FORM APPROVED COUNTY COUNSEL 5/21/15
BY: GREGORY P. PRIAMOS DATE

Departmental Concurrence

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

204

FROM: Riverside County Regional Medical Center

SUBMITTAL DATE:
May 5, 2015

SUBJECT: Ratify the Letter of Agreement with Inland Empire Health Plan and IEHP Health Access for a one year period [All Districts; $0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and authorize the Chairman to execute the Letter of Agreement with Inland Empire Health Plan and IEHP Health Access to provide Behavioral Health Services effective April 1, 2015 through March 31, 2016; and
2. Authorize the Hospital CEO or designee to sign amendments that do not change the substantive terms of the agreement, as approved by County Counsel.

BACKGROUND:
Summary
Through the Medi-Cal Expansion Behavioral Health Services (GAP services), Inland Empire Health Plan (IEHP) will provide expanded mental health services for all IEHP Medi-Cal members, who are deemed "mild" (not meeting specialty mental health criteria) as defined by California Department of Health Care Services (DHCS).

Zareh Sarrafian
Chief Executive Officer

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 0	$ 0	$ 0	$ 0	Consent ☐ Policy ☐
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS: Inland Empire Health Plan 100%

Budget Adjustment: No

For Fiscal Year: 14/15 - 15/16

C.E.O. RECOMMENDATION: APPROVE

BY: Christopher M. Hans

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

☐ Positions Added ☐ Change Order ☐ A-30 ☐ 4/5 Vote

Prev. Agn. Ref.: **District:** 5 **Agenda Number:** 3-47

Previous Agenda Reference

Services include but are not limited to, individual and group mental health, evaluation and treatment; psychological testing when clinically indicated; outpatient drug therapy monitoring; and psychiatric consultation services, which cannot be rendered by a Primary Care Physician or by a County Mental Health facility.

Impact on Residents and Businesses

The Hospital, its site-based clinics and community-based clinics serve residents in all five Riverside County supervisorial districts.

Contract History and Price Reasonableness

Riverside County Regional Medical (RCRMC) is the Provider responsible for submitting claims to IEHP for authorized covered services provided to Members. This Letter of Agreement (LOA) is for one year effective April 1, 2015 through March 31, 2016. Although this LOA is temporary, the services will assist members under the health plan until a permanent contract agreement is established. The revenue received through this LOA will enable the hospital to enhance its services towards the members of the health plan.

ZS:ns

LETTER OF AGREEMENT

This Letter of Agreement ("Agreement") is made and entered into by and between ***Inland Empire Health Plan*** and ***IEHP Health Access*** (collectively referred to as "IEHP HEALTH PLAN" or "PAYOR"), and **RIVERSIDE COUNTY REGIONAL MEDICAL CENTER** ("PROVIDER") for the provision of medical services to PAYOR's Members.

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

1. DUAL ELIGIBLE BENEFICIARY – shall mean an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c et seq.) and Medicare Part B (42 U.S.C. § 1395j et seq.) and is eligible for medical assistance under the Medi-Cal State Plan.

2. MEDICARE - A benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by Health Access as outlined in Attachment C. Medicare includes IEHP Health Plan's D-SNP product as well as the Capitated Financial Alignment Demonstration, also known as the "Duals Pilot Project," which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and DHCS.

3. PROVIDER shall render medical services as authorized by PAYOR to Member and agrees to accept the Fee Schedule listed in Attachment A. PROVIDER shall not bill, charge or attempt to collect any payments, surcharges or other remuneration, excluding applicable copayments, from Members of HMOs or other such programs as regulated by the Knox-Keene Health Care Service Plan Act of 1975 and the Department of Health Care Services through Title 22 of the California Code of Regulations, as amended.

4. Healthcare services provided by PROVIDER under this Agreement require prior authorization. All authorizations for services are only valid for the individual PROVIDER named in the authorization. Authorizations issued to a PROVIDER within a Provider Group are not considered "Group Authorization," but rather are only valid for the individual credentialed PROVIDER named in the authorization.

5. PROVIDER shall maintain a uniform medical record in accordance with community standards and in compliance with all applicable federal and state laws, rules and regulations for each Member. Upon request, PROVIDER shall allow IEHP HEALTH PLAN, the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and all other state and federal regulatory agencies to inspect medical records for Member(s) and shall provide copies of all medical records or other medical reports, without charge.

