior written authorization to treat the member from that Member's Primary Care Physician, from another appropriate Participating Provider, or from IPA. Failure to provide Covered Services only pursuant to such authorization may result in IPA's determination that Hospital will not receive compensation for unauthorized services. Nothing in this Agreement shall be construed to require IPA or its participating Providers to utilize Hospital for any or all Members.

2.2 Performance. All Covered Services shall be provided in accordance with the scope of Hospital's licensing, training, experience and qualifications and consistent with accepted standards of medical practice. Subject to the terms and conditions of this Agreement, Hospital shall determine the method, details, and means of performing all specialty Covered Services and shall be entitled to perform all usual and customary procedures relative to Hospital's practice.

2.3 Emergency Services. Unless IPA enters into other arrangements for the provision of Emergency care coverage, Hospital shall be responsible for responding to emergent needs of Members with respect to Covered Services for which Members have been referred to Hospital, twenty-four (24) hours per day, seven (7) days per week, including holidays.

2.4 Subcontractors.

2.4.1 Conduct of Subcontractors. Hospital shall ensure that all Subcontractors will (i) accept IPA's credentialing, peer review, quality management and utilization review procedures; (ii) except for Co-Payments or Deductibles, will not bill Members for Covered Services; (iii) obtain all applicable Authorization in accordance with IPA's Policies and Procedures and Provider Manual; (iv) maintain Hospital liability coverage in amounts no less than required of Hospital under this Agreement; and (v) fully comply with the terms of this Agreement.

2.4.2 Information Regarding Subcontractors. Within ten (10) business days after IPA's request, Hospital shall provide his/her forms of Subcontract(s), along with executed signature pages to each such Subcontract, to IPA, Payor and to such government agencies and accreditation surveyors as IPA may request. Hospital shall notify IPA within thirty (30) days after Hospital alters or amends any Subcontract. Hospital shall notify IPA immediately if any activity required for Hospital's performance under this Agreement is subcontracted to an offshore entity.

2.5 Excluded Individuals. Hospital shall not employ or contract with individuals excluded from participation in

Medicare under Section 1128 or 1128A of the Social Security Act or any other governmental program.

2.6 Delegated Functions. Hospital agrees to maintain delegated functions consistent with IPA requirements and compliant with MAO and/or Payor regulations and to comply with any applicable delegation requirements between an MAO and IPA in connection with any Covered Service provided to MAO Members.

2.7 Referral/Authorization. Hospital agrees to (i) be bound by IPA's policies and procedures relating to Referrals and related standards of quality assurance and utilization review which are established by IPA and Payors in accordance with the standards required under applicable laws, rules and regulations, and (ii) file appropriate notice and appeals in the event that Hospital deems that such procedures are inconsistent with his/her Hospital medical judgment with respect to the course of treatment of a Member.

2.8 Eligibility. Except for Emergency Services, Hospital shall verify the eligibility of all Members with the applicable Payor before providing specialty Covered Services. IPA shall have no financial responsibility to compensate Hospital for Covered Services rendered to any person who was not eligible to receive such services.

2.9 Referrals.

2.9.1 Prior Authorization. Except (i) in the event of an Emergency, (ii) where otherwise approved or directed in advance by IPA or by Payor, or (iii) where a Member's medical needs otherwise require, Hospital shall obtain advance authorization from IPA, or designee prior to any non-emergent hospital admission or other specified Hospital service, in accordance with IPA's Policies and Procedures.

2.9.2 Referral Procedure. Hospital shall (i) comply with IPA's policies and procedures relating to Referrals and related standards of quality assurance and utilization review which are established by IPA and Payors in accordance with the standards required under applicable laws, rules, and regulations, and (ii) file appropriate notices and appeals in the event that Hospital deems that such procedures are inconsistent with his/her Hospital medical judgment with respect to the course of treatment of a Member.

ARTICLE III
REPRESENTATIONS

3.1 Representations by IPA. IPA hereby warrants and represents that it is a California Professional medical corporation, in good standing with the California Secretary of State.

3.2 Representations by Hospital. All Hospital Services shall be provided by Hospital personnel in a facility maintained in accordance with generally accepted and professionally recognized standards of practice. Hospital services shall be rendered by qualified medical providers unhindered by fiscal and administrative management. Hospital agrees to maintain and demonstrate to IPA, upon request, throughout the term of this Agreement, compliance with the following:

a Licensure under California Health and Safety code Section 1200 et. seq.

b. Accreditation by the Joint Commission (TJC):

c. Reasonable evidence that all nurses and other ancillary and paramedical personnel who are employed by and contract with HOSPITAL are properly credentialed to provide services in the State of California;

d. All laboratory testing sites shall have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number.

3.3 Hospital Entity Disclosure. Hospital warrants that all information required by **Exhibit B** hereto, the entity disclosure form, is true, correct and complete.

ARTICLE IV
COMPENSATION

4.1 Compensation. Hospital shall be compensated for services provided pursuant to the terms of this Agreement as follows:

4.1.1 Fee For Services ("FFS") Claims

4.1.2.1 Submission of FFS Claims. Hospital shall bill IPA for all Covered Services provided by Hospital on a fee-for-services basis (as set forth in **Exhibit A** hereto) within one hundred eighty (180) days following the date of service. Hospital shall submit billing in such form and include such information as is required by IPA and/or Payor pursuant to IPA's Provider Manual or the applicable Payor Agreement. Failure of Hospital to submit said billing within one hundred eighty days of the date of service may, at IPA's sole discretion, result in refusal of payment by IPA, provided however, that IPA shall not refuse payment if Hospital is attempting to coordinate benefits with another Payor in accordance with IPA's and/or the Payor's policies and procedures and has notified IPA within one hundred eighty days after the date of service that Hospital is attempting to coordinate benefits.

4.1.2.2 Acknowledgment of FFS Claims. IPA shall identify and acknowledge the receipt of the FFS claim, whether or not complete, and disclose the recorded date of receipt by electronic means, by phone, website, or another mutually agreeable accessible method of notification by which Hospital may readily confirm IPA's receipt of the FFS claim. In the case of an electronic FFS claim, identification and acknowledgement shall be provided within two (2) working days of the date of receipt of the FFS claim by IPA. In the case of a paper FFS claim, identification and acknowledgement shall be provided within fifteen (15) working days of the date of receipt of the FFS claim by IPA.

