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

FROM: Department of Mental Health

SUBMITTAL DATE: November 22, 2011

SUBJECT: Approve the Health Care Services Agreement between Riverside County Department of Mental Health and Southern California Permanente Medical Group (Kaiser).

RECOMMENDED MOTION: Move that the Board of Supervisors ratify and:

1. Approve the FY 2010/2011 Health Care Services Agreement between the Riverside County Department of Mental Health and Southern California Permanente Medical Group (Kaiser);
2. Authorize the Chairman of the Riverside County Board of Supervisors to sign the Health Care Services Agreement; and
3. Authorize the Director of the Riverside County Department of Mental Health to annually renew this agreement and sign ministerial amendments through June 30, 2016.

BACKGROUND: The Riverside County Department of Mental Health (RCDMH), through its Inpatient Treatment Facility (ITF) and Emergency Treatment Services (ETS) Units, provides Inpatient Psychiatric Services, Crisis Intervention and Assessments to beneficiaries of the Southern California Permanente Medical Group (KAISER). **(Continued on Page 2)**

FORM APPROVED COUNTY COUNSEL
BY: ELEANA M. BOEVA DATE 11/16/11
Departmental Concurrence

JW: KAS:SL

Jerry Wengerd, Director
Department of Mental Health

FINANCIAL DATA	**Current F.Y. Total Cost:**	$0	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$0	**Budget Adjustment:**	No
	Annual Net County Cost:	$0	**For Fiscal Year:**	FY 2010/11

SOURCE OF FUNDS: N/A

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION: APPROVE

BY: Debra Cournoyer

County Executive Office Signature Debra Cournoyer

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

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Buster, seconded by Supervisor Benoit and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Buster, Stone, Benoit and Ashley
Nays:	None
Absent:	Tavaglione
Date:	December 6, 2011
xc:	Mental Health

Kecia Harper-Ihem
Clerk of the Board
By: _____ Deputy

Prev. Agn. Ref: 1/15/91 item 3.45; 8/12/97 item 3.46

District: ALL

Agenda Number: 3.21

ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

SUBJECT: Approve the Health Care Services Agreement between Riverside County Department of Mental Health and Southern California Permanente Medical Group (Kaiser).

BACKGROUND: (continued)
On January 15, 1991, Agenda Item 3.45, the Riverside County Board of Supervisors approved the original agreement between RCDMH and Kaiser for services provided at ETS and ITF to members of Kaiser. In addition, on August 12, 1997, Agenda Item 3.46, the agreement was amended to revise the negotiated rates of service between Kaiser and RCDMH. However, in 2009, Kaiser and RCDMH met and jointly decided that a new, modified contract was needed that outlines in detail the services to be rendered by RCDMH to members of Kaiser as mutually agreed to by both parties, and an agreement that outlines the newly established rates for client services as well. The new service agreement between Kaiser and RCDMH outlines the roles and responsibilities of each agency. RCDMH will provide the following services to beneficiaries of Kaiser: (1) 23-hour ETS crisis intervention; (2) ITF Inpatient Psychiatric Services; and (3) Crisis Intervention and Assessment. This new health care service agreement with Kaiser is intended to generate revenue for RCDMH, which will offset the costs of providing services.

Therefore, the RCDMH is requesting that the Board of Supervisors ratify and approve the FY 2010/2011 agreement between the RCDMH and Kaiser for the continued provision of services at ETS and ITF for Kaiser members.

FINANCIAL IMPACT:
Through this agreement, RCDMH projects estimated revenues of approximately $50,000 for FY 2010/11. This contract contains termination provisions in case of unavailability of applicable Federal, State, and/or County funds. No County funds are required.

PERIOD OF PERFORMANCE:
This service agreement with Kaiser will be effective from July 1, 2010 through June 30, 2011, and may be renewed annually through June 30, 2016.

JUSTIFICATION FOR DELAY:
Negotiations for the new contract with Kaiser began in June 2009. The RCDMH has worked as diligently and expeditiously as possible to come to amicable terms with Kaiser. Subsequently, all terms of this agreement were finalized in late October 2011.

HEALTH CARE SERVICES AGREEMENT

BETWEEN

SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP

AND

THE RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

DEC 0 6 2011 3.21

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HEALTH CARE SERVICES AGREEMENT

This Health Care Services Agreement ("Agreement") is entered into between Southern California Permanente Medical Group, a California partnership ("Permanente") and Riverside County Department of Mental Health ("Contractor") and is effective as of July 1, 2010 ("Effective Date").

RECITALS

A. Kaiser Foundation Health Plan, Inc., a California nonprofit public benefit corporation ("Health Plan") operates health care benefit plans and provides or arranges for the provision of medically necessary health care services to Members (as defined below).

B. Health Plan has entered into an agreement with Kaiser Foundation Hospitals, a California nonprofit public benefit corporation **("KFH"),** under which KFH agrees to provide or arrange for certain medically necessary hospital or facility services for Members.

C. Health Plan has entered into an agreement with Permanente under which Permanente agrees to provide or arrange for certain medically necessary professional and outpatient services for Members.

D. Permanente desires to arrange for the provision of certain health care services to Members by contracting with Contractor. Contractor desires to provide Services (as defined below) to Members in accord with the terms of this Agreement.

AGREEMENT

NOW THEREFORE, the parties agree as follows:

ARTICLE 1. DEFINITIONS

Following are definitions of terms used in this Agreement. There may be additional terms defined in the body of the Agreement.

1.1 **Authorization** means KP's (as defined below) approval for the provision of Covered Benefits to Members (i) by persons designated to provide such approval, (ii) pursuant to KP's Utilization Management programs, and (iii) in accordance with Policies. Further, "Authorization" also means the document or electronic documentation indicating KP's approval, as the context requires. "Authorized" means provided pursuant to and in compliance with an Authorization.

1.2 **Claim** means a request for payment for Services rendered to a Member submitted in accordance with the terms of this Agreement and Policies.

1.3 **Clean Claim** means an itemized Claim that (i) is submitted for payment of Covered Services, (ii) is completed with all data elements, (iii) contains no defect or error that prevents timely adjudication, and (iv) complies with applicable Law (defined below).

1.4 **CMS** means the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, or any successor entity.

1.5 **Complaint** means any verbal or written expression of a Member's dissatisfaction with a Practitioner or Facility that is not amenable to prompt resolution at the point of service and requires follow-up and investigation (for example, a grievance).

1.6 **Confidential Information** means (i) the terms of this Agreement, (ii) any patient information, including a Member's name, address and health records; (iii) information concerning any matter relating to the business of the other, including the other party's employees, products, services, membership, prices, operations, business systems, planning and finance, policies, procedures and practice guidelines; and/or (iv) materials, data, data elements, records or other information obtained from the other party during the course of or pursuant to this Agreement.

1.7 **Covered Benefit(s)** mean(s) the health care services and benefits that a Member may be entitled to receive under the applicable Membership Agreement, as determined by Health Plan (or the applicable Payor).

1.8 **Covered Service(s)** mean(s) those Services rendered by Contractor to Members that are (i) Covered Benefits, (ii) medically necessary, and (iii) Authorized or otherwise approved for payment.

1.9 **Emergency Services** means those Covered Services necessary to screen, evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the Member's health or, in the case of a pregnant woman the health of the woman or her unborn child; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part, all as described in the federal Emergency Medical Treatment and Active Labor Act (42 USC 1395dd) and its implementing regulations and any similar State law ("EMTALA").

1.10 **Essential Permit** means any license, certification, registration, accreditation or clinical privilege of a Practitioner or Facility required to provide Services.

1.11 **Facility(ies),** if any, means those facilities (including without limitation hospitals, skilled nursing facilities, and dialysis centers), institutions, locations or any other sites (such as medical offices), used by Contractor (or any Subcontractor) to provide Covered Services.

1.12 **HIPAA** means, collectively, the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91) and regulations issued thereunder.

1.13 **Kaiser** means the Kaiser Permanente medical care program, which includes all Kaiser Payors (defined below) except Group Health Cooperative.

1.14 **Kaiser Administrative Services Organization or Kaiser ASO** means Health Plan, KFH, and/or Permanente, and any entity controlled by or under common control with Health Plan, KFH and/or Permanente or having an exclusive contract with such entities for the provision of health care services to Members or another entity that has contracted to perform certain administrative and/or management services on behalf of an Other Payor (defined below).

1.15 **Knox Keene Laws** means the Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health and Safety Code Section 1340 et seq.) and all regulations promulgated thereunder (California Code of Regulations Title 28 Section 1300 et seq.).

1.16 **KP** means Health Plan, KFH or Permanente, or any combination of one or more of them, as applicable.

1.17 **Law** means local, state or federal law, regulation, rule, or executive order, or CMS instructions, as applicable.

1.18 **Medi-Cal Contracts** means all prepaid Medi-Cal program contracts (i) between Health Plan (or KP Cal) and the State of California or (ii) between Health Plan and an organization under contract to the State of California, or (iii) between Kaiser and the Medicaid agency in any state other than California under which Members are enrolled.

1.19 **Member** means an individual entitled to health care services (at the time such services are rendered) under a Membership Agreement issued by a Payor, or another arrangement with a Kaiser Payor.

1.20 **Member Cost Share** means a copayment, deductible, coinsurance or any other charge payable by a Member for Covered Services pursuant to the Member's Membership Agreement.

1.21 **Membership Agreement** means any arrangement pursuant to which a Member is entitled to receive health care services and that is issued, sponsored or underwritten by a Payor, including, without limitation, the relevant service agreement, evidence of coverage or other description of coverage, summary plan description or benefit summary.

1.22 **Official(s)** mean(s) (i) individuals who represent, in an official capacity, a local, state or federal government agency or regulatory body with jurisdiction over KP or Contractor, (ii) representatives of any accreditation agency or organization (such as the National Committee for Quality Assurance ("NCQA") or a peer review body or other peer review or professional organization applicable to KP or Contractor, (iii) such other officials entitled by Law or pursuant to government contracts with KP (including Medicare Advantage contracts, Federal Employees Health Benefits Program ("FEHBP") contracts, and Medicaid Contracts) to monitor health care services provided to Members; and (iv) the designees of any of the above.

1.23 **Payor** means Kaiser Payor and/or Other Payor.

1.23.1 **Kaiser Payor** means any one or more of the following entities when such entities have responsibility for the provision or arrangement of health care services to Members: (i) a corporation or other organization owned or controlled, either directly or through subsidiary corporations, by Kaiser Foundation Health Plan, Inc. or under common control with Kaiser Foundation Health Plan, Inc., (ii) any regional Permanente Medical Group; and (iii) Group Health Cooperative; including, without limitation, those entities listed on Exhibit 4 as "Kaiser Payors."

1.23.2 **Other Payor** means any public or private entity other than a Kaiser Payor that (i) sponsors, administers, and/or funds a plan of health

benefits coverage or is otherwise responsible for the arrangement for health care services rendered to Members under a Membership Agreement and (ii) enters into an administrative and/or management service agreement with a Kaiser ASO; including, without limitation, those entities listed on Exhibit 4 as "Other Payors."

1.24 **Policies** means all policies, procedures, guidelines and, as applicable, formularies, of Payors as set forth from time to time in manuals, letters, bulletins and newsletters, whether made available to Contractor by mail, email, website, or other media.