6. PROVIDER shall prepare and maintain such records, including books, records and papers related to medical services provided to Members, and provide access to such information to IEHP HEALTH PLAN, and other applicable state and federal regulatory agencies as may be necessary to comply with federal and state laws, rules and regulations. This obligation shall survive the termination of this Letter of Agreement for minimum of ten (10) years.

7. PAYOR shall make payments to PROVIDER in accordance with Attachment B hereto, provided the member is eligible with the PAYOR at the time services are rendered. PROVIDER shall submit claims to PAYOR for authorized covered services provided to Members within one hundred and eighty (180) days from the date of service. The claim must be submitted on a CMS 1500 or a UB-04 claim form and shall include all Member identifying information and the authorization number provided by PAYOR relating to medical services provided pursuant to this Agreement.

8. PAYOR shall compensate PROVIDER within forty-five (45) working days of receipt of a complete **CMS 1500 or a UB 04** form from PROVIDER. Any compensation disputes must be filed within 365 calendar days of payment or denial and shall be handled in accordance with Health and Safety Code § 1371 et seq.

9. PAYOR and PROVIDER shall abide by any applicable State and Federal laws and regulations including, but not limited to, all provisions found in the Knox-Keene Health Care Service Plan Act of 1975, as amended.

10. PAYOR'S financial obligation under this agreement is subject to the Member's eligibility being effective with PAYOR at the time services are rendered.

11. Throughout the term of this Agreement, PROVIDER shall maintain, at its sole cost and expense, policies for insurance providing coverage for PROVIDER's general liability and professional liability (errors and omissions), and any other insurance coverage PROVIDER deems prudent and customary in the exercise of PROVIDER's business operations, in amounts as may be necessary to protect PROVIDER and its officers, agent, and employees in the discharge of its responsibilities and obligations under this Agreement. Upon request, PROVIDER shall furnish PAYOR with evidence of such insurance coverage.

The term of this Letter of Agreement shall become effective as of **APRIL 1, 2015** and shall continue in effect until **MARCH 31, 2016**.

12. Either party may terminate this Agreement without cause by providing the other party thirty (30) working days prior written notice to terminate via Certified Mail.

13. Any notices required to be given herein by either party to the other shall be effected by certified letter to the appropriate address as follows:

IEHP HEALTH PLAN
Inland Empire Health Plan
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
(909) 890-2000
Attn: Director of Contracts

PROVIDER
Riverside County Regional Medical Center
26520 Cactus Avenue
Moreno Valley, CA 92555
Attention: Contract Administrator

14. Completed billing forms for services must be sent to:

Inland Empire Health Plan
Attn: Claims Department – IEHP Direct Auth.
PO Box 4349
Rancho Cucamonga, CA 91729-4349

15. Payment for services rendered will be sent to:

Riverside County Regional Medical Center
26520 Cactus Avenue
Moreno Valley, CA 92555
Attention: Contract Administrator

16. The relationship between PAYOR and PROVIDER is an independent contractor relationship. Neither PROVIDER nor its employee(s) and/or agent(s) shall be considered to be an employee(s) and/or agent(s) of PAYOR, and neither PAYOR nor any employee(s) and/or agent(s) of PAYOR shall be considered to be an employee(s) and/or agent(s) of PROVIDER. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.

17. This Agreement, including all attachments, which are incorporated herein by this reference, constitutes the entire agreement by and between the parties regarding the matters contemplated by this Agreement, and supersedes any and all other agreements, promises, negotiations or representations, either oral or written, between the parties with respect to the subject matter and period governed by this Agreement.

18. No alteration and/or amendment of any terms or conditions of this Agreement shall be binding, unless reduced to writing and signed by the parties hereto. Amendments required due to legislative, regulatory or other legal authority do not require the prior approval of PROVIDER and shall be deemed effective immediately upon PROVIDER's receipt of notice.

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

20. The provisions of the Government Claims Act (Government Code section 900 et seq.) must be followed first for any disputes arising under this Agreement.

21. This Agreement shall be governed by and construed in accordance with the laws of the State of California. All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the counties of San Bernardino or Riverside, State of California.

22. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – IEHP PLAN and PROVIDER are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009 (HITECH), Public Law 111-5, enacted February 17, 2009, and the laws and regulations promulgated subsequent hereto, for purposes of services rendered pursuant to the Agreement. Both parties agree to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA and HITECH. Both parties further agree that it shall be in compliance with the requirements of HIPAA, HITECH and the laws and regulations promulgated subsequent hereto.