4.1.2.3 Time for Reimbursement of FFS Claims. IPA shall reimburse Hospital for each Clean Claim as soon as practical, but no later than the time frames set by the California Department of Managed Health Care and/or the Centers for Medicare and Medicaid Services for timely payment of claims. For each claim that is denied, adjusted or contested, the IPA shall provide an accurate and clear written explanation of the reasons for the action taken. If IPA fails to pay Clean Claim or notify Hospital regarding contested claims in accordance with the time frames set forth in the applicable statutes, IPA shall pay Hospital interest and applicable penalties as required by Section 1300.71(i) and 1300.71(j) of Title 28 of the California Code of Regulations and/or by the Code of Federal Regulations. All requests for adjustment or reconsideration must be submitted to IPA within three hundred sixty-five (365) days of IPA's initial payment or denial of the underlying claim(s). Claims and requests for adjustment or reconsideration not submitted in accordance with this section may be denied by IPA. Hospital agrees to accept the compensation provided under this Section, less any risk withholds as payment in full for all FFS specialty Covered Services provided by Professional.

4.1.2.4 Overpayment of FFS Claims. If IPA determines that it has overpaid a FFS Claim, it shall, within 365 days, or the time allotted by federal or state regulations, following such overpayment, notify Hospital in writing through a separate notice ("Overpayment Notice") identifying the FFS Claim, the name of the Member, the date of service and explanation of the basis upon which IPA believes the amount paid on the FFS Claim was in excess of the amount due, including interest and penalties on the FFS Claim. If the Hospital contests the IPA's Overpayment Notice, Hospital shall, within thirty (30) working days of receipt of said Overpayment Notice, notify IPA in writing of the basis upon which Hospital believes the FFS Claim was not overpaid. If Hospital does not contest the Overpayment Notice within the time frame described herein, Hospital shall reimburse IPA within thirty (30) working days of

receipt of the Overpayment Notice.

4.2 Covered Services. For all Covered Services provided by Hospital under this Agreement, Hospital shall bill IPA in accordance with federal and state regulations, IPA's Provider Manual and the applicable requirements of this Agreement.

4.3 Member Billing.

4.3.1 No Member Surcharge. Except as provided in the Member's Evidence of Coverage and in concert with applicable deductibles, co-payments or coinsurance, and Section 4.5 herein, Hospital shall not, under any circumstances, surcharge or otherwise bill a Member for any Covered Services. Should IPA or Payor receive notice of any surcharge by Professional, IPA and/or Payor may take any action it deems appropriate, including but not limited to, demanding repayment by Hospital to Member, repaying surcharge to Member by offsetting the cost of the same against any amounts otherwise owing to Professional, or terminating this Agreement.

4.3.2 Medicare/Medicaid Beneficiaries. Hospital shall not hold Medicare/Medicaid-eligible beneficiaries liable for Medicare Part A and Medicare Part B cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the beneficiaries under Title XIX of the Social Security Act. In no event shall Hospital hold such beneficiaries responsible for any cost sharing for Covered Services when a state entity is responsible for paying such amount. Where the state is responsible for paying the cost share amount, Hospital shall accept IPA's contracted rate as payment in full or shall bill the appropriate state source for the appropriate cost share amount as required by 42 C.F.R. 422.504(g)(1)(iii).

4.4 Unauthorized Referrals. Hospital shall not make unauthorized referrals of Covered Services to non-Preferred Providers.

4.5 Member Responsibility. Hospital shall bill and collect from the Member all Copayments and Deductibles specifically permitted in a Member/Payor contract. Whenever possible, Hospital shall collect any such Member Copayments at the time Covered Services are rendered.

4.6 Non-Covered Services. For Non-Covered Services provided to any Member, Hospital may bill such Member directly, provided that prior to providing such Non-Covered Services, Hospital shall advise such Member of non-coverage and shall obtain, in writing, such Member's acknowledgment and acceptance of individual financial responsibility ("Patient Acknowledgment").

4.7 Actions to Collect Amounts Owed. Hospital shall not maintain any action at law or equity against any Member to collect any sum owed to Hospital by IPA or by Payor for Covered Services rendered pursuant to this Agreement. Hospital shall not pursue any available legal or other remedy against IPA for any IPA or Payor nonpayment or underpayment to Hospital for Covered Services provided to an Member unless, and to the extent that, IPA has already received payment from a Payor for such Covered Services and has failed to pay Hospital for such Covered Services as required by this Agreement.

4.8 Member Hold Harmless. Hospital agrees to hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the Payor or IPA. In no event, including but not limited to, nonpayment or breach of an agreement by the Payor, IPA, or intermediary, or the insolvency of the Payor, IPA, or intermediary, shall Hospital bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Hospital shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This

provision does not prohibit collection of applicable coinsurance, deductibles, or Copayments, as specified in the Evidence of Coverage or the 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.

4.9 Applicability of Federal and State Law. Hospital hereby acknowledges that health services provided hereunder to Members may be paid for with federal and state funds and, as such, payments for such services are subject to laws applicable to individuals or entities receiving federal and state funds.

4.10 Third-Party Insurance Payments. Hospital shall not attempt recovery in circumstances under which compensation may be available through casualty insurance, tort liability, or workers' compensation. Hospital shall report to IPA, and as applicable the Department of Health Care Services or the Department of Managed Health Care and other applicable governmental agencies within fifteen (15) business days after discovering any circumstances that may result in casualty insurance payments, tort liability payments, or workers' compensation award.

4.11 Fee Schedules and Other Required Information. IPA shall provide Hospital with the information and fee schedules described in Sections 1300.71(l) and Section 1300.71(o) of Title 28 of the California Code of Regulations ("Sections") in a paper or electronic format, which may include a website containing this information.

4.12 Insolvency or Dissolution of IPA. Notwithstanding any provision to the contrary contained in this Agreement, in the event of the insolvency or dissolution of IPA, Hospital shall, at the request of one or more contracting Payors, accept payment from said Payor(s) at the rates provided in the applicable Payor/IPA agreement for Covered Services provided to the Members of said Payor(s) and Hospital agrees to perform the applicable provisions of this Agreement for the benefit of said Payor(s).