1.25 **Practitioner** means those health care practitioners (including without limitation physicians, nurses, physician assistants, nurse practitioners, and therapists) who, by way of ownership of, employment by, or contracts with Contractor (or any Subcontractor) provide Covered Services.

1.26 **Services** means those services, supplies and facilities that Contractor or its Subcontractors customarily provide for the delivery of health care services, including all consults, studies, tests and procedures that are ordinary and necessary for the diagnosis and treatment of Contractor's patients. Services also include all administrative services provided by Contractor (or its Subcontractor) pursuant to this Agreement.

1.27 **Subcontractor** means any person or entity, including a facility, individual practitioner (other than an employee of Contractor), practitioner group, or any other individual (including a substitute Practitioner), that provides or arranges for Covered Services to Members pursuant to a direct or indirect agreement or other arrangement with Contractor.

ARTICLE 2. SERVICES

2.1 **Provision of Services.** Contractor shall provide or arrange for the provision of Services to Members in accord with this Agreement. Contractor shall ensure that Services are readily available and accessible during normal business hours and, as medically necessary on a same-day basis 24 hours per day, 7 days per week, and shall provide Services in a prompt and efficient manner without delays in appointment scheduling and waiting times and consistent with applicable recognized standards of practice, the appropriate standard of care and Policies. References to the responsibilities and obligations of "Contractor" in this Agreement shall be interpreted to apply (i) to all of Contractor's employees and agents and at all Facilities of Contractor involved in providing Services and (ii) each Subcontractor and its employees, agents and Facilities providing Services.

2.2 **Non-Exclusivity; No Volume Guarantee.** This is not an exclusive Agreement; Contractor and Kaiser may enter into similar agreements with other parties; and Kaiser reserves the right to arrange for any Services for Members from any other Contractor. Kaiser does not represent, warrant or covenant any minimum volume of patients or Members that will be referred to Contractor.

2.3 **Operational Responsibilities.**

2.3.1 **Verification.** Contractor shall use its best efforts to verify (i) that a person seeking Services is in fact an eligible Member as of the date of provision of Services, (ii) the Services rendered to such Member are Covered Benefits and are

properly Authorized (including the scope and duration of Services) or (iii) are Services for which Authorization is not required. Contractor's receipt of an identification card issued by a Payor from a person claiming to be a Member shall be indicative but not conclusive of the person's status as a Member. With respect to Services that are not Emergency Services, if Contractor is unable to verify (i) through (iii) listed above, Contractor may nevertheless provide Services to the person if Contractor notifies the Member that such Services are not Covered Benefits and the Member shall have financial responsibility for such Services; provided, further, that no Payor shall have financial responsibility for such Services. However, if it is subsequently determined that such person was an eligible Member and that such Services were Covered Services, the applicable Payor shall pay for such Services to the extent otherwise provided by this Agreement.

2.3.2 **Emergency Services**. If Contractor provides Emergency Services to a Member or, following stabilization of an Emergency Medical Condition, other Covered Services, Contractor shall (i) notify KP and (ii) assist KP with the transfer of Members to other Facilities or Practitioners, as directed by KP. To the extent allowable by applicable Law, KP may retrospectively review Claims for Emergency Services to determine whether they meet the criteria for compensation.

2.3.3 **Nondiscrimination.** Contractor shall provide Services to Members without discrimination on the basis of race, ethnicity, color, gender, sex, creed, religion, ancestry, national origin, age, health status, physical or mental disability, genetic information, veteran's status, marital status, sexual orientation, gender identity, income, source of payment, evidence of insurability (including conditions arising out of acts of domestic violence), status as a Member or as a participant in a publicly financed program, whether a Member has filed a Complaint, whether a Member has executed an advance directive, or other status protected by applicable Laws. Contractor shall make Services available to all classes of Members, in the same manner, in accordance with the same standards, and with the same availability, as to Contractor's other patients. In addition, during the performance of this Agreement, Contractor shall comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Rehabilitation Act of 1973, all as amended; shall provide reasonable access and accommodation to persons with disability to the extent required of a health services Contractor under the Americans with Disabilities Act, or any applicable state law or regulation.

2.4 **Practitioners and Facilities.**

2.4.1 **Qualifications and Standards.** Contractor shall ensure that all Practitioners providing Services under this Agreement are qualified and competent to provide such Services and all Facilities are maintained in good repair. Contractor represents and warrants that it and its Practitioners, Facilities and Subcontractors providing Covered Services shall be and shall remain throughout the term of this Agreement, as applicable, duly licensed by the State of California and accredited by the relevant accreditation organization(s) required by KP, certified by the relevant certification organization(s), and certified by the Medicare and Medicaid programs, under Title XVIII and Title XIX, respectively, of the Social Security

Act. Contractor shall comply with the standards of any organization accrediting KP, as they apply to the Covered Services provided by Contractor under this Agreement. In addition, Contractor further represents that each Practitioner providing Covered Services shall, as applicable and as required to provide Services (i) maintain a current, unrestricted license to practice their profession or vocation in the State of California, (ii) provide Covered Services only within the scope of his/her licensure, certification, registration, training and experience, (iii) maintain staff membership at one or more local facilities necessary to perform required Covered Services and (iv) maintain unrestricted clinical privileges at one or more local facilities necessary to perform required Covered Services; and (v) be certified by the appropriate medical specialty board(s) or by the appropriate vocational or professional board(s) or agency(ies) to provide Covered Services, as required by Law or by Policies. Contractor shall promptly provide documentary evidence of its and Practitioners' and Facilities' licensing, certification, registration accreditation and qualifications (i) upon request and (ii) upon any material change to them. Upon request, Contractor shall provide KP with copies of survey reports, investigations, assessments, formal evaluations or citations of Contractor that may materially affect Contractor's ability to perform its obligations under this Agreement.

2.4.2 **KP Credentialing**. Contractor, including its Practitioners and Facilities, shall be and shall remain throughout the term of this Agreement, credentialed and privileged, or recredentialed and reprivileged, as applicable, consistent with KP's credentialing requirements prior to providing Covered Services to Members. Contractor and its Subcontractors, Practitioners and Facilities shall cooperate with KP's credentialing and privileging processes.

2.4.3 **Subcontracts.** Subject to Section 9.1, if Contractor arranges for the provision of Covered Services to a Member by any Subcontractor, Contractor shall enter into a written subcontract with such Subcontractor ("Subcontract") prior to the provision of any Covered Services to Members by such Subcontractor. Such Subcontract shall require the Subcontractor (and its Practitioners and Facilities) to comply with the same terms applicable to Contractor under this Agreement. Upon request, Contractor shall provide KP access to and copies of Subcontracts.

2.5 **Suspension or Exclusion of Participation of a Practitioner or Facility**.

2.5.1 **Suspension or Exclusion Without Cause**. Permanente may, at any time and for any reason or no reason, suspend or exclude the participation of a Practitioner or Facility under this Agreement by giving at least sixty (60) days written notice to Contractor.

2.5.2 **Suspension or Exclusion With Cause.** Permanente may immediately suspend or exclude the participation of a Practitioner or Facility under this Agreement (without terminating the Agreement), as specified in a written notice if: (i) any Official revokes, suspends, restricts or fails to renew any Essential Permit applicable to Practitioner or Facility; or (ii) Practitioner or Facility demonstrates conduct (through act or omission) likely to result in revocation, suspension, restriction or nonrenewal of an Essential Permit applicable to Practitioner or Facility, as determined by KP in good faith; (iii) Practitioner or Facility

misrepresents or falsifies information submitted for an Essential Permit; (iv) Contractor, Practitioner or Facility is sanctioned, debarred, suspended, excluded or otherwise deemed ineligible from participation in any federal health care programs, including Medicare or Medicaid or criminal charges are filed against a Practitioner or Facility for any act involving professional misconduct or moral turpitude; (v) Practitioner or Facility fails to comply with or rectify noncompliance with any material provision of this Agreement or Policies (including KP's QI and UM programs) within a time period acceptable to KP; (vi) Practitioner or Facility fails to adequately provide or becomes incapable of adequately providing Covered Services; or (vii) Practitioner or Facility demonstrates conduct (through act or omission) that threatens the health, safety or privacy of a Member, as determined by KP in good faith.

2.6 **Quality Improvement and Utilization Management.**

2.6.1 **Quality Assurance and Quality Improvement (collectively, "QI")**. Contractor acknowledges that KP is required by Law and by accreditation standards to monitor the QI activities of Contractor. With respect to Covered Services, Contractor shall participate in KP's QI program as established and amended from time to time. KP will make best efforts to provide Contractor with fourteen (14) business days advanced notification prior to such amendments. Contractor shall investigate and respond promptly to issues regarding quality of care, accessibility and other Complaints related to Covered Services. Contractor shall use best efforts to remedy promptly any unsatisfactory condition related to the care of Members by a Practitioner or at the Facilities, as determined by KP or any Official. The parties shall work together to resolve promptly problems related to the provision of Covered Services as they arise. If required by Officials or Law, Contractor shall maintain a QI program that, at all times during the term of this Agreement, meets all state and federal licensing, accreditation and certification requirements applicable to Contractor.

Contractor acknowledges that it was notified at least fifteen (15) working days prior to signing this Agreement (as required under California Health and Safety Code Section 1375.7) of the requirement that it comply with the Kaiser Permanente quality improvement and utilization review programs as described in this Section and other provisions of this Agreement.

2.6.2 **Utilization Management and Review (collectively, "UM")**. Contractor shall participate in KP's UM programs (including prospective, concurrent and retrospective review), as established and amended from time to time, and cooperate with KP's UM committees and staff. KP UM may conduct routine UM reviews on a daily basis, without prior notification. If a non-routine review is planned, KP staff will make best efforts to provide Contractor with fourteen (14) business days advanced notification unless otherwise required to meet state and federal licensing, accreditation and certification requirements. Contractor acknowledges that UM decision-making is based on the appropriateness of care and service and existence of coverage and that KP does not compensate individuals responsible for UM decision-making with financial incentives that specifically reward them for issuing denials of coverage or service, or that encourage decisions that result in underutilization.

2.6.3 **QI/UM Information**. Contractor shall supply KP with periodic reports and other information (including Contractor's policies and procedures, patient care protocols, any mutually agreed upon quality indicators, survey reports, investigations, assessments, formal evaluations or citations) pertaining to Services provided to Members by Contractor in such manner and time frames that enable KP to conduct its QI and UM activities and to meet all federal, state, accreditation and contractual reporting requirements (including with respect to QI and UM activities, and Delegated Activities(defined below)). Upon request, Contractor shall provide any data, information and records that KP is required to review for KP's QI and UM programs, licensing, accreditation, or otherwise as required by Law and KP's government contracts.

2.7 **Delegation.** KP may, at its discretion, delegate to Contractor utilization management, credentialing, medical records review and other activities consistent with regulatory and accreditation standards ("Delegated Activities"). To the extent that there are Delegated Activities under this Agreement, those activities shall be identified in writing to Contractor and KP shall retain the right to audit, monitor and oversee the Delegated Activities (including implementing a corrective action plan to address any deficiencies identified by Government Officials or KP), and Contractor shall cooperate fully with KP in doing so. KP reserves the right to revoke such delegation at any time upon notice.