IN WITNESS WHEREOF, the parties hereto have entered into this Letter of Agreement as of **MAY 5, 2015**.

PROVIDER: RCRMC

By:__________________________________

Title:________________________________

Date:________________________________

PAYOR: IEHP

By:__________________________________
David Carrish

Title: Director of Provider Contracting

Date: 5-5-15

TIN#: **95-6000930**

NPI#: **1386852416**

ATTACHMENT A

BEHAVIORAL HEALTH SERVICES

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

Healthcare services provided by Provider under this agreement require prior authorization. All authorizations for services are only valid for the individual Provider named in the authorization. Authorizations issued to a Provider within a Provider Group are not considered "Group Authorization," but rather are only valid for the individual credentialed Provider named in the authorization. Covered services must be personally performed by the authorized Provider and not be assigned or delegated to any employee, intern, assistant, associate or agent of Provider, except upon prior written approval by IEHP and Health Access. Any such authorizations given by IEHP and Health Access must not be deemed a waiver of Provider's obligation to obtain prior authorization thereafter for similar assignment and delegation. All referrals to other IEHP Behavioral Health Providers must be submitted to IEHP and Health Access for prior authorization. Provider must only refer Members to IEHP and Health Access contracted hospitals and facilities.

Within five (5) working days from the Member's initial evaluation, Provider must provide coordination of care reports to IEHP and Health Access and to the Member's Primary Care Physician (PCP), according to IEHP Policy and Procedure Manual and consistent with HIPAA guidelines. The report must contain a summary of clinical findings and treatment recommendations.

Specialty Services shall include:

Behavioral Health

Behavioral Health (I/P): Professional services when ordered and performed by a participating behavioral health professional for the treatment of an acute phase of a behavioral health condition during a certified confinement in a participating hospital. Limit of one hundred ninety (190) days in a lifetime.

Substance Abuse (I/P): Professional services for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system. Limit of ninety (90) days each benefit period.

Behavioral Health (O/P): Behavioral Health Services when ordered and performed by a participating behavioral health professional. Behavioral health services for Medicare covered mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department.

Substance Abuse (O/P): Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate.

ATTACHMENT A
(Continued)
BEHAVIORAL HEALTH SERVICES

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

Medi-Cal Expansion Behavioral Health Services (GAP services)-IEHP will provide expanded mental health services for all IEHP Medi-Cal members, who are deemed "mild" (Not meeting Specialty Mental Health Criteria) as defined by DHCS, and shall be, but will not be limited to, individual and group mental health evaluation and treatment; psychological testing when clinically indicated; outpatient drug therapy monitoring; and psychiatric consultation services, which cannot be rendered by a Primary Care Physician or by a County Mental Health facility, and must be pre-authorized by IEHP.

(THIS SECTION HAS BEEN INTENTIONALLY LEFT BLANK)

ATTACHMENT B

BEHAVIORAL HEALTH COMPENSATION SCHEDULE

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

PROVIDER shall accept such reimbursement as payment in full for those authorized Behavioral Health Services provided to Members. Claims will be paid for preauthorized CPT Codes at the corresponding rate less the applicable copayment. Reimbursement shall not exceed billed charges:

LCSW/MFT SERVICES:

CPT Code	Outpatient Services*	Rate
90791	Psychiatric diagnostic evaluation (no medical services)*	80% Medicare
90832	Psychotherapy (30 minutes)	80% Medicare
90834	Psychotherapy (45-50 minutes)	80% Medicare
90846	Family Psychotherapy without patient present (45-50 minutes)	80% Medicare
90847	Family Psychotherapy with patient (45-50 minutes)	80% Medicare
90853	Group Psychotherapy (90 minutes)	80% Medicare

PSYCHOLOGIST SERVICES:

CPT Code	Outpatient Services*	Rate
90791	Psychiatric diagnostic evaluation (no medical services)*	80% Medicare
90832	Psychotherapy (30 minutes)	100% Medicare
90834	Psychotherapy (45-50 minutes)	100% Medicare
90846	Family Psychotherapy without patient present (45-50 minutes)	100% Medicare
90847	Family Psychotherapy with patient (45-50 minutes)	100% Medicare
90853	Group Psychotherapy (90 Minutes)	100% Medicare
96101	Psychological Testing (per hour physical time)	100% Medicare
96118	Neuropsychological Testing (per hour physical time)	100% Medicare
	Services Provided in Psychiatric Hospitals	
99222	Initial Hospital Care, per day	100% Medicare
99223	Initial Hospital Care, per day	100% Medicare
99233	Subsequent Hospital Care, per day	100% Medicare
	Services Provided in Medical Facilities	
99212	Medical/Surgical Floor Consultation (20-30 minutes)	100% Medicare
99213	Medical/Surgical Floor Consultation (50-60 minutes)	100% Medicare