ARTICLE V
COORDINATION OF BENEFITS

5.1 Definition. Coordination of Benefits ("COB") refers to the determination of which of two or more health benefit plans shall apply, either as primary or secondary coverage, for the rendition of hospital, surgical or medical services to a Member. Such coordination is intended to preclude the Hospital from receiving an aggregate of more than one hundred percent (100%) of covered charges from all coverage. When the primary and secondary benefits are coordinated, determination of liability shall be in accordance with the usual procedures employed by the California Department of Insurance and applicable state regulations.

5.2 COB Obligations of Professional. Unless otherwise agreed to by the IPA, Hospital agrees to coordinate with IPA for proper determination of COB and to bill and collect from the responsible payor(s) such charges for which the other payor is responsible. Hospital shall report all collections received in accordance with this Section to IPA.

ARTICLE VI
OBLIGATIONS OF PROFESSIONAL

6.1 Scope of Services. IPA and Hospital agree that:

6.1.1 Hospital may at all times provide Hospital medical services to Hospital's own patients, or to patients of other physicians or medical groups; provided, however, that in rendering medical services to such patients, Hospital shall neither represent nor imply in any way that such medical services are being rendered by or on behalf of IPA.

6.2 Participation in Initiatives. Hospital agrees to participate in IPA initiatives related to correct coding, medical

record documentation, and improvements in Hierarchical Conditions Categories (HHC) and Risk Adjustment Factors (RAF).

6.3 Personnel, Equipment and Supplies. Hospital shall supply all necessary office personnel, equipment, instrumentalities and supplies required to perform Covered Services and which are usual and customary for a hospital in the community.

6.4 Accessibility. Hospital agrees to be available to provide Covered Services or to provide coverage for said services twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. Hospital shall be available to provide Members same day appointments when medically necessary. Hospital further agrees to maintain office hours of at least eight (8) hours per day, five (5) days per week. Additionally, Hospital agrees to participate in IPA's or Payor's system for monitoring and evaluating accessibility of care, including but not limited to, waiting times and appointment availability, and addressing issues and concerns that may develop.

6.5 Location of Services. Except where medically indicated, Hospital shall render Covered Services to members in Hospital's office. Hospital shall notify IPA in writing of any change of location for the provision of Covered Services at least sixty (60) days prior to the effective date.

6.6 Insurance.

6.6.1 Workers' Compensation Insurance. Hospital agrees to provide, at Hospital's sole cost and expense, workers' compensation insurance for Hospital's agents, servants, and employees throughout the entire term of this Agreement, in accordance with the laws of the State of California, as amended from time-to-time.

6.6.2 Malpractice Insurance. Unless otherwise agreed to by Hospital and IPA, Hospital shall provide, at Hospital's sole cost and expense, throughout the entire term of this Agreement, a policy of Hospital malpractice liability insurance with a licensed insurance company admitted to do business in the State of California, or an inter-indemnity trust (also referred to as a self-assessment trust) established and operated in accordance with California law and approved by IPA, in a minimum amount of one million dollars ($1,000,000) per claim and three million dollars ($3,000,000) in the annual aggregate, to cover any loss, liability or damage alleged to have been committed by Professional, or by Hospital's agents, servants, independent contractors, or employees. If such Hospital liability coverage is on a "claims made" rather than "occurrence" basis, then subsequent to the termination of this Agreement, Hospital shall obtain extended reporting malpractice coverage ("tail" coverage) to cover any periods during which Hospital provided services under the term of this Agreement, for a period of five (5) years following the effective termination date of the policy. If feasible and the additional cost is no more than nominal, Hospital shall include IPA as an additional named insured on such policy. Hospital shall use best efforts to obligate Hospital's insurance carrier to provide written notices to IPA at least thirty (30) days prior to any cancellation or amendment of Hospital's policy.

6.6.3 Comprehensive General Insurance. Hospital shall provide, at Hospital's sole cost and expense, throughout the entire term of this Agreement, a policy or policies of comprehensive general insurance covering Hospital's principal place of business and insuring Hospital against any claim of loss, liability or damage committed or arising out of the alleged condition of said premises, or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of the operation of a motor vehicle for business purposes by Professional, Hospital's agents, servants or employees, both in a minimum amount of one hundred thousand dollars ($100,000) per claim and three hundred thousand dollars ($300,000) in the annual aggregate.

6.6.4 Proof of Insurance. On or before the Effective Date, Hospital shall provide IPA with copies of insurance policies or other evidence of compliance with the foregoing insurance requirements acceptable to IPA. Hospital shall provide IPA with a minimum of thirty (30) days' prior written notice in the event any of the policies set forth in this Article VI are canceled, changed or amended. Hospital shall from time to time, on the reasonable request of IPA, furnish to IPA, as the case may be, written evidence that the policies of insurance required under this Section are in full force and effect and valid and existing in accordance with the provisions of said Sections.

6.6.5 The insurance requirements described herein may be met with a program of self-insurance or a combination of insurance and self-insurance. However, if HOSPITAL elects to change programs of self-insurance coverage, the HOSPITAL agrees they will meet the insurance requirements, as described above.

6.7 Performance. Hospital shall devote sufficient time, attention and energy necessary for the competent and effective performance of Hospital's duties under this Agreement.

6.8 Compliance with Law and Ethical Standards. Hospital shall at all times during the term of this Agreement comply with all applicable federal, state or municipal laws and regulations, 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, the regulatory requirements and MAO guidelines promulgated by CMS, which are more fully documented in MAO's policies, procedures, and manuals, all applicable rules and regulations of the Medical Board of California or the Osteopathic Medical Board of California, and the ethical standards of the American and California Medical Associations. Hospital agrees to cooperate with IPA so that IPA may meet any requirements imposed on IPA by Payors, by state and federal law, as amended, and by all regulations issued pursuant thereto.