2.8 **Relationship with Members**.

2.8.1 **Communication.** Subject to applicable confidentiality requirements, Practitioners may freely communicate with a Member (or an authorized representative) about the Member's treatment options, without regard to benefit coverage limitations. Information about health care service and treatment options (including the option of no treatment) must be provided to Members in a culturally competent manner and with appropriate access to language assistance, as required of KP under applicable Law and by Officials. Notwithstanding the foregoing, neither Contractor nor KP shall engage in any conduct that constitutes tortious interference with the other party or the relationships created thereby.

2.8.2 **Notification of Termination.** KP retains the right to notify Members of (i) termination of the Agreement under Section 4.2 or (ii) suspension or exclusion of participation of a Practitioner or Facility under Section 2.5, prior to the effective date of termination or suspension/exclusion; and Contractor is responsible for providing information and otherwise assisting KP in making such notifications. If Contractor is a physician specialist or specialist group: (a) Health Plan is responsible to notify Members prior to the effective date of termination of any physician specialist's contractual opportunity to treat Members under this Agreement; and (b) Contractor is responsible for providing information and otherwise assisting Health Plan in making such notifications.

2.9 **Notice of Changes in Contractor Status**. Without limitation, Contractor shall use best efforts to notify KP in writing at least ninety (90) days prior to cessation or suspension of any Services. Furthermore, Contractor has an affirmative obligation to be aware of and shall notify KP in writing within 5 working days of Contractor becoming aware of the pending occurrence of, and within 5 working days after the occurrence of, any of the following events:

- any license, certification, accreditation, or clinical privilege of a Contractor, a Practitioner or Facility is revoked, suspended, restricted, expired or not renewed;

- Contractor, a Practitioner or Facility is sanctioned, debarred, suspended, excluded or otherwise deemed ineligible from participation in any federal health care programs, including Medicare or Medicaid;

- there is any formal report submitted to the medical board (or similar practitioner board) or licensing agency of any state or U.S. territory, or the National Practitioner Data Bank, of adverse credentialing or peer review action regarding Contractor, a Practitioner or a Facility, or there is any material change in the credentialing or privileging status of Contractor, a Practitioner or a Facility;

- any unusual occurrence that (i) affects any Member receiving Covered Services and (ii) that is required to be reported to any governmental or regulatory body or to an accreditation organization;

- any change in Contractor's legal status, tax identification number, Medicare or Medicaid identification number(s), or any material change in ownership, control, name, or location; and

- any other event or circumstance that materially impairs Contractor's ability to provide Covered Services in accordance with this Agreement.

2.10 **Prohibition of Offshore Contracting**. Provider shall not downstream any obligation of this Agreement which requires access, use or disclosure of the personal health information (PHI), as such term is defined by HIPAA, to any Subcontractor that is not located in the United States, or is not subject to the direct jurisdiction of a competent court of the United States.

ARTICLE 3. BILLING AND PAYMENT

3.1 **Payment of Compensation.** Subject to all other terms of this Agreement, the responsible Payor shall pay Contractor for Covered Services submitted on a Clean Claim as set forth in Exhibit 1. Under no circumstance shall Permanente have any financial responsibility to compensate Contractor for Services rendered by Contractor to Members covered under an Other Payor's Membership Agreement, notwithstanding the provision of administrative and/or management services by a Kaiser ASO. This provision shall not be construed in any manner to (i) create an express, implied or quasi-contractual relationship between any Other Payor and Contractor or (ii) impose joint liability on any Payor for the obligations of another Payor. The responsible Payor's obligation to compensate Contractor is commensurate with the scope and duration of the applicable Authorization. Except for Emergency Services, a Payor may terminate an Authorization prior to its expiration date, upon written notification to Contractor; provided however, that a Payor will not revoke or modify an Authorization to the extent that Provider already has provided Services in good faith reliance on the Authorization, or as otherwise permitted by Law.

The parties acknowledge that Contractor is entitled to, and has received, Exhibit 1 (the fee schedule) and other information required by Title 28, California Code of Regulations, Section 1300.71(o).

3.2 **Adjustments to Payment.** A Payor may review and audit any and all Claims. If a Payor determines that coding does not comply with commonly accepted standards, that Services rendered are not appropriate and medically necessary, or that payment is not in accord with this Agreement, the responsible Payor may deny, reduce or otherwise adjust payment to Contractor to the extent permitted by Law. If an audit conducted by a Payor shows that Contractor owes money to a Payor, the responsible Payor shall notify Contractor, and Contractor shall refund such overpayment to the Payor within thirty (30) working days after receiving Payor's notice requesting the refund. After such period, the Payor is hereby authorized to offset the amount of the overpayment identified in an uncontested notice of overpayment against any money owed to Contractor, to the maximum extent permitted by Law. If this Agreement is terminated for any reason prior to Payor's full recovery of such overpayment, the remaining amount shall become due and owing immediately upon the effective date of the termination.

3.3 **Denials.** The responsible Payor reserves the right to deny a Claim if Contractor fails to submit it in accord with this Article 3. To the extent allowable under Law, the responsible Payor may deny payment of a Clean Claim for Covered Services rendered (i) by a Practitioner or in a Facility that fails to meet the applicable requirements in Section 2.4 on the date(s) of service, (ii) to a Medicare Member or Medi-Cal Member by a Practitioner or a Facility that is sanctioned under or debarred, suspended, or excluded from or has opted out of participation in Medicare or Medicaid, or (iii) in any manner or by any person prohibited by Law or by Kaiser's government contracts.

3.4 **Member Hold Harmless.** Except as expressly provided herein, Contractor shall look solely to the responsible Payor for compensation for Covered Services rendered to Members and Contractor agrees that in no event (including non-payment by Payor, insolvency of Payor or breach of this Agreement) shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, Official, the State of California or any of its agencies, or any Medi-Cal plans, for Covered Services provided under this Agreement. Contractor understands and agrees that surcharges against Members are prohibited by Law and/or pursuant to Membership Agreements and KP shall take appropriate action if surcharges are imposed. A surcharge is an additional fee that is charged to a Member for Covered Services but is not expressly permitted under the applicable Membership Agreement or, where applicable, permitted by Law or Official.

3.5 **Billing Members for Non-Covered Benefits; Services Not Authorized**. Contractor shall bill and collect Member Cost Share amounts from Members, but Contractor may not bill a Member for more than the applicable Member Cost Share for Services that are not Covered Services unless, before providing the Services, Contractor notifies the Member that the Services are not Covered Services and the Member nonetheless insists that Contractor provide such Services.

3.6 **Liens and Third Party Claims.** Contractor shall not, directly or indirectly through assignment or otherwise, assert any lien claim, subrogation claim, or any other claim against a Member, or any other person or organization against which a Member may hold a potential claim for personal injury, or against the proceeds of a Member's personal injury recovery based on Services that Contractor provided to the Member under this Agreement for an injury or illness allegedly caused by a third party. Unless prohibited by applicable Law, the responsible Payor alone shall have the right to pursue and collect

such claims for its own account, and Contractor agrees to assist these collection efforts by promptly informing the responsible Payor or its designee of Services provided by Contractor for which there may be potential third party liability.

3.7 **Coordination of Benefits**. When Health Plan is primary under applicable coordination of benefits ("COB") rules, Permanente shall pay Contractor as set forth in Section 3.1. When Health Plan is secondary under applicable COB rules, Contractor shall first bill the primary payor(s) and forward to Permanente a copy of such other payor('s) explanation of payment along with the billing information specified in Section 3. For Covered Services provided to Members, but covered by other payors, Contractor shall comply with the Payor's coordination of benefits program, consistent with Policies.

ARTICLE 4. TERM AND TERMINATION

4.1 **Term**. This Agreement shall begin on the Effective Date, and unless terminated earlier in accord with this Article 4, shall continue for one (1) year (the "Initial Term"). The contract may thereafter be renewed annually, up to an additional four (4) years by mutual, written consent of both parties and subject to the availability of applicable funds unless either party terminates the Agreement in accord with this Article 4. Thereafter, the Agreement shall be automatically renewed for one (1) year terms unless either party terminates the Agreement in accord with this Article 4.

4.2 **Termination of this Agreement**.

4.2.1 **Termination Without Cause**. Either party may terminate this Agreement at any time and for any reason or no reason by giving at least ninety (90) days written notice to the other party.

4.2.2 **Termination With Cause.** Either party may terminate this Agreement with cause if the other party materially breaches this Agreement. Termination will become effective if the breaching party does not cure, or commence to cure, the breach to the satisfaction of the non-breaching party within 30 days of the date specified in a written notice to the other party. In addition, Permanente or Contractor may terminate this Agreement, effective on a date specified in a written notice to the other party, if Contractor objects to a material modification of this Agreement made necessary to comply with federal, state and/or local laws and regulations, or the requirements of an applicable regulatory agency or private accreditation agency, or in order for Permanente or Health Plan to participate in government-funded Health Plan products and the parties are unable to agree upon an appropriate modification in light of Contractor's objection. In addition, Contractor may terminate this Agreement upon thirty (30) days written notice to Permanente: (1) if sufficient funds are not available for continuation of Services; (2) if there is a change in status, or delegation, assignment or alteration of this Agreement.

4.2.3 **Immediate Termination.**

4.2.3.1 **By Permanente.**

Permanente may terminate this Agreement immediately, as specified in a written notice if: (i) any Official revokes, suspends, restricts or fails to renew any

Essential Permit; (ii) Contractor, or any Subcontractor, Practitioner or Facility, is sanctioned, debarred, suspended, excluded, or otherwise deemed ineligible from participation in any federal health care programs, including Medicare or Medicaid; (iii) Contractor or a Practitioner has been convicted of a criminal offense under 42 USC 1320(a)-7(a), but has not yet been debarred, suspended, excluded or otherwise deemed ineligible from participation in any federal health care programs, including Medicare and Medicaid, (iv) Contractor or a Practitioner is listed by the Office of Foreign Assets Control as a "Specially Designated National"; (v) Contractor demonstrates conduct (through act or omission) that threatens the health, safety or privacy of a Member, as determined by KP in good faith; (vi) Contractor files a petition in or for bankruptcy, reorganization or an arrangement with creditors, makes a general assignment for the benefit of creditors, is adjudged bankrupt, unable to pay debts as they come due, has a trustee, receiver or other custodian appointed on its behalf, or has a case or proceeding commenced against it under any bankruptcy or insolvency law; or (vii) Contractor undergoes dissolution, merger or consolidation, the sale of all or substantially all of its assets or a direct or indirect change of control, ownership or legal structure.

4.2.3.2 **By Contractor.**

Contractor may terminate this Agreement immediately, as specified in a written notice if, in the opinion of the Director of Mental Health or his designee, either party is failing or has failed to provide for the health and safety of patients served under this Agreement.

4.3 **Effect of Termination**.