ATTACHMENT B
(Continued)
BEHAVIORAL HEALTH COMPENSATION SCHEDULE

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

NURSE PRACTITIONER SERVICES:

CPT Code	Outpatient Services*	Rate
90792	Psychiatric diagnostic evaluation with medical services	80% Medicare
90832	Psychotherapy (20-30 minutes)	80% Medicare
99212	Pharmacologic Management (approx. 10-20 minutes)	80% Medicare
99213	Pharmacologic Management (approx. 15-25 minutes)	80% Medicare
	Services Provided in Psychiatric Hospitals	
90833	Psychotherapy with E/M (20-30 minutes with patient or family)	80% Medicare
99222	Initial Hospital Care, per day	80% Medicare
99223	Initial Hospital Care, per day	80% Medicare
99233	Subsequent Hospital Care, per day	80% Medicare
99238	Hospital Discharge Day Management	80% Medicare
	Services Provided in Medical Hospitals	
99212	Medical/Surgical Floor Consultation (25-30 Minutes)	80% Medicare
99213	Medical/Surgical Floor Consultation (50-60 Minutes)	80% Medicare

PSYCHIATRIST SERVICES:

CPT Code	Outpatient Services*	Rate
90792	Psychiatric diagnostic evaluation with medical services	100% Medicare
90833	Psychotherapy with E/M (20-30 minutes with patient or family)	100% Medicare
99212	Pharmacologic Management (approx. 10-20 minutes)	100% Medicare
99213	Pharmacologic Management (approx. 15-25 minutes)	100% Medicare
	Services Provided in Psychiatric Hospitals	
99222	Initial Hospital Care, per day	100% Medicare
99223	Initial Hospital Care, per day	100% Medicare
99233	Subsequent Hospital Care, per day	100% Medicare
99238	Hospital Discharge Day Management	100% Medicare
	Services Provided in Medical Hospitals	
99212	Medical/Surgical Floor Consultation (25-30 Minutes)	100% Medicare
99213	Medical/Surgical Floor Consultation (50-60 Minutes)	100% Medicare

ATTACHMENT B
(Continued)
BEHAVIORAL HEALTH COMPENSATION SCHEDULE

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

MISC. REIMBURSEMENTS ITEMS:

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

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

*IEHP and Health Access require Initial Treatment, Request for Additional Services and Discharge Reports under this Agreement. Compensation for these required reports are built into the rates listed above.

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

Reimbursement for authorized services not listed above shall be paid at Eighty Percent (80%) of Medicare.

Completed claims authorized Health Care Services must be sent to:

Inland Empire Health Plan
Attn: Claims Department
P.O. Box 4349
Rancho Cucamonga, CA 91729-4349

NOTE: Billing with Modifiers:
Psychiatrist – No Modifiers Required
Psychologist – AH
Social Worker – AJ
Marriage Family Therapist – AK
Nurse Practitioner - SA

ATTACHMENT C

PARTICIPATING PROVIDERS

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

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

FACILITY NAME	ADDRESS	GROUP NPI	OFFICE HOURS
Riverside County Regional Medical Center-Family Medicine Residency	26520 Cactus Avenue Moreno Valley, CA 92555	1386852416	Monday-Friday 8:00a.m.-5:00p.m.

Provider Name	License# and NPI	Phone/Referral Fax	Type
1. Barbara C. Ackerman, PhD	PSY18733/1639126410	951-486-4919	Psychologist

ATTACHMENT D

MEDICARE ADVANTAGE PROGRAM

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

I. DEFINITIONS

For purposes of this Attachment, the following definitions shall apply. All regulatory references in the brackets are to sections contained in 42 CFR Part 422, unless otherwise indicated.

1.1. **Downstream Entity** means all entities or individuals below the level of the First Tier Entity (e.g., individual providers that contract with an IPA or Administrative Service Entities), typically referred to as subcontractors, related entities, and management companies. Downstream Entity shall also be referred to as a Provider.

1.2. **End Stage Renal Disease (ESRD)** means members who require kidney dialysis for the remainder of life.