6.9 Compliance with TJC and HEDIS Guidelines. Hospital shall comply with TJC and HEDIS guidelines and the requirements of any other applicable accrediting agency, as amended from time to time. Said compliance shall include, but shall not be limited to, cooperation with IPA and/or Payors by providing information required by IPA or the Payors to demonstrate compliance with said TJC and HEDIS guidelines. IPA acknowledges that all information provided pursuant to this section is confidential information and subject to the same restrictions as set forth in Section 8.1 of this Agreement.

6.10 Hospital Roster. Hospital agrees that IPA and/or Payor(s) may use Hospital's name, address, telephone number, and services available with willingness to accept new patients, and other marketing information in the IPA and/or Payor roster of Hospital participants. Such rosters may be inspected by and are intended to be used by prospective patients, prospective IPA physicians and others.

6.11 Maintenance of and Access to Records. Hospital agrees to maintain such records and provide such information to IPA, to Payors, and to applicable state and federal regulatory agencies for compliance, as may be required. Hospital agrees to permit access to and inspection by IPA, Payors, the California Department of Managed Health Care, the California Department of Health Services, the United States Department of Health and Human Services, the Department of Justice, the General Accounting Office, and the Controller General of the United States, and their authorized representatives, at all reasonable times and upon demand, of all of those facilities, books and records maintained or utilized by Hospital in the performance of Covered Services pursuant to this Agreement, including information reflecting the cost of Covered Services and any payments received from Members or from others on such Member's behalf, and encounter data. Hospital agrees to retain such books and records, including encounter data, for a term of not less than the longest of the following: (a) ten (10) years from and after the termination of this Agreement; (b) ten (10) years from and after the provision of the applicable Covered Services; (c) such time as may be required to complete any government audit that may be initiated with respect to such records; or (d) as long as may be required by the provisions of any

applicable state or federal law.

6.12 HIPAA Compliance. Hospital agrees to comply with the requirements of HIPAA and the HITECH Act. To this end, Hospital acknowledges that, by entering into this Agreement, he/she has entered into an Organized Health Care Arrangement with IPA to protect patient privacy while minimizing disruption to quality care. For each Member, Hospital agrees to deliver a notice of privacy practices to Member no later than the Hospital's first date of service to the Member.

6.13 Nondiscrimination of Employees. Hospital agrees that he/she will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and denial of family care leave. Hospital shall ensure the evaluation and treatment of his/her employees and applicants for employment are free from discrimination and harassment. Hospital will comply with the provisions of the Fair Employment and Housing Act and the applicable regulations promulgated thereunder. Hospital shall, if necessary, give notice of his/her obligations under this clause to labor organizations with which he/she has a collective bargaining or other agreement.

6.14 Nondiscrimination of Members. Hospital agrees: (a) not to differentiate or discriminate in its provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, or veteran status, to the extent required by applicable federal, state and local laws, regulations and ordinances; and (b) to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Payor patients consistent with existing medical ethical/legal requirements for providing continuity of care to any patient. Additionally, Hospital shall facilitate and/or arrange for interpretive and translation services for those Members with limited English proficiency or with a visual or other communicative impairment and will facilitate availability of, or provide for, auxiliary aids, including sign language interpreters for sensory impaired Members.

6.15 Cooperation with Medical Directors. Hospital understands that Payors shall place certain obligation upon IPA regarding the quality of care received by Members and that Payors in certain instances shall have the right to oversee and review the quality of care administered to Members. Hospital agrees to cooperate with IPA and applicable Payor Medical Directors in the Medical Directors' review of the quality of care administered to Members.

6.16 Cooperation with Independent Quality Review. Hospital agrees to comply with IPA and Payor-required medical policies, quality assurance programs, and medical management programs. Hospital further agrees to cooperate with independent quality review and improvement organizations' activities pertaining to the provision of services to Members.

6.17 Compliance with IPA Pharmaceutical Formularies. Unless medical necessity dictates otherwise, Hospital shall comply with all pharmaceutical formularies developed and/or adopted by IPA and Payors.

6.18 Notice of Non-Compliance. Hospital shall notify IPA immediately, in writing, should he/she be in violation of this Agreement, including, but not limited to, the requirements set forth in Section 3.2 (Representations by Professional), Section 6.6, (Insurance) Section 6.7 (Compliance with Law and Ethical Standards), Section 6.11 (Compliance with IPA Policies, Procedures and Provider Manual), Section 6.12 (Compliance with HCQA and HEDIS Guidelines), Section 6.13 (Hospital Roster), Section 6.14 (Maintenance of and Access to Records), Section 6.15 (HIPAA Compliance), Section 6.16 (Nondiscrimination of Employees) and Section 6.16 (Nondiscrimination of Members) of this Agreement.

6.19 Hospital shall notify IPA in writing within fifteen (15) days of each and every report of TJC or any other accreditation agency, which contains any citation of HOSPTIAL 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 Hospital to carry out the duties and obligations under this Agreement.

6.20 Notice of Revocation, Suspension or Restriction of Drug Enforcement Agency Number. Hospital shall notify IPA immediately, in writing, should HOSPITAL Drug Enforcement Agency Number be revoked, suspended or restricted.

6.21 Documentation and Coding. Documentation in the Member's medical record shall be consistent with Hospital standards and shall meet the AMA guidelines specifically related to coding and supporting documentation. Hospital shall cooperate with IPA to ensure compliance with state and federal statutes governing documentation and coding, and to prevent any potential for fraudulent billing or documentation. All coding shall be in accordance with current coding guidelines, including those set forth by the AMA, and CMS. Coding shall be to the highest level of specificity (5th digit, if applicable).

ARTICLE VII
OBLIGATIONS OF IPA

7.1 Provision of Certain Services. IPA will be responsible to provide or arrange all program administration, financial management and control, claims processing, billing and collections, and the operation of comprehensive quality assurance and utilization review programs consistent with IPA's institutional objectives and within the requirements of managed care service agreements. IPA will develop and maintain written policies and procedures relating to such activities and to hospital compensation and will make such written policies and procedures available to Professional.

7.2 Prompt Payment. IPA will comply with all payment provisions of law, including prompt payment of all authorized Covered Services to Hospital in accordance with CMS and Department of Managed Health Care standards.