4.3.1 **Continuation of Care Obligations**. Upon termination of this Agreement, Contractor shall continue to provide Covered Services pursuant to all of the terms and conditions set forth in this Agreement to Members who are under the care of Contractor at the time of termination for those specific conditions for which Member is under the care of Contractor and in accordance with the limitations and mandated time period applicable by Law to Health Plan to preserve the continuity of care for those Members. As required by Law, in the event of KP insolvency or other cessation of operations, Contractor shall continue to provide Covered Services through the period for which dues or premiums have been paid, or if a Member is confined in a Facility on the date of insolvency or other cessation of operations, until the Member can be discharged in accord with an appropriate professional standard of care.

4.3.2 **Cooperation in Transfer of Members**. Upon termination of this Agreement, Contractor shall cooperate with KP in the transfer of Members to other practitioners or facilities contracting with KP to include providing KP, upon request, with all patient information and documents deemed necessary by KP to affect an orderly transfer. Further, Contractor shall deliver to KP any equipment, records or other document which, if the Agreement had been completed, would have been required to be furnished to KP. Contractor shall also take such action as may be necessary, or as KP may direct, for the protection and preservation of the equipment, records or other documents, related to this Agreement, which are in the possession of Contractor and in which KP has or may acquire an interest.

4.3.3 **Termination of Services Provided to Certain Members**. In the event that the (i) Medicare Advantage contract between CMS and Health Plan or (ii) FEHBP contract between the Federal Office of Personnel Management ("OPM") and Health Plan, is terminated or is not renewed, this Agreement shall be terminated as to Medicare Advantage Members or FEHBP Members (respectively), unless CMS or OPM (respectively) determines, and Health Plan agrees, that such Members should continue to receive care pursuant to this Agreement. If termination is required, KP shall provide Contractor written notice of the date upon which the termination will become effective, consistent with CMS's or OPM's direction.

4.3.4 **Final Claim**. Contractor shall submit final claims for Services provided hereunder promptly after either party receives a notice of termination, or promptly after expiration of this Agreement, but in no event later than ninety (90) days from the effective date of termination unless an extension is granted, in writing, by KP.

4.3.5 **Remedies.** The right and remedies of the parties under this Article 4 are not exclusive and shall be in addition to any other rights and remedies provided by Law or under this Agreement.

4.4 **Survival of Obligations**. With respect to the provision of Covered Services to Members during the term of this Agreement, the obligations of Contractor under Section 2.4.3 (Subcontracts), Section 2.6.1 (Quality Assurance and Quality Improvement), Section 2.6.2 (Utilization Management and Review), Section 2.7 (Delegation), Section 3.2 (Adjustments to Payment), Section 3.4 (Member Hold Harmless), Section 3.5 (Billing Members), Section 3.7 (Coordination of Benefits), Article 4 (Term and Termination), Article 5 (Dispute Resolution), Article 6 (Records and Confidentiality), Article 7 (Compliance), Article 8 (Insurance and Indemnification), Section 9.1 (Assignment and Delegation), Section 9.7 (Use of Name), Section 9.8 (Publicity), and any other supplemental provision in any exhibit that modifies one of the named Sections above, or any other provision specifically named as a surviving provision in an exhibit shall survive the termination of this Agreement, regardless of the cause giving rise to termination. Section 3.4 (Member Hold Harmless) and Section 4.3.1 (Continuation of Care Obligations) shall be construed to be for the benefit of Members.

ARTICLE 5. DISPUTE RESOLUTION

5.1 **Disputes Between KP and Contractor Generally.** The dispute resolution provisions set forth herein shall apply to all claims and disputes between the parties arising from, relating to, or in connection with, this Agreement, including the performance of or failure to perform any term, condition or covenant herein ("Disputes").

5.1.1 **Provider Appeals Process.** KP maintains a provider appeals process to resolve Disputes arising from this Agreement. This process is administered in a manner consistent with the requirements of the Knox-Keene Laws and is described in the Policies. Disputes must be submitted in accordance with Policies.

5.1.2 **Meet and Confer.** For any dispute not subject to the provider appeals process or not resolved thereby, or if any party to the Agreement has a Dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the Dispute. The parties agree to meet and confer

within thirty (30) days of a written request submitted in conformity with Section 9.10 by any party to the Agreement in an effort to settle any Dispute. If the written request specifically references this Section 5.1.2 and any party to the Agreement fails to meet within the thirty (30) day period, that party shall be deemed to have waived the meet and confer requirement, and at the other party's option, the Dispute may proceed immediately to arbitration.

5.1.3 **Mediation.** If the parties are not able to resolve the Dispute through the meet and confer process, upon mutual agreement they may submit the Dispute to mediation to be conducted by a retired judge of the California (Superior Court or above) or United States courts (the "Mediator") in accordance with the mediation procedures set forth in Exhibit 2.

5.1.4 **Arbitration.** If the Dispute is not resolved by the parties through the methods described in Section 5.1.1, Section 5.1.2, or Section 5.1.3, then it shall be submitted to binding arbitration in Riverside County, California as set forth in Exhibit 2.

5.2 **Disputes Between Member and Contractor.** If Contractor is unable to resolve any Member Complaints and/or grievances to a Member's satisfaction, Contractor shall notify KP immediately and shall cooperate with KP in identifying, processing and resolving such Complaints. Contractor shall comply with Health Plan's resolution of any such Complaints. Contractor shall notify any Member for whom a Complaint and/or grievance cannot be resolved that they may contact Health Plan's Membership Services Department by telephoning (800) 464-4000 to pursue the Complaint further. All decisions regarding Covered Benefits are reserved to Health Plan and Contractor shall refer Members who have inquiries or disputes regarding Covered Benefits to Health Plan for response and resolution. Contractor shall promptly notify KP of (i) receipt of any Complaints from or on behalf of Members that have not been, in the reasonable judgment of Contractor, resolved within two (2) working days; (ii) Complaints to Contractor regarding discrimination against Members race, ethnicity, color, gender, sex, creed, religion, ancestry, national origin, age, health status, physical or mental disability, genetic information, veteran's status, marital status, sexual orientation, gender identity, income, source of payment, evidence of insurability (including conditions arising out of acts of domestic violence), status as a Member or as a participant in a publicly financed program, whether a Member has filed a Complaint, whether a Member has executed an advance directive, or other status protected by applicable Laws, (iii) contact by an attorney for any Complaint; (iv) any professional liability claims filed or asserted regarding Services provided to Members under this Agreement by or on behalf of Contractor, (v) any Complaints of an alleged violation of HIPAA made to Contractor by Members.

5.3 **Disputes Between an Other Payor and Contractor.** For claims payment disputes arising from, or related to, Services rendered to Members for which an Other Payor is financially responsible and for which the Contractor is not acting as the Member's authorized representative, the parties agree that the dispute resolution process set forth in Section 5.1 shall be applicable. Such claims payment disputes shall not constitute a material breach of the Agreement.

ARTICLE 6. RECORDS AND CONFIDENTIALITY

6.1 **Maintenance of Records.** Contractor shall maintain records (including, but not limited to, financial, accounting, administrative, patient medical records, images, and prescription files) related to Services provided to Members, to the cost thereof, to payments received from Members or others on their behalf, and to the financial condition of Contractor ("Records"), regardless of the form of such Records (e.g., paper, film, electronic file, or some other form). Contractor shall maintain Records in accord with (i) applicable state and federal requirements, including privacy and confidentiality requirements, (ii) general standards applicable to that form of book-keeping or record-keeping, and (iii) Policies. Contractor shall preserve Records for the longest of: (i) one (1) year after the Member reaches the age of majority, if the Member is a minor; (ii) six (6) years from the effective date of termination of this Agreement or from the date of completion of any audit conducted by DHHS (defined below), the Comptroller General or their designees, whichever is longer, or longer if so required by CMS (for example, ten (10) years for Records of Medicare Advantage Members); or (iii) the period of time required by Law and by the Medicare and Medicaid programs and contracts to which Kaiser is subject.

6.2 **Access to Records.** To the extent permitted by Law and subject to reasonable request and notification, the applicable Payor and its authorized agents shall have access to and may inspect Records, including for the purpose of (i) meeting legal, regulatory and accreditation requirements applicable to the applicable Payor or (ii) addressing any inquiry from an Official. In addition, Contractor shall allow KP access to Contractor's QI and UM information concerning Services provided to Members and shall provide for timely access by Members to their medical records and other relevant information. Upon request, Contractor shall promptly forward to the applicable Payor, without charge: (i) copies of initial consultation reports upon completion of such consultations; (ii) summaries of patient care or patient results upon completion of such patient care or discharge, both as directed by the applicable Payor; and (iii) copies of Records (via facsimile or other electronic means, if requested), including medical records of Members transferred or repatriated following termination of this Agreement pursuant to Section 4.2 or following suspension or exclusion of participation of a Practitioner or Facility under Section 2.5. Subject to reasonable request and notification, the applicable Payor may arrange for, and Contractor shall cooperate with, copying of Records to which it is entitled under this Agreement through a copying service.

6.3 **Access for and Disclosure to Officials.** Contractor shall comply with all provisions of the Omnibus Reconciliation Act of 1980, the Balanced Budget Act of 1997, and the Medicare Prescription Drug Improvement and Modernization act of 2003 regarding access to books, records, documents, and contractual agreements. Without limitation, Contractor shall maintain, provide access to, and provide copies of Records, this Agreement and other information to Officials. Such Records shall be available at all reasonable times at Contractor's place of business or at some other mutually agreeable location or as required by such Officials.

6.4 **Inspection.** In addition, at reasonable times and with reasonable notification, Contractor shall, and shall obligate its Subcontractors, Practitioners and Facilities to, permit and cooperate with inspections of their sites and Records by KP and/or Officials.

6.5 **Incorporation of Prior Medical Data.** If KP provides to Contractor medically acceptable copies of prior medical histories, tests (such as laboratory, radiology or other diagnostic tests), reports (such as pre-admission and pre-operative reports) and examinations (collectively, "Medical Data") for a Member, such Medical Data shall become part of Contractor's medical record for that Member to the extent permitted by Law. Contractor shall accept such Medical Data and shall not require Members to repeat such Medical Data, unless required by the Member's medical condition, the accreditation organization applicable to Contractor, professional codes of ethics or standards of practice, or applicable Law.

6.6 **Confidentiality of Information**. In compliance with, and subject to, all applicable Law, the parties shall keep in strictest confidence all Confidential Information of the other party and neither party shall disclose the other party's Confidential Information to a third party unless authorized in writing in advance by the other, provided however that patient information may be disclosed to the patient, the patient's authorized representative, Practitioners participating in their care, and others as permitted by Law. In addition, except as permitted by Law, data shared with employers, whether self-insured or insured, shall not implicitly or explicitly identify a Member without the written consent of the Member. The foregoing prohibitions on disclosure do not apply to information that (i) is required by Law to be disclosed or to be provided to Officials; (ii) is required by accreditation organizations of KP or Contractor; (iii) is disclosed in legal or government administrative proceedings; (iv) was publicly known at the time of the disclosure; (v) becomes publicly known through no fault of the disclosing party after the disclosing party's receipt of the Confidential Information; (vi) was developed by the disclosing party independently of and without reference to any of the other party's Confidential Information; (vii) is disclosed as necessary to enforce a party's rights for coordination of benefits, liens, reimbursement or subrogation; or (viii) is disclosed as necessary to a party's agents to perform essential corporate activities (including activities delegated in accord with Section 9.1, as permitted by Law). The prohibitions on disclosure also do not apply to payment information provided to Members regarding Member Cost Share.