1.3. **First Tier Entity** means the contracted provider, which is the first level of contractor with the Health Plan (e.g., Individual Practice Association (IPA), Hospital, Physician, Specialist, Ancillary Provider or Physician Hospital Association (PHO) who or which has a direct contract with Health Plan).

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

1.5. **CMS Agreement** means the Medicare Advantage contract between CMS and the MAO.

1.6. **Dual Eligible Beneficiary** means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c *et seq.*) and Medicare Part B (42 U.S.C. § 1395j *et seq.*) and is eligible for medical assistance under the Medi-Cal State Plan.

1.7. **Medicare** means a benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Health Plan contracted with CMS as outlined in this Attachment. Medicare includes IEHP Health Plan's D-SNP product as well as the Capitated Financial Alignment Demonstration, also known as the "Duals Pilot Project," which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and the California Department of Health Care Services.

1.8. **Medicare Advantage Organization (MAO)** means a Health Plan or Provider Sponsored Organization that has entered into an agreement with the CMS to provide Medicare beneficiaries with health care options.

1.9. **Member** means an individual who has enrolled in or elected coverage through a MAO.

1.10. **Provider** means a First Tier Entity.

II. ACCESS: RECORDS AND FACILITIES

Provider agrees:

2.1. To give the Department of Health and Human Services (HHS), CMS and the Comptroller General or their designees the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems, medical records, patient care documentation, and other records of Provider, its contractors, subcontractors, or related entities for the later of ten (10) years, or for periods exceeding ten (10) years, for reasons specified in the federal regulation. [422.504(e)(2), (3), and (4); 422.504(i)(2)(ii)]

2.2. To safeguard the privacy and confidentiality of any information that identifies a particular Member, and abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. [422.118(a)]

2.3. To maintain the records and information of Members in an accurate and timely manner. [422.118(c)]

2.4. To ensure that medical information pertaining to Members is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas. [422.118(b)]

2.5. To comply with MAO's standards for timeliness for appointments and waiting times for each type of service. [422.112(a)(6)(i)]

2.6. To ensure timely access by Members to the records and information that pertain to them. [422.118(d)]

III. ACCESS: BENEFITS AND COVERAGE

Provider agrees:

3.1. To not discriminate based on health status. [422.110(a)]

3.2. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for emergency and urgently needed services consistent with federal regulations, if such services are MAO's liability. [422.100(b)]

3.3. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for renal dialysis services for Members temporarily outside the service area consistent with federal regulations, if such services are MAO's liability. [422.100(b)(1)(iv)]

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

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

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

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

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

3.9. To maintain procedures to ensure that Members are informed of specific health care needs that require follow-up and receive, as deemed medically necessary by Provider, training in self-care and other measures that Members may take to promote their own health. [422.112(b)(5)]

IV. MEMBER PROTECTIONS

Provider agrees:

4.1. To work with the MAO regarding conducting a health assessment of all new Members within ninety (90) days of the effective date of enrollment. [422.112(b)(4)]

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

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

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

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

4.6. That Members eligible for Medicare and Medicaid will not be liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts, and Provider will accept the MAO payment as payment in full or bill the appropriate State source. [422.504(g)(1)(iii)]

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

4.8. To provide for continuation of health care benefits for all Members for the duration of the contract period for which CMS premiums have been paid. [422.504(g)(2) and (3)]

4.9. To ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [422.112(a)(8)]

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

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

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

4.12. To not encourage disenrollment of a Member because of the onslaught of ESRD. [422.110(b)]

V. DELEGATION

Provider agrees:

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

5.2. That MAO may only delegate activities or functions to a Provider, related entity, contractor or subcontractor in a manner consistent with the requirements set forth in 42 CFR § 422.504(i)(4)(i). [422.504(i)(3)(ii)]

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

5.4. That if MAO delegates selection of providers, contractors, or subcontractors to Provider or another organization, MAO retains the right to approve, suspend, or terminate any such arrangement. [422.504(i)(5)]

5.5. That any contract delegating activities or functions to a Provider, related entity, contractor or subcontractor, shall include language that incorporates the Capitated Financial Alignment Demonstration product offering, also known as the "Duals Pilot Project," i.e. the definition of Medicare as specified hereinabove.