ARTICLE VIII
MEDICAL RECORDS

8.1 Medical Record Retention. Hospital shall maintain with respect to each Member receiving Covered Services hereunder a single standard medical record in such form, containing such information, and preserved for such time period(s) as are required by state and federal law. Information contained in a Member's medical records shall be confidential, and shall be maintained as such in accordance with all applicable state and federal laws. Hospital shall safeguard the privacy of any information that identifies a particular Member. To the extent permitted by law, in accordance with procedures required by law, and upon not less than three (3) business days' prior written notice from IPA, Hospital shall provide to IPA copies of said records at IPA cost. Notwithstanding anything to the contrary contained in this Agreement, IPA shall not be required to obtain the Member's written consent prior to inspecting and/or obtaining medical records pursuant to this Section, unless otherwise required by law.

ARTICLE IX
UTILIZATION MANAGEMENT, QUALITY MANAGEMENT; GRIEVANCE PROCEDURES

9.1 UTILIZATION MANAGEMENT Program. HOSPITAL agrees to participate in the UM Program established by IPA and to abide by decisions resulting from that review, subject to the rights of reconsideration available under this Agreement. HOSPITAL agrees to provide access to IPA, or designee, for the purpose of conducting concurrent review and case management on Members who are receiving services at HOSPITAL. IPA or designee shall adhere to the reasonable procedures established by HOSPITAL regarding such access. IPA shall not retrospectively deny any Hospital Services approved as Medically necessary provided that the information given by HOSPITAL to IEP or designee, is substantially true and accurate regarding the medical condition of the Member.

9.2 Quality Management Program. HOSPITAL shall implement an ongoing quality management program which shall

develop procedures for ensuring that the quality of care provided by HOSPITAL conforms with generally accepted and professionally recognized standards of practice in compliance with the standards developed by IPA. If a potential quality of care issue is identified based on member complaints, or other information IPA shall alert HOSPITAL to initiate appropriate action. HOSPITAL further agrees to assist HOSPITAL in the investigation of any potential quality of care issue, and in the implementation of any corrective action plan as requested.

9.3 Grievance Procedure – Member Complaints. A grievance procedure shall be established for processing of any patient complaint regarding Covered Services furnished by Professional. Such procedure shall be established by IPA and contracting Payors, in their sole and absolute discretion. Hospital shall comply with and, subject to Hospital's right of appeal, shall be bound by such grievance procedure. At no time shall a Member's medical condition be permitted to deteriorate because of delay in provision of care that HOSPITAL disputes. Both parties agree to notify the other party of any Member complaints within five (5) working days.

9.4 Appeals. Hospital agrees to adhere to Medicare's appeals, expedited appeals and expedited review procedures for MAO Members, including gathering and forwarding information on appeals to MAO, as necessary. In addition, Hospital agrees to adhere to all appeals and expedited review procedures requested by IPA, the California Department of Health Care Services, the California Department of Managed Health Care, and Payors for Members.

ARTICLE X
TERM AND TERMINATION

10.1 Term. The initial term of this Agreement shall commence on the Effective Date and shall continue for a period of one (1) year ("Initial Term"). This Agreement shall be automatically renewed for successive one (1) year periods ("Renewal Term") on the same terms and conditions contained herein, unless otherwise amended in accordance with the terms hereof.

10.2 Termination Without Cause. During the Initial Term and any Renewal Term, this Agreement may be terminated by IPA upon ninety (90) days' notice to Professional. Following the Initial Term, Hospital may terminate this Agreement at any time without cause upon at least one hundred eighty (180) days' prior written notice to the other party. IPA may, at its sole and absolute discretion, shorten the time period upon receipt of a request for such termination from Professional.

10.3 Termination for Material Breach. In the event of a material breach of this Agreement by either party hereto, the non-breaching party shall have the right to terminate this Agreement by giving written notice to the breaching party that describes the nature of such material breach (the "Breach Notice"). In the event such breach is not cured to the reasonable satisfaction of the non-breaching party within thirty (30) days of the breaching party's receipt of the Breach Notice, this Agreement shall terminate at the election of the non-breaching party upon the giving of a written notice of termination. Grounds for material breach of this Agreement by IPA may include, among other things, excessive Member grievances, failure to maintain the insurance required pursuant to Article VI hereof, imposition of restriction or probation on licensure or DEA Number, breach of significant administrative requirements (e.g., maintenance of records), failure to comply with HIPAA and HITECH, failure to conform with IPA policies and procedures, the IPA Provider Manual, a Payor's policies and procedures, utilization management or quality assurance standards.

10.4 Immediate Termination by IPA. Notwithstanding any other provision of this Agreement to the contrary, this Agreement shall terminate immediately upon the occurrence of any of the events enumerated below. Notice of such immediate termination shall be given by IPA to Hospital. Hospital's rights to review of such termination by IPA shall be limited to whether or not the event causing the immediate termination has occurred.

10.4.1 Suspension, Restriction or Exclusion from Federal Health Care Programs. In the event Hospital is suspended, restricted or excluded from Medicare, Medi-Cal, or any federal health care program, this

Agreement shall immediately terminate.

10.5 Notice to Payors. IPA shall promptly provide written notice of Hospital's termination to those Payors with which IPA maintains a contractual relationship as of either the date of such notice of termination or the actual termination, whichever occurs earlier.

10.6 Termination by Mutual Consent. Notwithstanding anything to the contrary contained in this Article X, this Agreement may be terminated at any time by mutual written consent of the parties to this Agreement.

10.7 Responsibility for Members at Termination. In the event of termination of this Agreement for any reason other than those enumerated in Section 10.4, Hospital shall continue to provide Covered Services to Members who are receiving Covered Services from Hospital on the effective date of termination of this Agreement for a "Continuing Care Period" defined as the period beginning on the effective date of termination and continuing until the later of the date that the Covered Services being rendered to the Member by Hospital are completed or, in the case of a Medicare Member, for the period for which CMS premiums are paid, unless IPA or a Payor makes reasonable and medically appropriate provision for the assumption of such Covered Services by another Participating Provider. IPA shall compensate Hospital for those Covered Services pursuant to the fee for service rates set forth in **Exhibit A**. Notwithstanding the foregoing, Hospital shall provide Covered Services during and after the Continuing Care Period to the extent necessary to comply with applicable state and federal laws and regulations, including California Health and Safety Code Section 1373.96 ("Section 1373.96"). Upon the request of IPA, Hospital shall identify to IPA, in writing, any Members who may be eligible for Continuing Care Services pursuant to Section 1373.96, including, but not limited to: (a) Members receiving treatment for an acute condition; (b) Members receiving treatment for a serious chronic condition; (c) pregnant Members; (d) Members receiving treatment for a terminal illness; (e) newborn children Members between birth and age thirty-six (36) months; and (f) Members requiring surgery or other procedures authorized by the Payor in accordance with the requirements of Section 1373.96.