6.7 **HIPAA.** Contractor understands and agrees that this Agreement and certain data exchanged hereunder may be subject to HIPAA. If Contractor is or becomes a "Covered Entity" as defined by HIPAA, Contractor shall comply with all relevant HIPAA requirements. If Contractor is a "Business Associate" of KP as defined by HIPAA, Contractor shall execute a Business Associate Agreement with KP.

6.8 **Certification of Accuracy of Data.** Contractor recognizes that KP is required to certify the accuracy, completeness and truthfulness of data that CMS and other local, state and federal governmental agencies and accrediting organizations request. Such data includes encounter data, payment data, and any other information provided to KP by its Contractors. Contractor hereby represents and warrants that any such data submitted to KP by Contractor shall be accurate, complete and truthful. Upon KP's request, Contractor shall make such certification in the form and manner specified by KP in order to meet KP's legal, regulatory, accreditation and contractual requirements.

ARTICLE 7. COMPLIANCE

7.1 **Compliance with Laws**. Contractor represents and warrants that it is currently and for the term of the Agreement shall remain in compliance with all applicable Law, professional codes of ethics or standards of practice. Contractor shall cooperate with KP

in maintaining Health Plan's compliance with applicable Law to include compliance with Laws as required to maintain Health Plan's licenses. Contractor shall promptly provide written notification to KP (i) of the initiation of any legal action, accreditation organization action, or regulatory or governmental action that has more than a minimal likelihood of materially affecting Contractor's ability to perform its obligations under this Agreement; (ii) of an investigation regarding sanction under or debarment, exclusion or suspension from any federal program, including Medicare or Medicaid; (iii) of any peer review action, inquiry or formal corrective action proceeding, or investigation is initiated against Contractor, or any Practitioner or Facility by any peer review body or accreditation organization; (iv) if Contractor or any Practitioner or Facility is the subject of any legal or governmental action concerning qualifications or ability to perform Services; (v) of any professional liability claim filed or asserted regarding Services provided to Members by or on behalf of Contractor; and (vi) of the initiation of any legal action related to Covered Services filed by a Member against Contractor, a Practitioner, or a Facility.

7.2 **Medicare/Medicaid.** With respect to Covered Services provided to Medicare Advantage Members, Contractor shall comply with all applicable Laws governing the Medicare Advantage program and with the obligations in the contract between CMS and Health Plan governing KP's participation in it; any provision required to be in this Agreement by the Laws governing the Medicare Advantage program shall bind the parties, whether or not provided in this Agreement. With respect to Covered Services provided to Medi-Cal Members, Contractor shall comply with (i) the applicable policies and procedures regarding identifying, referring and treating special Medi-Cal Member populations and (ii) all applicable obligations in the Medi-Cal Contracts, including the following requirements regarding employment discrimination:

- Contractor shall 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, AIDS, ARC), mental disability, medical condition (including cancer), age (over 40), marital status, or denial of family care leave;

- Contractor shall ensure that the evaluation and treatment of its employees and applicants for employment are free of discrimination and harassment; and

- Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 and implementing regulations in 2 CCR 7285.0 et. seq.).

The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990(a-f), set forth in Chapter 5 of Division 4, Title 2 CCR, are incorporated into this Agreement by reference and made part hereof as if set forth in full.

7.3 **Government Contractor.** Contractor recognizes that as a government contractor, KP is subject to various Laws regarding equal opportunity and affirmative action which also may be applicable to KP's subcontractors, including Contractor and its Subcontractors. Contractor, therefore, agrees that any and all applicable equal opportunity and affirmative action clauses from the Federal Acquisition Regulations (FAR) at 48 CFR Part 52 shall

be incorporated herein by reference as required by federal laws, executive orders and regulations, including the following FAR clauses: (a) Equal Opportunity (Feb. 1999) at FAR 52.222-26; (b) Affirmative Action for Disabled Veterans of the Vietnam Era (April 1998) at FAR 52.222-35; (c) Affirmative Action for Workers with Disabilities (June 1998) at FAR 52.222-36, and (d) Small Business Subcontracting Plan (Oct. 1999) at FAR 52.219-9.

7.4 **Compliance with Policies.** Contractor shall cooperate and comply with all Policies of which Contractor knows or reasonably should have known. Policies may be modified by Payors from time to time, but no Policy change shall be retroactive without the express written consent of Contractor. In the event of an inconsistency between this Agreement and a Policy, this Agreement shall control unless otherwise expressly stated in the Policy.

7.5 **ERISA.** Notwithstanding any other terms of the Agreement, Other Payors that are the sponsors of self-funded health plans formed pursuant to the requirements of the federal Employee Retirement Income Security Act of 1974 at 29 USC 1001 *et seq.* ("ERISA"), as may be amended and interpreted from time to time, as well as the self-funded health plans formed pursuant to the ERISA requirements, shall not be subject to any terms and conditions included in the Agreement for the purpose of complying with state laws that are preempted by ERISA.

ARTICLE 8. INSURANCE AND INDEMNIFICATION

8.1 **Insurance.** Contractor shall maintain or cause to be maintained the following coverage either through insurance, or through self-insurance programs that are deemed acceptable to KP, covering itself and each Subcontractor (in the event that subcontractors are utilized) through whom Contractor provides Services at the following levels: (i) commercial general liability and property damage insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate, (ii) a policy of professional liability insurance with limits of liability not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate and (iii) such other insurance or self insurance acceptable to KP as shall be necessary to insure Contractor against any claim or claims for damages arising under this Agreement, including claims arising by reason of personal injury or death in connection with the performance of any Service, or use of any property or facility pursuant to this Agreement. Such insurance coverage shall apply to all Facilities of Contractor and to Services provided by Contractor and its Subcontractors to members at any KP facility or other site. Contractor will maintain in full force and effect appropriate automobile (as applicable), workers' compensation, and unemployment insurance as necessary to cover the provision of Services by Practitioners and as otherwise required by Law.

8.2 **Standards.** All insurance required under this Section shall be obtained from a company(ies) that is duly licensed to do business in the State of California, or the state in which Services are delivered, and that either (i) has a Best's rating of at least A or has a comparable rating from another rating company or (ii) is acceptable to KP. Contractor shall provide certificates of insurance evidencing such coverage to KP upon execution of this Agreement in a form acceptable to KP, and from time to time thereafter upon request. KP may also accept those self-insurance programs that are deemed appropriate by KP in its sole discretion.

8.3 **Tail Coverage.** If Contractor obtains one or more claims-made insurance policies to fulfill its obligations under this Section, Contractor will (i) maintain coverage with the same company during the term of this Agreement and for at least five (5) years following termination of this Agreement, or (ii) purchase or provide coverage that assures protection against claims based on acts or omissions that occur during the period of this Agreement but which are asserted after the claims-made insurance policy has expired.

8.4 **Indemnification**.

8.4.1 **Contractor Indemnification.** Contractor shall indemnify and hold harmless KP and each of their respective officers, directors, partners, shareholders, agents and employees to the extent permitted by Law, from and against any and all demands, claims, losses, damages, liability, costs, expenses (including the payment of attorneys' fees and costs actually incurred, whether or not litigation is commenced), judgments or obligations, actions or causes of action whatsoever, to the extent arising from or in connection with any acts, failures to act or the performance of or failure to perform obligations hereunder by Contractor, its officers, partners, employees, Subcontractors or agents.

8.4.2 **Reciprocal Indemnification**. KP shall indemnify and hold harmless Contractor, its officers, directors, partners, shareholders, agents and employees to the extent permitted by Law, from and against any and all demands, claims, losses, damages, liability, costs, expenses (including the payment of attorneys' fees and costs actually incurred, whether or not litigation is commenced), judgments or obligations, actions or causes of action whatsoever, to the extent arising from or in connection with any acts, failures to act or the performance of or failure to perform obligations hereunder by Permanente, its officers, partners, employees, or agents.

8.4.3 **Health Plan Obligations.** To the extent required by the Knox Keene Laws, nothing in this Agreement shall be construed to require indemnification from Contractor for any liability imposed upon Health Plan as a result of Health Plan's duty to provide or arrange for the provision of medically necessary health care services to Members where the health care services are a benefit provided under the applicable Membership Agreement.

8.5 **Cooperation of Parties**. The parties shall cooperate with each other in the investigation and disposition of any claim arising out of or relating to this Agreement, provided that nothing shall require any party to the Agreement to cooperate to their own legal detriment, to disclose any documents, records or communications that are protected from such disclosure under the peer review privilege, the attorney-client privilege or the attorney work-product doctrine or other rules governing such privileged materials.

ARTICLE 9. MISCELLANEOUS

9.1 **Assignment and Delegation.** Except as otherwise provided in this Agreement, Contractor shall not assign this Agreement, subcontract or delegate any of its duties and obligations under this Agreement without the prior written consent of Permanente. However, all obligations of Contractor under this Agreement shall be enforceable against any successors and assigns. Any material change of ownership or control of Contractor shall be deemed an assignment. If any change of control or ownership of Contractor occurs, Contractor shall ensure that the applicable buyer, lessee or transferee agrees to

enter into a services agreement with KP pursuant to which such buyer, lessee or transferee will provide Services to Members under the same terms and for the same rates as Permanente is obligated to pay to Contractor for such Services under this Agreement. Any succession or assignment shall not relieve or otherwise affect the liability of the predecessor or assignor, who shall remain liable, jointly and severally with the successor or assignee.

9.2 **Legally Required Modification**. Notwithstanding any other provision of this Agreement, if KP reasonably determines that a modification of this Agreement is necessary to cause it to conform with Law, or the requirements imposed upon KP by an accrediting or regulatory agency, or in order for KP to participate in government-funded health plan products (a "Legally Required Modification"), then KP shall give Contractor written notice of the proposed Legally Required Modification and the date on which it is to go into effect, which shall not be less than forty-five (45) working days following the date of the notice, unless a different period is required by Law or Officials, and the legally required modification shall be effective on that date specified in the notice. If a modification is proposed to a material term of the Agreement by changing or revising a manual, policy or procedure document referenced in this Agreement, KP shall give Contractor forty-five (45) working days' notice of the modification and, if the parties do not mutually agree upon the modification, Contractor may terminate this Agreement prior to the modification's scheduled implementation date.

9.3 **Active Encouragement.** In accordance with California Health and Safety Code Section 1395.6, KP "actively encourages" Members to use contracted providers for non-emergency services through the use of financial incentives such as reduced Member Cost Share.

9.4 **No Third Party Beneficiaries**. Nothing in this Agreement shall be construed to give any person other than Contractor or KP any benefits, rights or remedies. No action to enforce the terms of this Agreement may be brought by any person other than Contractor or KP.

9.5 **Independent Contractor.** Contractor enters into this Agreement, and shall remain throughout the term of this Agreement, as an independent contractor. Nothing in this Agreement is intended to create nor shall it be construed to create between KP and Contractor a relationship of principal, agent, employee, partnership, joint venture or association. Neither KP nor Contractor has authorization to enter into any contracts, assume any obligations or make any warranties or representations on behalf of the other. No individual through whom Contractor renders Services shall be entitled to or shall receive from KP compensation for employment, employee welfare and pension benefits, fringe benefits, or workers' compensation, life or disability insurance or any other benefits of employment, in connection with providing Services. Contractor represents and warrants that it shall be responsible for all legally required tax withholding for itself and its employees.