5.6. That any contract or arrangements with First Tier, Downstream and Related Entities for medical providers, shall include language that clearly states the medical provider's Emergency Medical Treatment & Labor Act (EMTALA) obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

5.7. That any contract or arrangements with First Tier, Downstream and Related Entities for

medical providers, shall include language that prohibits the contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:

(a) Communication with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or

(b) Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.

5.8. That Assignment or delegation of the Subcontract will be void unless prior written approval is obtained from Department of Health Care Services.

5.9. That any contract or arrangements with First Tier, Downstream and Related Entities for medical providers, shall include language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in the connection with any claim or action brought against the contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.

VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

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

6.2. To pay claims promptly according to CMS standards and comply with all payment provisions of state and federal law. CMS requires non-contracted provider clean claims to be paid within thirty (30) days of receipt, interest on clean claims to be paid in accordance with §§ 1816 and 1842(c)(2) of the Social Security Act if such claims are not paid within 30 days, and other claims from non-contracted provider to be paid or denied within 60 days of request. [422.520(a)]

6.3. MAO is obligated to pay a contracted Provider under the terms of the contract between the MAO and the Provider. [422.520(b)]

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

VII. REPORTING AND DISCLOSURE

Provider agrees:

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

7.2. To submit and certify the accuracy, completeness and truthfulness of all encounter data. [422.504(a)(8); 422.504(l)]

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

7.4. To submit, as required by CMS, a complete and accurate risk adjustment data, and a sample of the medical records for validation of risk adjustment data. [422.310(d)(3), (4); 422.310(e)]

VIII. QUALITY ASSURANCE / QUALITY IMPROVEMENT

Provider agrees:

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

8.2. To comply with MAO's medical policy, Quality Assurance program, and Medical Management program. [422.152; 422.202(b); 422.504(a)(5)]

IX. COMPLIANCE

Provider agrees:

9.1. That the MAO or First Tier Entity must notify any Provider, in writing, of the reason(s) for denial, suspension or termination determinations that affect health care professionals, the right to appeal the action, and the process and timing for requesting a hearing. [422.202(d)(1)]

9.2. That MAO and First Tier Entity must provide at least 60 days written notice to each other before terminating the contract without cause. [422.202(d)(4)]

9.3. With respect to Downstream Entities, to provide both the First Tier Entity and the MAO at least 60 days written notice before terminating a contract without cause. [422.202(d)(4)]

9.4. To comply with HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164, and Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act and the anti-kickback statute. [422.504(h)]

9.5. 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.

9.6. To comply with (and require that all Downstream Entities comply with) all applicable MAO procedures and MAO's Medicare Advantage Participating Provider Operations Manual including, but not limited to, the accountability provisions. [422.504(i)(3)(ii)]

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

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

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

9.10. To adhere to Medicare's grievance and expedited grievance procedures for Members, including gathering and forwarding information to MAO, as necessary. [422.562(a); 422.564]

9.11. To adhere to all guidelines and requirements for marketing as set forth by CMS. This includes, but is not limited to, discouraging Providers from [42 CFR 422.2268; 423.2268]:

9.11.1 Attempting to explain MAO membership and costs;

9.11.2 Being the exclusive source of membership information;

9.11.3 Acting as agents of the MAO;

9.11.4 Acting outside their role as medical providers of care;

9.11.5 Discriminating in favor of "healthy" patients.

9.12. Providers may do the following:

9.12.1. Display plan-marketing materials for all plans with which the Provider participates, or display materials for those plans that provide them;

9.12.2. In compliance with Medicare marketing guidance and regulations, cooperatively advertise and market with MAO.

X. ADOPTION OF MEDICARE CONTRACT REQUIREMENTS

Provider agrees:

10.1. That all contracts must be signed and dated.

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

10.3. To comply with the regulatory requirements and MAO's guidelines promulgated by Medicare, which are more fully documented in MAO's policies, procedures, and manuals. [422.202(b)]

10.4. To comply with Medicare laws, regulations and CMS instructions which are more fully documented in MAO's policies, procedures and manuals. [422.504(i)(4)(v)]

10.5. That any services or other activities performed by Provider in accordance with a contract between MAO and Provider are consistent and comply with MAO's obligations under the CMS Agreement. [422.504(i)(3)(iii)]

XI. INTERPRETATION OF ATTACHMENT

Provider and MAO agree:

11.1. Except as provided in this Attachment, all other provisions of the Agreement between MAO and First Tier Entity not inconsistent herein shall remain in full force and effect.

11.2. This Attachment shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall terminate upon the termination of such Agreement.

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