10.8 Termination of Hospital by Payor. Notwithstanding any other provision of this Agreement, in the event that a Payor notifies IPA that said Payor wishes to remove Hospital from the Payor roster of Participating physicians/providers, IPA shall have the right to terminate Hospital's participation with said Payor upon thirty (30) days' prior written notice.

10.9 Failure to Provide Documentation. Hospital shall execute and return to IPA all documents required by a Payor and which have been approved by IPA. If Hospital fails to execute and return any such document within fifteen (15) calendar days, then Hospital shall be deemed to have voluntarily resigned and terminated Hospital's Agreement with IPA. IPA shall give Hospital ninety (90) days' prior written notice of such termination.

10.11 Termination Due to Force Majeure. Notwithstanding anything to the contrary contained in this Agreement, IPA and/or Hospital, as applicable, shall be excused from providing services hereunder for any period Hospital and/or IPA is prevented from providing such services pursuant to this Agreement, in whole or in part as a result of acts of God, civil or military authority, acts of terrorism, war, fires, explosions, earthquakes, floods, or other cause beyond the reasonable control of IPA and/or Hospital and such nonperformance shall not be grounds for default under this Agreement. Notwithstanding the foregoing, IPA and Hospital shall make good faith efforts to perform under this Agreement in the event of any such circumstances. If either party is unable to perform its obligations under this Agreement for reasons described in this Section for a period of sixty (60) continuous calendar days, either party may terminate this Agreement upon providing the other party with thirty (30) calendar days' prior written notice.

ARTICLE XI
GENERAL PROVISIONS

11.1 Notices. Any notices required or permitted to be given hereunder by either party to the other may be given by personal delivery in writing, by overnight mail or by registered or certified mail, postage prepaid, with return receipt requested. Notices shall be addressed to the parties at the addresses set forth below, but each party may change such party's address by written notice given in accordance with this Section. Notices delivered personally shall be deemed communicated as of actual receipt; overnight mail notices shall be deemed communicated as of the following business day; and mailed notices shall be deemed communicated as of three (3) days after mailing.

If to IPA: ALPHA CARE MEDICAL GROUP
2589 E. WASHINGTON BLVD
PASADENA, CA 91107
Attn: ADMINISTRATOR

If to HOSPITAL: RIVERSIDE COUNTY REGIONAL MEDICAL CENTER
26520 CACTUS AVENUE
MORENO VALLEY, CA 92555
ATTN: EXECUTIVE ADMINISTRATION

11.2 Severability.

11.2.1 The invalidity or unenforceability of any term or provision of this Agreement shall not affect the validity or enforceability of any other term(s) or provision(s).

11.2.2 In the event that a provision of this Agreement is rendered invalid or unenforceable, and its removal has the effect of materially altering (a) the obligations of IPA in such manner as, in the sole judgment of IPA, will cause IPA to act in violation of its Articles of Incorporation or Bylaws, or (b) the obligations of either IPA or Hospital in such manner as, in the sole judgment of the affected party, will cause serious financial hardship to such party, the party so affected shall have the right to terminate this Agreement upon thirty (30) days' prior written notice to the other party.

In the event of termination pursuant to this Section, the relevant provisions of Article X shall govern such termination.

11.3 Entire Agreement of the Parties. This Agreement supersedes any and all prior agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein and contains all of the covenants and agreements between the parties with respect to the rendering of Covered Services. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, oral or otherwise relating to the subject matter contained herein, have been made by either party, or anyone acting on behalf of either party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding.

11.4 Amendment. Amendments to this Agreement shall become effective upon forty-five (45) days' prior written notice to Professional. If Hospital rejects the proposed amendment within that forty-five (45) day period, Hospital shall be deemed to have terminated this Agreement, effective ninety (90) days' following Hospital's notice of rejection of the proposed amendment. If Hospital does not reject the proposed amendment within the 45 day notice period, or does not respond to the proposed amendment within the 45 day notice period, then said amendment shall be deemed to have been accepted by Hospital upon expiration of such time period.

11.5 Modification of Agreement. At the sole discretion of IPA, Exhibit A may be modified from time to time, with prior written notice to Professional.

with prior written notice to Professional.

11.6 Assignment. This Agreement shall be binding upon, and shall inure to the benefit of, the parties to hereto, and their respective heirs, legal representatives, successors and assigns. Hospital may not assign any of his/her rights or delegate any of his/her duties hereunder without the prior written consent of the IPA.

11.7 Independent Contractor. At all relevant times and pursuant to the terms and conditions of this Agreement, Hospital is, and shall be construed to be, an independent contractor practicing Hospital's profession and shall not be deemed to be, or construed to be, an agent, servant or employee of IPA.

11.8 Confidentiality. The terms of this Agreement, in particular the provisions regarding compensation, and any financial, operating, proprietary or business information relating to IPA or a Payor that is not otherwise public information, are confidential and shall not be disclosed except as necessary to the performance of this Agreement or as required by law without the prior written consent of IPA.

11.9 Waiver. The waiver of any provision, or the breach of any provision, of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

11.10 Headings. The subject headings of the articles and sections of this Agreement are included for purposes of convenience only and shall not affect the construction or interpretation of any of its provisions.