9.6 **Force Majeure.** Either party shall be excused from any inability to meet its obligations under this Agreement due to extraordinary circumstances beyond its reasonable control occasioned by war, acts of government, labor disputes, acts of terrorism, fire, flood, earthquake, extreme weather or other acts of nature provided that the affected party gives prompt written notice to the other party within two (2) days of discovery, or as soon as

practicable, of any of the foregoing events or conditions, including a description with the date of occurrence and the anticipated duration. Any party giving such notice must use its best efforts to minimize potential adverse effects to the other party and the other party shall be entitled to take any necessary measures or actions, including temporarily subcontracting the obligations of the noticing party, until the fulfillment of the obligations under the Agreement can be resumed for the balance of the term.

9.7 **Use of Name.** Each party reserves to itself the right to, and the control of the use of, its names, symbols, trademarks and service marks, presently existing or hereafter established, and no party shall use another party's names, symbols, trademarks or service marks in any advertising or promotional materials or communication of any type or otherwise without the latter party's prior written consent. Notwithstanding the foregoing, Contractor consents to KP's use of Contractor's name, address and telephone number in lists of practitioners and facilities and other marketing materials that KP may publish from time to time during the term of this Agreement.

9.8 **Publicity.** In the interest of presenting accurate information to the general public and Members, and of maintaining good public relations, the parties shall consult with each other regarding any issue relating to this Agreement or the delivery of Covered Services to Members under this Agreement which gives rise to media interest or public relations concern and shall cooperate in developing any statements or press releases in connection with any such issue.

9.9 **Governing Law.** The validity, enforceability and interpretation of any provision of this Agreement shall be governed by the laws of California and by federal law. Any provision required to be in this Agreement by Law regulating Health Plan shall bind the parties whether or not specifically articulated in this Agreement. This Agreement shall be construed and governed in accord with applicable contractual requirements imposed upon KP by the Medicaid, Medicare, relevant State public employment benefits and FEHBP contracts to which KP is a party.

9.10 **Procedure for Giving Notice**. All notices provided under this Agreement shall be in writing, signed by an authorized signatory, and shall be deemed given upon receipt if sent as follows: (i) confirmed fax; (ii) personally delivered; (iii) first class mail by United States Postal Service; (iv) confirmed overnight mail by United States Postal Service; (v) a commercial service with confirmed delivery; or (vi) certified mail (return receipt requested), each addressed as follows:

Southern California Permanente Medical Group
393 East Walnut Street, 7th Floor
Pasadena, CA 91188
Attn: Marilyn Owsley, Business Administrator
(626) 405-3289

Riverside County Department of Mental Health
4095 County Circle Drive (or subsequent address)
Riverside, CA 92503
Attention: Jerry Wengerd, Director of Mental Health (and any successor or designee)
(951) 358-4501

If notice is mailed, delivery is effective at the date and time shown on the confirmation or return receipt. Any party may change its address for notice purposes by prior written notice to the other party.

9.11 **Interpretation of the Agreement.** This Agreement shall be interpreted according to its fair intent and not for or against any one party on the basis of whether such party drafted the Agreement. The captions or section headings are for convenience of reference only and shall not affect in any way the meaning or interpretation of this Agreement.

9.12 **Entire Agreement.** Except with respect to any Delegated Activities that may be described in a separate writing, this Agreement, together with all exhibits attached hereto and incorporated by this reference, contains all the terms and conditions between the parties and supersedes any prior contracts, agreements, negotiations, proposals or understandings relating to the subject matter of this Agreement.

9.13 **Waiver.** A failure of any party to exercise any provision of this Agreement shall not be deemed a waiver. Any waiver of any provision of this Agreement shall be in writing and signed by the party against whom the waiver is sought to be enforced. Any such waiver shall not operate or be construed as a waiver of any other provision of this Agreement or a future waiver of the same provision.

9.14 **Severability.** If any provision is determined invalid, void or unenforceable, in whole or in part, the remaining provisions shall remain in full force and effect.

9.15 **Statutory and Other References.** Any reference to a statute, regulation, government agency or regulatory body, accreditation standard, or accreditation organization refers to the statute, regulation, government agency or regulatory body, accreditation standard, or accreditation organization as amended from time to time, and to any successor statute, regulation, government agency or regulatory body, accreditation standard, or accreditation organization.

9.16 **Counterparts.** This Agreement may be executed in separate counterparts, none of which need contain the signatures of all parties, and each of which, when so executed, shall be deemed an original, even if an executed signature page is maintained as a facsimile copy. Such counterparts shall together constitute and be one and the same instrument.

9.17 **Remedies Cumulative.** The rights and remedies of this Agreement shall not be exclusive and are in addition to any other rights and remedies provided by Law or at equity.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their respective duly authorized representatives.

SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP

By: _____

Marilyn Owsley
Business Administrator

Date: 6/17/11

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

By: _____

Bob Buster
Supervisor and Chairman
Riverside County Board of Supervisors

Date: DEC 06 2011

Contractor Tax ID(s): 95-6000930

ATTEST:
KECIA HARPER-IHEM, Clerk
By _____ DEPUTY

FORM APPROVED COUNTY COUNSEL
BY _____ 6/15/11
LARISA R-MCKENNA DATE

DEC 06 2011 3.21

EXHIBIT 1

BILLING AND PAYMENT

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

Rates Effective July 1, 2010

1. **Definitions**

Commercial Member means a member who is not a Medicare Member or Medi-Cal Member.

Medicare Member means any one or more of the following categories of Member:

- **Medicare Advantage Member** means a Member enrolled under a Medicare Advantage contract between Health Plan (or another Kaiser Payor) and the Centers for Medicare and Medicaid Services ("CMS") of the US Department of Health and Human Services ("DHHS").

- **Medicare Cost Member** means a Member enrolled under a Medicare Cost contract between Health Plan (or another Kaiser Payor) and CMS.

- **Medicare Fee For Service Member ("FFS")** means a Member (i) entitled to coverage under Part A only or Part B only or Parts A and B of Medicare but (a) not enrolled under a Medicare Advantage contract or a Medicare Cost contract between Health Plan (or another Kaiser Payor) and CMS and (b) for whom the Medicare program is the primary payor for Medicare-covered services under Medicare reimbursement rules, or (ii) enrolled under a Medicare Advantage contract and a hospice patient receiving care from Contractor for Services unrelated to the hospice patient's terminal condition.

Medi-Cal Member means a Member enrolled under Medi-Cal Contracts or Members enrolled under other Medicaid contracts in states other than California.

2. **Instructions Relating to Claims**

Contractor shall submit/receive HIPAA electronic transactions for the exchange of information for Services to be rendered and/or that have been rendered to each Member. The electronic transactions are described in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104 – 191.

If Contractor is not yet approved by Kaiser Permanente for EDI electronic transactions, Contractor agrees to submit standard CMS 1500/UB-04 paper claims and agrees to work mutually with Kaiser Permanente to submit/receive HIPAA electronic transactions.

Contractor shall submit all Claims for Services provided hereunder so that Claims are received by Permanente, or the applicable Payor, no later than 180 days after the date that each applicable Service was provided, unless a longer period is mandated by applicable

Law or Policies. Payment for Claims received after the applicable deadline may be denied.

Contractor shall submit Claims in the format and manner, and to the location(s), identified to Contractor in Policies. Notwithstanding the foregoing, Contractor shall submit all Claims for Services rendered to Medicare Cost Members and Medicare FFS Members to CMS.

3. **Compensation.** When payment is due from Permanente for Covered Services under this Agreement, Permanente shall pay Contractor within forty-five (45) working days (or within such other time periods applicable to the Claim under Law) after Permanente's receipt of a complete, uncontested, undenied Claim for Covered Services submitted in accordance with this Agreement, in each circumstance less the applicable Member Cost Share . When payment is due from an Other Payor, payment shall be made according to this Agreement and applicable Policies.

In accordance with the provisions of Article 3 (Billing and Payment), the responsible Payor shall pay compensation to Contractor for Covered Services rendered to Members per Medicare guidelines and as follows. Contract rates shall apply regardless of the location where Services are rendered.

Case Rates. The following Case Rates apply to all Services related to a course of treatment for a diagnosis or group of related diagnoses during a course of treatment to a specific Member provided by Contractor. Payment of the Case Rate includes not only the Services described by any indicated code(s) and/or descriptions which trigger or otherwise describe the Case Rate, but all other Services delivered during the course of treatment. However, Contractor must include all codes performed on the Claim form to describe clearly the Services rendered. The Case Rate(s) shall be paid per patient case, per day, not per physician.

Service Description	Case Rates
Adult and Adolescent Inpatient Services	$85 per day
Emergency Treatment Services (ETS)	$275 per day

Annual Rate Inflation:

Rates outlined above shall be effective and remain fixed from July 1, 2011 through June 30, 2012. Thereafter, rates shall increase at the rate of 3% annually, on the anniversary date of the Agreement, as follows:

July 1, 2012 - 3%
July 1, 2013 - 3%
July 1, 2014 - 3%
July 1, 2015 - 3%

Thereafter, rates shall continue to increase at the rate of 3% annually for the duration of the Agreement.

For Commercial And Medicare Advantage Members. Covered Services not listed above shall be at paid the lesser of (1) 100% of the amount payable pursuant to the relevant Medicare Fee Schedule in effect for the locality, as assigned by CMS, on the date of Service; or (2) covered billed charges, in each case less any Member Cost Share.

In the event no Medicare Fee Schedule code and amount is available for the applicable service(s), 50% of covered billed charges shall be paid for Services, less any Member Cost Share.

For Medi-Cal Members, Covered Services not listed above shall be paid the lesser of (1) 100% of the amount payable pursuant to the relevant Medi-Cal program fee-for-service amount as of the date of Service; or (2) covered billed charges, in each case less any Member Cost Share.

In the event no Medi-Cal program fee-for-service amount is available for the applicable service(s), 50% of covered billed charges shall be paid for Covered Services, less any Member Cost Share.

Medicare Cost Members and Medicare FFS Members. Following receipt from Contractor of a copy of the Medicare Summary Notice and a Claim, Payor shall pay Contractor (1) any applicable Member Cost Share for which Payor is responsible; and (2) any amount due for Covered Services that are not covered by Medicare, according to the lesser of (a) the applicable rates set forth in this Agreement or (b) covered billed charges. However, the responsible Payor shall not pay for Services rendered by Practitioners who are not Medicare certified unless such Services meet Medicare program requirements for reimbursement, even if such Services would otherwise be Covered Services. To the extent that a Covered Service is not a covered Medicare benefit, but is rendered by Medicare certified Practitioners or would otherwise meet Medicare program requirements for reimbursement, the responsible Payor shall compensate Contractor at 100% of the relevant Medicare Fee Schedule in effect for the locality, as assigned by CMS, on the date of Service. In the event no Medicare Fee Schedule code and amount is available for the applicable service(s), 50% of covered billed charges shall be paid for Services, less any Member Cost Share.