11.11 Proprietary Information. Hospital shall maintain in confidence all Member information including, but not limited to, the Member's name, address, telephone number and any other information that identifies a particular Member ("Member Information"), and all other IPA Confidential Information. For purposes of this Agreement, "Confidential Information" shall include, but shall not be limited to, all Payor Agreements and the information contained therein regarding IPA, Payors, employer groups, the financial arrangements between any hospital and IPA or any Payor and IPA, and all manuals, policies, forms, records, files, (other than patient medical files) and patient and employee lists of IPA. Hospital shall not disclose or use any Member Information or Confidential Information for his/her benefit or gain either during the term of this Agreement or thereafter; provided, however, that Hospital may use the name, address and telephone number or other medical information of a Member if Medically Necessary for the proper treatment of such Member or with the express prior written permission of IPA, Payor and the Member. Upon termination of this Agreement, Hospital shall provide and return to IPA the Confidential Information in his/her possession or under his/her control in a reasonable manner to be specified by IPA.

11.12 No Third Party Beneficiaries. Nothing in this Agreement, expressed or implied, is intended or shall be construed to confer upon any person, firm or corporation other than the parties hereto and their respective successors or assigns, any remedy or claim under or by reason of this Agreement or any term, covenant or condition hereof, as third party beneficiaries or otherwise, and all of the terms, covenants and conditions hereof shall be for the sole and exclusive benefit of the parties hereto and their successors and assigns.

11.13. "Dispute Resolution: Provider and IPA shall adhere to the following internal escalation procedures in order to expeditiously resolve any problems arising under this Agreement and will attempt in good faith to fashion a remedy to such problems as appropriate.

One individual or selected alternative, from each party will be designated and will attempt to resolve the problem. If a resolution is not reached between these authorized individuals within five (5) days after referral to them of a problem, the dispute shall be escalated to Executive Review as specified below.

Executive Review shall be conducted as follows: Within thirty (30) days of any party's request for Executive Review, an executive level employee of each party shall be designated by the party to meet with his/her counterpart to attempt to settle the dispute. Initially, the designee for Provider shall be the Billing Manager and the designee of IPA. If said executives are unable to resolve the dispute within ten (10) days of the conclusion of said first level of Executive Review, either party may request that the problem be escalated to a second level of Executive Review, at the management level or their designee within Provider and IPA, who shall meet to attempt to settle the dispute.

This Agreement is to be construed under the laws of the State of California. The parties agree to the jurisdiction and venue of the appropriate courts in the County of Riverside, State of California. Should action be brought to enforce or interpret the provision of the Agreement, the prevailing party shall be entitled to attorney's fees in addition to whatever other relief is granted."

11.14 Responsibility for Own Acts. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of any kind which may result or arise out of any malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

IN WITNESS WHEREOF, the parties hereto have entered in this Agreement as of the date first set forth above.

Alpha Care Medical Group, Inc.

By: _____

KEVIN TYSON, MD
(Printed or typed name)

Title: **CEO**

Date: 4-17-13

Hospital

By: _____

Douglas D. Bagley
(Printed or typed name)

Title: Hospital Director/CEO

Date: 4/29/13

Tax ID #: 95-6000930

FORM APPROVED COUNTY COUNSEL
BY: _____ 6/7/13
NEAL R. KIPNIS DATE

EXHIBIT A
COMPENSATION

I. Fee schedule.

Services authorized by IPA and defined as IPAs financial responsibility, shall be reimbursed at the following fee schedule:

A. Medi-Cal Members shall be reimbursed at one hundred percent (100%) of Medi-Cal allowable fee schedule, less any applicable co-payment and/or deductible.

B. Healthy Kids Members shall be reimbursed at one hundred percent (100%) of Medi-Cal allowable fee schedule, less any applicable co-payment and/or deductible.

C. Healthy Families Members shall be reimbursed at one hundred percent (100%) of Medi-Cal allowable fee schedule, less any applicable co-payment and/or deductible.

D. Commercial Members shall be reimbursed at sixty-five percent (65%) of billed charges, less any applicable co-payment and/or deductible.

E. Medicare Members shall be reimbursed at one hundred percent (100%) of Medicare allowable rates, less any applicable co-payment and/or deductible.

II. CCS-Eligible Conditions. The California Children's Services Program is financially responsible for payment of health care costs to treat CCS-eligible conditions. Hospital understands and agrees that IPA is not financially responsible for payment of services to treat CCS-eligible conditions.

III. Medicare Secondary Payer (MSP) Hospital agrees to coordinate benefits with primary payer for MSP members in accordance with Medicare regulations. IPA will follow the Medicare rules and payment as a secondary payer.

IV. Fee-for Service Reimbursement. Fee-for Service reimbursement for all services in this Exhibit shall not exceed billed charges. IPA will pay the lesser of billed charges or the fee-for-service reimbursement. Fee-for-Service reimbursement shall be less any applicable Co-payments and/or Deductibles. Hospital shall be responsible for the collection of any Co-payments and/or Deductibles from members.

V. Directions for Claim Submission. Claims MUST be received in accordance with the provisions of Article IV of the Agreement.

VI. Financial Responsibility. IPA shall reimburse Professional for services that are the financial responsibility of IPA. Health Plan payer shall reimburse Professional for services that are Health Plan financial responsibility.

EXHIBIT B
DISCLOSURE FORM

(Welfare and Institutions Code Section 14452)

COUNTY OF RIVERSIDE, ON BEHALF OF THE RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

(Name of Hospital as written on First Page of Contract)

The undersigned hereby certifies that the following information regarding the above-named Hospital ("Entity") is true and correct as of the date set forth below.

1. Officers/Directors/General Partners:

COUNTY OF RIVERSIDE, BOARD OF SUPERVISORS

2. Co-Owner(s):

3. Stockholders owning more than ten percent (10%) stock of the Entity:

4. Major creditors holding more than five percent (5%) of Entity's debt:

5. Form of Entity (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

GOVERNMENT ENTITY

Dated: 4/2a/13 Signature: Cathy Giannini

Print Name: Cathy Giannini

EXHIBIT C
HOSPITAL PROVIDER(s) AND LOCATIONS(s) INCLUDED WITH AGREEMENT

Print Name	Specialty	Address
Riverside County Regional Medical Center	Hospital	26520 Cactus Avenue Moreno Valley, CA 92555

EXHIBIT D

MEDICARE ADVANTAGE FIRST TIER ENTITY

DOWNSTREAM PROVIDER CONTRACT ADDENDUM

This Downstream Provider Contract Addendum ("Addendum") is entered into by

Alpha Care Medical Group ("First Tier Entity") and **Hospital** ("Downstream Provider") effective **April 1, 2013**, in order to add contract language required by the Centers for Medicare and Medicaid Services, "(CMS") for participation in the Medicare Advantage ("MA") Program.