Periodic Updates. The parties acknowledge that any codes and ranges of codes set forth in this Exhibit may be updated periodically. New, successor, or replacement codes shall automatically be added or substituted for any codes and ranges of codes set forth herein so long as the Services described by the replacement codes remain substantially similar to those of the superseded codes.

Calculation of Member Cost Share. Where Member Cost Share is a deductible or based on a percentage calculation (such as for coinsurance), such amount shall be based on or calculated using the negotiated rate specified in Exhibit 1.

PERMANENTE Initials _____ CONTRACTOR Initials: _____

Date: 6/17/11 Date: 12/6/11

EXHIBIT 2

MEDIATION AND ARBITRATION

A. Mediation

1. **Mediator Selection.** The mediator shall be selected as soon as reasonably possible but in no event later than thirty (30) days following the parties agreement to mediate. The parties agree that mediation is most likely to be productive if they use an experienced mediator agreeable to both parties and they shall, therefore, use their best efforts to agree on a Mediator as soon as practical after they agree to mediate. If they are unable to agree upon a Mediator during that thirty (30) day period, the matter shall be submitted to Judicial Arbitration Mediation Service ("JAMS") for selection of a JAMS panel Mediator.

2. **Mediation Procedures.** The mediation shall commence as soon as possible after the Mediator is identified but in no event later than thirty (30) days after the Mediator is identified, unless the parties mutually agree to a different schedule. The mediation of the Dispute shall be completed in no more than one full day, unless the parties agree otherwise or the Mediator believes that additional time would more likely than not lead to resolution of the Dispute.

3. **Mediation Settlement.** If, as a result of mediation, a voluntary settlement is reached, the parties agree that such settlement will be reduced to writing and signed by all parties. This signed agreement will be treated the same as, and have the same force and effect as, an arbitration award rendered pursuant to Section 5.1.4.

4. **Attorneys' Fees/Costs.** The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the mediation. KP and Contractor shall share equally the costs of the mediation.

5. **Mediation Venue.** The mediation shall be conducted in Riverside County, California.

6. **Mediation Confidentiality.** The entire mediation process shall be confidential and the privileges and protections of Chapter 2, Division 9 of the California Evidence Code shall apply.

B. Arbitration

1. **Notice of Arbitration.** Notice of the party's demand to arbitrate the Dispute shall be given as set forth in Section 9.10.

2. **Venue/Applicable Law.** The arbitration shall be conducted in Riverside County, California. The construction, validity and performance of all arbitrations conducted pursuant to this Agreement shall be governed by the law of the State of California,

including California Code of Civil Procedure Section 1280 et seq., and specifically Section 1283.05, and Section 2 of the Federal Arbitration Act.

3. **Administration of Arbitration.** Unless otherwise agreed to by the parties, the binding arbitration shall be administered by JAMS in accordance with the JAMS rules applicable to commercial arbitrations (titled as of the date of this Agreement, "JAMS Comprehensive Arbitration Rules and Procedures" and referred to herein as "JAMS Rules"), except that this Agreement shall control in instances where it conflicts with the JAMS Rules.

4. **Arbitrator Selection and Fees.** The parties prefer that the arbitrator ("Arbitrator") be a retired judge of the California Superior, Appellate or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the Arbitrator may be an attorney with at least fifteen (15) years of experience including at least five (5) years in managed health care. If the parties are unable to agree on the Arbitrator within thirty (30) days of the date JAMS accepts the arbitration, the Arbitrator shall be selected by JAMS from a list of four potential arbitrators (all of whom shall be on JAMS' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this Section shall prevent a party from disqualifying an Arbitrator based on a conflict of interest. The parties shall be responsible for their own attorney's fees and costs incurred in preparing for and attending the arbitration. KP and Contractor shall share equally the fees of the Arbitrator.

5. **Joinder of Interested Parties.** The parties agree that any and all proper parties may be joined in the arbitration, but the parties agree to proceed with arbitration of all Disputes between them even if other parties refuse to participate. The parties agree that in no event shall a Member be considered a proper party for purposes of this Agreement, and the Arbitrator shall not have the power to join a Member as a party.

6. **Written Decision.** The Arbitrator shall issue a written reasoned decision setting forth the parties' contentions, findings of fact and conclusions of law applying California and applicable federal law (the "Decision") within thirty (30) days of the conclusion of the arbitration of each Dispute. For arbitration awards of two hundred fifty thousand ($250,000) or more, the Arbitrator shall issue a tentative Decision within such thirty (30) day period and the parties may each file a response to the tentative Decision within ten (10) days of the date it is issued. In addition, at the request of any party to the Agreement, the Arbitrator shall conduct a hearing on the tentative Decision, which shall be held within thirty (30) days of the date of the tentative decision or the earliest possible date thereafter that is mutually agreed to by the parties and the Arbitrator. The Arbitrator shall then have twenty (20) additional days to issue the final Decision. The Arbitrator's final Decision shall be conclusive and binding, and it may be confirmed thereafter as a judgment by the Superior Court of the State of California, subject only to challenge on the grounds set forth in California Code of Civil Procedure Section 1281 *et seq.*

7. **Waiver of Rights.** By agreeing to binding arbitration as set forth in Section 5.1.4, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a Dispute between them were determined by litigation in a court, including the right to a jury trial, attorneys' fees and certain rights of appeal.

8. **Confidentiality Requirements.** The parties acknowledge and agree that Disputes based on contract interpretation arise, or are likely to arise, in the ordinary course of business

and that this fact creates unusually sensitive issues with respect to the exchange of information related to their Dispute(s). The parties agree that it is not their intent to use the discovery process described herein, regardless of the forum, to obtain the other party's highly confidential and proprietary business information, nor will the parties so use the information except to the extent that such information is critical to the presentation of a party's case or defense. Where appropriate, the parties shall enter into protective orders, and those protective orders shall include creating a category of discovery documents "for attorney's eyes only," which shall provide that counsel, including in-house counsel, to whom such documents are provided shall not participate in, or provide any such information contained therein to those who participate in, the business negotiations or transactions between the parties. Further, the parties agree to fully cooperate with each other in ensuring that discovery materials which are subject to protective orders are and remain sealed by a court and/or Arbitrator, including joining in any motion or application for an order that the court/Arbitrator accepts and seals such documents and/or information. At the conclusion of the Dispute, whenever feasible, each party shall return or destroy all such information and shall provide to the other party an authorized representative's attestation indicating that all such information has been returned or destroyed.

9. **Injunctive Relief.** The parties agree that a breach of the confidentiality obligations set forth in this Agreement, including Article 6, would cause irreparable injury to the injured party which could not be compensated adequately in damages and that the injured party shall be entitled, in addition to any other remedies or damages, to injunctive relief to restrain violation of such confidentiality obligations, without the necessity of providing irreparable injury. Such injunctive relief shall be granted without requiring the injured party to post bond or other security. Any party to the Agreement may seek such temporary or preliminary injunctive relief in a court of competent jurisdiction to restrain a violation of the confidentiality obligations, or other provisions of this Agreement, but any permanent injunctive relief, including permanent relief to restrain the violation of other obligations under this Agreement, shall be resolved by arbitration in accordance with Section 5.1.4 above. The Arbitrator(s) shall have authority to issue final injunctive relief, and any orders necessary to carry out that relief, and such orders shall be confirmed as an enforceable judgment in a court of competent jurisdiction.

EXHIBIT 3

FEDERAL PROGRAM COMPLIANCE

Medicare [Medicare Managed Care Manual (100-16) Section 100.4]

In addition to all other obligations and rights set forth in this Agreement, Contractor shall comply with the following provisions with respect to Members who are enrolled in a Medicare Advantage or Medicare Managed Care Cost Program. While this Exhibit and the Agreement are intended to complement one another, should there be an irreconcilable conflict between them, this Exhibit shall control as to issues arising from services rendered to Medicare Advantage Members.

1. Medical Records. [42 Code of Federal Regulations §422.118)] Contractor shall (a) abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (b) ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (c) maintain medical records and information in an accurate and timely manner; and (d) ensure timely access by Members to the records and information that pertain to them.

2. Prompt Payment. [42 Code of Federal Regulations §422:520(b)] Contractor shall be paid for Covered Services rendered to Members within the lesser of forty five (45) working days of receipt of a properly submitted, supported and undisputed claim or the time period set forth in this Agreement.

3. Member Hold Harmless. [42 Code of Federal Regulations §422.504(g)(1)(i)&(i)(3)(i)] Contractor agrees that in no event including, but not limited to, nonpayment by or insolvency of Health Plan or breach of this Agreement, shall Contractor bill; charge; collect a deposit from; seek compensation, reimbursement, or remuneration from; impose surcharges; or have any recourse against a Member or a person acting on behalf of a Member for fees that are the legal obligation of Health Plan. This Agreement does not prohibit Contractor from collecting deductibles, Member Cost Share or fees for non-covered Services to the extent permitted by the applicable benefit plan. If a Medicare Advantage Member is also enrolled in Medi-Cal (or another State Medicaid program) and any such Medicaid program is responsible for the Member Cost Share, Contractor shall not hold the Member liable for such Member Cost Share, and Contractor shall accept payment pursuant to this Agreement as payment in full or bill Medicaid for such member Cost Share. This Section 3 shall be construed in favor of the Member as an intended third party beneficiary. It shall survive the termination of the Agreement, the insolvency of Health Plan, and shall supersede any oral or written agreement between Contractor and a Member.

4. Continuation of Benefit. [42 Code of Federal Regulations §422.504(g)(2)] In the event of the termination or expiration of this Agreement, Health Plan's insolvency, or other cessation of business, Contractor shall continue to provide Services and pharmaceuticals for all Members through the period for which premium was paid and, for Members who are confined in an inpatient facility on the date of insolvency or other cessation of business, through discharge. This Section 4 shall be construed in favor of the Member as an intended third party beneficiary. It shall survive the termination of the Agreement, the insolvency of Health Plan, and shall supersede any oral or written agreement between Contractor and a Member.

5. Audit. [42 Code of Federal Regulations §422.504(e)(4)&(i)(2)] The Department of Health and Human Services, the U.S. Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of Contractor involving transactions related to the Health Plan's Medicare Advantage contract with the U.S. during the period of this Agreement for ten (10) years after termination or expiration of this Agreement or the date of completion of any audit, whichever is later. Contractor shall retain such contracts, books, documents, papers, and records for this period.

6. Accountability and Delegation. [42 Code of Federal Regulations §422.504(i)(3)(ii)] Health Plan shall only delegate activities or functions to Contractor pursuant to a written delegation agreement in compliance with 42 Code of Federal Regulations §422.504(i)(4)&(5), which require, among other things, a covenant of Contractor that it will comply with all applicable Medicare laws, regulations, and CMS instructions.

7. Exclusion. [42 Code of Federal Regulations §422.752(a)(8)] Contractor represents it is not excluded from participation in Medicare under Sections 1128 or 1128A of the Social Security Act and further represents that it does not knowingly employ or contract with an individual or entity so excluded. This representation shall be continuing throughout the term of this Agreement and Contractor shall promptly notify Health Plan if such representation can no longer be made.

8. Certification of Data. [42 Code of Federal Regulations §422.504(l)(3)] The chief executive officer of Contractor, the chief financial officer, or an individual delegated the authority to sign on behalf of one of these officers, shall certify from time to time, as requested by Health Plan, that the encounter data and other data supplied by Contractor is (based on their best knowledge, information, and belief) are accurate, complete and truthful.

9. Termination Without Cause. [42 Code of Federal Regulations §422.202(d)(4)] If the Agreement may be terminated without cause, the minimum period of notice shall be at least 60 days, but shall be greater if provided in the Agreement.

10. Access to Books and Records. If this Agreement is determined to be subject to the provisions of Section 952 of P.L. 96-499, which governs access to books and records of contractors of Contractor Services to Medicare providers, Contractor agrees to permit representatives of the Secretary of the U.S. Department of Health and Human Services and the U.S. Comptroller General to have access to this Agreement and to the books, documents, and records of Contractor, as necessary to verify the costs of this Agreement in accordance with criteria and procedures contained in applicable federal regulations.

11. Advanced Directive. [42 Code of Federal Regulations §422.128(b)(1)(ii)(E)&(F)] The Member's medical record shall reflect, in a prominent part, whether or not the Member has executed an advance directive. Contractor may not condition the provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an advanced directive.

12. Physician Incentive Plan Disclosure and Compliance. [42 Code of Federal Regulations §422.208 and 210]

a. Representations. Contractor hereby affirmatively represents that Contractor complies, and during the term of the Agreement shall comply, with the applicable requirements of Title 42 CFR Sections 422.208 and 422.210 or successor regulations (the "PIP Rules"),

including physician incentive plan disclosure and maintenance of stop-loss protection, and shall comply with information requests and audits by KP and CMS regarding compliance with the PIP Rules. Contractor further affirmatively represents that, during the term of the Agreement, Contractor's contracts with Subcontractors shall require Subcontractors to comply with such PIP Rules, information requests and audits of Contractor and Subcontractors.

b. Disclosure and Compliance. Upon request, Contractor shall obtain and disclose to KP and CMS the terms of any at-risk payment arrangements between Contractor and any Subcontractors, as well as between a Subcontractor and its Subcontractors, and shall provide evidence of compliance with applicable requirements of the PIP Rules, such as stop-loss protection. For example, if Contractor contracts with a physician group, Contractor shall obtain and disclose such terms of the payment arrangement between Contractor and the physician group, as well as the terms of the payment arrangement between the physician group and any individually contracted physicians providing services to Members, and shall provide evidence of compliance with any applicable stop-loss protection requirements under the PIP Rules. Contractor shall obtain and provide such information in a format specified by or acceptable to such requesting entity, and shall include all information required under the PIP Rules.

13. Women's Health. [42 CFR § 422.100 and 112] For each woman Member, upon request of such woman Member, Contractor shall provide direct access to a women's health specialist for routine and preventive health services provided as basic Covered Benefits and to mammography screening.

14. Vaccines. [42 CFR § 100] Contractor shall provide direct access to influenza and pneumococcal vaccines. Members shall not be required to pay for these vaccines.

Federal Employee Health Benefits Program

In addition to all other obligations and rights set forth in this Agreement, Contractor shall comply with the following provisions with respect to Members who are enrolled in the Federal Employees Health Benefits Program. While this Exhibit and the Agreement are intended to complement one another, should there be an irreconcilable conflict between them, this Exhibit shall control as to issues arising from services rendered to Federal Employees Health Benefits Program Members.

Notice of Significant Events. [FEHBP Contract §1.10, 5 Code of Federal Regulations §1652.222-70] Contractor agrees to notify Health Plan of any Significant Event within ten working days after the Contractor becomes aware of it. A "Significant Event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon Contractor's ability to meet its obligations under the Agreement.

Patients' Bill of Rights. [FEHBP Contract §1.20] Contractor and Health Plan shall comply with the Federal Employee Health Benefits Plan Patients' Bill of Rights as it may from time to time be amended.

Continuation of Care. [FEHBP Contract §1.24] In the event Health Plan terminates its FEHBP contract with the U.S. Office of Personnel Management or terminates this Agreement other than for cause, or in the event Health Plan terminates its participating plan agreement with Contractor

other than for cause, Contractor and the affected Health Plan agrees that specialty physician care shall continue to be rendered and paid under the terms of this Agreement for those Members who are undergoing treatment for a chronic or disabling condition or who are in the second or third trimester of pregnancy for up to 90 days, or through their postpartum period, whichever is later. Contractor shall also promptly transfer all medical records to the designated new provider during or upon completion of the transition period, as authorized by the Member, and shall give all necessary information to Health Plan for quality assurance purposes.

Medi-Cal and Related State Assistance Program Provisions.

The following additional provisions are required by state law, regulations and/or contracts between Health Plan and California Department of Health Care Services ("DHCS") or another subcontractor to DHCS for services for Medi-Cal Members (such contracts referenced as "Medi-Cal Contracts"), and govern the delivery of Services to Members who are entitled to Contractor Services pursuant to Medi-Cal Contracts.

Services for Members. [Medi-Cal contracts] Services for Members shall be readily available, and shall meet or exceed the standards for medical practice developed by Plan and approved by DHCS.

Maintenance and Availability of Records.

(i) [Medi-Cal contracts] Contractor shall submit reports as required by Plan in order for Plan to satisfy its obligations under the Medi-Cal programs and Medi-Cal Contracts.

(ii) [Medi-Cal contracts] Contractor shall provide to Plan information regarding owners and creditors of Contractor, and such other information Plan may be required by law, government agencies or accrediting entities to provide to Members, agencies, or others.

(iii) [22 CCR 53250(e)] Contractor shall make all of its books and records pertaining to the goods and services furnished under the terms of this Agreement (including description and date of service and name of Member), available for inspection, examination or copying by DHCS, CDPH, the California Attorney General, and the federal Department of Health and Human Services during normal working hours, at reasonable times at Contractor's place of business, or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least five years from the close of the fiscal year in which this Agreement was in effect.

(iv) [22 CCR 53250(e)] Contractor shall maintain and make available to DHCS, upon request, copies of all Contractor's subcontracts and ensure that all such subcontracts are in writing and require that Contractor's subcontractors make all applicable books and records available at all reasonable times for inspection, examination or copying by DHCS and retain such books and records for a term of at least five years from the close of the fiscal year in which the subcontract is in effect.

(v) [22 CCR 53250(e)] Contractor shall permit DHCS to examine any books or records pertaining to Services provided to a Medi-Cal Member and to visit and inspect the premises upon DHCS' request.

Changes to this Agreement. [22 CCR 53250(a) & (e)] Amendments to this Agreement shall be effective only upon prior approval of DHCS, in those instances where prior approval by DHCS is required. DHCS approval must be obtained within thirty (30) days prior to a substantial change in the availability or location of services by Contractor to Members. Assignment or delegation of this Agreement by Contractor shall be void unless prior written approval is obtained from DHCS in those instances where prior approval by DHCS is required.

No Recourse Against Members. [Medi-Cal contracts & 22 CCR 53250(e)] Contractor shall hold harmless both the State of California, Medi-Cal Plans, Members or persons acting on a Member's behalf, in the event Plan cannot or will not pay for services performed by Contractor pursuant to this Agreement. Contractor agrees to hold harmless Members if Medi-Cal laws or contracts provide for insufficient funding to cover program benefits. Contractor shall not bill or seek any reimbursement from any Member for Services provided pursuant to this Agreement, except as expressly authorized by this Agreement, law or DHCS.

Compliance with Laws. [Medi-Cal contracts] Contractor shall comply with all requirements and standards applicable to Medi-Cal providers, including any surety bond requirements and any requirements imposed upon Plan through Medi-Cal contracts. Without limitation, Contractor shall not discriminate against any Member on the basis of race, color, age, sex, religion, ancestry, national origin, physical or mental disability or any reason in violation of Title VI of the Civil Rights Act of 1964 (42 USC Section 2000(d) and implementing rules and regulations). Contractor shall 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, AIDS, ARC), mental disability, medical condition (including cancer), age (over 40), marital status, or denial of family care leave. Contractor shall ensure that the evaluation and treatment of its employees and applicants for employment are free of discrimination and harassment. Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 and implementing regulations in 2 CCR 7285.0 et. seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990(a-f), set forth in Chapter 5 of Division 4, Title 2 CCR, are incorporated into this Agreement by reference and made part hereof as if set forth in full. Contractor shall promptly forward to Plan and DHCS any complaints by Medi-Cal Members or subcontractors regarding discrimination against Medi-Cal Members. Contractor shall comply with any policies and procedures developed by Plan regarding identifying, referring, and treating special Medi-Cal Member populations. Contractor shall ensure that any facilities owned, occupied or operated by Contractor are licensed, accredited (where applicable), in compliance with licensing standards, in compliance with all applicable local, state and federal standards including fire and safety standards, and conduct proper sterilization and disinfection of equipment.

EXHIBIT 4

PAYORS

Kaiser Payors

Kaiser Foundation Health Plan, Inc. (Northern California, Southern California, Hawaii)
Kaiser Foundation Health Plan of Colorado
Kaiser Foundation Health Plan of Georgia, Inc.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Kaiser Foundation Health Plan of the Northwest
Kaiser Foundation Health Plan of Ohio
Group Health Cooperative

Kaiser Foundation Hospitals
Kaiser Permanente Insurance Company
KP Cal

The Permanente Medical Group, Inc.
Southern California Permanente Medical Group
Colorado Permanente Medical Group, P.C.
Hawaii Permanente Medical Group, Inc.
Mid-Atlantic Permanente Medical Group, P.C.
Northwest Permanente, P.C., Physicians and Surgeons
Ohio Permanente Medical Group, Inc.
Permanente Dental Associates
The Southeast Permanente Medical Group, Inc.

Other Payors

24 Hour Fitness
American International Group, Inc.
County of Kern
Pinnacol Assurance
TEC Equipment, Inc.
The Episcopal Church Medical Trust
The Men's Wearhouse, Inc.
The MITRE Corporation
Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for Employees of KFHP, Inc., KFH, and KP OnCall in Southern California (certain salaried and non-union, non-exempt employees; certain non-union hourly employees), Appendix to Kaiser Permanente Self-Funded Health Benefit Plan
Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for Employees of KFHP, Inc. and KFH in Northern California (certain salaried and non-union, non-exempt employees; certain non-union hourly employees), Appendix to Kaiser Permanente Self-Funded Health Benefit Plan
Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan of Georgia, Appendix to Kaiser Permanente Self-Funded Health Benefit Plan

Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for National Business Unit Employees in California, Appendix to Kaiser Permanente Self-Funded Health Benefit Plan

Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for National Business Unit Employees in Colorado, Appendix to Kaiser Permanente Self-Funded Health Benefit Plan

Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for National Business Unit Employees in Georgia, Appendix to Kaiser Permanente Self-Funded Health Benefit Plan

Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for National Business Unit Employees in Mid-Atlantic States, Appendix to Kaiser Permanente Self-Funded Health Benefit Plan

Kaiser Foundation Health Plan, Inc., as the sponsor of Kaiser Employee Medical Health Plan for National Business Unit Employees in Northwest, Appendix to Kaiser Permanente Self-Funded Health Benefit Plan