Whereas, CMS requires that specific terms and conditions be incorporated into sub contracts between a First Tier Entity and a Downstream Provider to comply with the provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Pub. L.108-73) (MMA).

Whereas, Downstream Provider desires to provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

Whereas, First Tier Entity desires that Downstream Provider provide services to Medicare beneficiaries who enroll in the Medicare Advantage Program; and

Whereas, Downstream Provider agrees to comply with the terms and conditions specified by CMS in the form of this Addendum to the Agreement between Downstream Provider and First Tier Entity.

NOW, THEREFORE, the parties agree as follows:

DEFINITIONS

"Agreement" means the agreement between the First Tier Entity and Downstream Provider that specifies the contractual relationship between the First Tier Entity and Downstream Provider for the provision of services to Members.

"Downstream Provider" means an entity or individual that is contracted by a First Tier Entity to provide services to Members. A Downstream Provider includes, but is not limited to physicians, ancillary providers, and other health care providers.

"First Tier Entity" means the entity that contracts with a Medicare Advantage Organization, (MAO) to provide services to Members. A First Tier Entity includes but is not limited to medical group, individual practice association ("IPA"), or hospital.

"Centers for Medicare and Medicaid Services" ("CMS") means the agency within the Department of Health and Human Services that administers the Medicare Program.

"Completion of Audit" means Completion of Audit by CMS of an MAO, MAO subcontractors or related entities.

"Final Contract Period" means Final Contract Period between CMS and the MAO with whom the First Tier Entity has entered into an Agreement.

"Industry Collaboration Effort" ("ICE") is a collaboration of health plans, providers and industry associations working on health care issues.

"Medicare Advantage Organization" ("MAO")" means a Health Plan that has entered into an agreement with the CMS to provide services to Medicare beneficiaries under the Medicare Advantage Program.

"Medicare Advantage" ("MA") means the program offered by the federal government in which Medicare beneficiaries

have several options to receive health care services.

"Member" means an individual who has enrolled in or elected coverage through an MAO. A Member is also known as a Member.

OPL 77 REQUIRED PROVISIONS

Operational Policy Letter (OPL) 98.077 (revised) requires the Downstream Provider to comply with the following requirements:

1. Downstream Provider agrees to give the Department of Health and Human Services (HHS), 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 (10) years, or for periods exceeding ten (10) years, from the end of the Final Contract Period or Completion of Audit, whichever is later for reasons specified in the federal regulation, for Members enrolled in a MAO. 42 CFR 422.504 (e) (4).
2. Downstream Provider agrees to comply with all confidentiality and Member record accuracy requirements. 42 CFRs 422.118 and 422.502. (a)(13).
3. Downstream Provider agrees to hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or First Tier Entity. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or other intermediary, or the insolvency of the MAO, First Tier Entity, or other intermediary, shall Downstream Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Downstream Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the MAO 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. 42 CFRs 422.502(g) and (i)(3)(i)(A).
4. Downstream Provider agrees to perform, if applicable, the functions that are delegated consistent with the First Tier Entity requirements, MAO requirements, and federal regulation. Downstream Provider also agrees to comply with any applicable delegation requirements and regulations between the MAO and First Tier Entity. 42 CFRs 422.502(i)(3)(iii) and 422.502(i)(4).
5. First Tier Entity agrees to pay Downstream Provider promptly according to CMS standards and comply with all payment provisions of law. 42 CFR 422.520(b).
6. Downstream Provider agrees to comply with CMS reporting requirements as specified in Sec 422.257 (encounter data) and Sec 422.516 (informational data). 42 CFR 422.502(a)(8).
7. Downstream Provider agrees to comply with CMS accountability provisions, including but not limited to the requirement to comply with Medicare laws, regulations, and CMS instructions, which are more fully documented in the MAO's policies and procedures. 42 CFRs 422.502(i)(3)(ii)(A) and 422.502(i)(4)(v).
8. Downstream Provider agrees that cost sharing for dual eligible Members is limited to the Medicaid (including Medi-Cal) cost sharing limits, and that for those dual-eligible Members the Downstream Provider will accept the Medicare Advantage Organization or First Tier Entity payment as payment in full or will separately bill the appropriate state source for any amounts above the Medicaid (or Medi-Cal) cost sharing. 42 CFR 422.504(g)(1)(iii)
9. First Tier Entity delegates selection of providers to the Downstream Provider; Medicare Advantage Organization and First Tier Entity retain the right to approve, suspend, or terminate such arrangement, as agreed to herein. 42 CFR 422.504(i)(5)
10. First Tier Entity specifies the Downstream Provider's delegated activities and reporting responsibilities, as agreed to herein. 42 CFR 422.504(i)(3)(ii) and 422.504(i)(4)(i)

11. CMS, MAO and First Tier Entity reserve the right to revoke the delegated activities and reporting requirements in instances where CMS, MAO or First Tier Entity determines that Downstream Provider has not performed satisfactorily as agreed to herein. 42 CFR 422.504(i)(3)(ii) and 422.504(i)(4)(ii)

12. MAO, or First Tier Entity if MAO has delegated this function to First Tier Entity, will monitor the performance of the Downstream Provider on an ongoing basis, as agreed to herein. 42 CFR 422.504(l)(3)(ii) and 422.504(l)(3)(ii)

Except as provided in this Addendum, all other provisions of the Agreement between Hospital 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 continue concurrently with the term of such Agreement.

ALPHA CARE MEDICAL GROUP:

Signature: _____

Print Name: **KEVIN TYSON, MD**

Title: **CEO**

Date: 4-17-13

HOSPITAL:

Signature: _____

Print Name: Douglas Bagley

Title: Hospital Director/CEO

Date: 4/11/13

FORM APPROVED COUNTY COUNSEL
BY: _____ 4/17/13
NEAL R. KIPNIS DATE