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

ITEM: 3.6
(ID # 11536)
MEETING DATE:
Tuesday, February 4, 2020

FROM: OFFICE ON AGING:

SUBJECT: OFFICE ON AGING: Approve the Provider Services Agreement for the Health Homes Program with Molina Healthcare of California for the provision of health care services to health plan members, for the period effective upon full execution through June 30, 2021, or when the Health Homes Program pilot is terminated by the State, whichever comes first, Districts 1, 2, 3, and 5. [Total Cost: $450,897 - 100% Local - Molina Healthcare of California] (4/5 Vote Required)

RECOMMENDED MOTION: That the Board of Supervisors:

1. Approve the Provider Services Agreement for the Health Homes Program with Molina Healthcare of California, for the provision of health care services to health plan members, for the period effective upon full execution through June 30, 2021, or when the Health Homes Program pilot is terminated by the State, whichever comes first, and authorize the Chairman of the Board to sign the agreement on behalf of the County;
2. Authorize the Riverside County Office on Aging (RCOoA) Director, or Deputy Director, to administer the agreement and sign any other forms, certifications, assurances, reports, or other documents which are related to the agreement as required by Molina Healthcare of California to effectuate the agreement, as approved as to form by County Counsel and consistent with the Board's approval;

ACTION:Policy, 4/5 Vote Required

Jewel Lee, Director of Office on Aging 1/22/2020

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Perez, seconded by Supervisor Jeffries and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Hewitt
Nays:	None
Absent:	None
Date:	February 4, 2020
xc:	OOA, Auditor

Kecia R. Harper
Clerk of the Board
By: Deputy

3. Authorize the RCOoA Director, or Deputy Director, to sign amendments, approved as to form by County Counsel and consistent with the Board's approval, that make modifications to the Provider Services Agreement for the Health Homes Program with Molina Healthcare of California that stay within the intent of the agreement; and
4. Approve and direct the Auditor-Controller's Office to make the budget adjustments shown on Schedule A.

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 174,729	$ 276,168	$ 450,897	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: 100% Local - Molina Healthcare of California			**Budget Adjustment:**	**Yes**
			For Fiscal Year:	19/20-20/21

C.E.O. RECOMMENDATION: [CEO use]

BACKGROUND:

Summary

Molina Health Care of California, (a Health Plan), is requesting to contract with Riverside County Office on Aging (RCOoA) to serve as a Community Based-Care Management Entity (CB-CME) to render certain Health Care services to Health Plan's Health Home Program (HHP) eligible Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

The HHP is a California Department of Health Care Services (DHCS) mandated Medi-Cal Program authorized under Section 2703 of the Affordable Care Act. The HHP serves eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries.

RCOoA will be responsible for providing HHP Services to one-hundred (100) adults over the age of 55 in the following cities: Riverside, Corona, Hemet, Perris, Lake Elsinore, Wildomar, Temecula, Murrieta, Menifee, Sun City, and Moreno Valley. The HHP services are defined by the DHCS Health Homes Program Guide as a set of six (6) specific care coordination services: 1) Comprehensive Care Management, 2) Care Coordination, 3) Health Promotion, 4) Comprehensive Transitional Care, 5) Individual and Family Support, and 6) Referral to Community and Social Support Services. RCOoA is required to coordinate and integrate care across the continuum of services for the provision of HHP services.

Impact on Residents and Businesses

The Health Homes Program will be providing services for one-hundred (100) adults over the age of 55 who are eligible Medi-Cal beneficiaries with complex medical needs and chronic

conditions that may benefit from enhanced care management and coordination in the cities listed above. The HHP program will empower and support the member to live independently in their home and community, promote healthy aging and community involvement. The expected outcome is a reduction in hospital admissions, emergency department visits, and skilled nursing facility admissions.

Additional Fiscal Information

The Provider Services Agreement for the Health Homes Program with Molina Healthcare of California is a revenue generating agreement for RCOoA. Molina Healthcare of California will pay RCOoA a monthly rate for each member to whom services are provided; there is no maximum contract amount set forth in this agreement. The compensation RCOoA is expecting to receive from the Provider Services Agreement for the Health Homes Program with Molina Healthcare of California for services rendered for FY 19/20 and 20/21 is $174,729 and $276,168 respectively, for an expected total of $450,897. RCOoA included an estimated funding amount of $407,136 for current FY, with the intention of the program starting July 1, 2019. Therefore, the attached budget adjustment, in the amount of $232,407 is necessary to reflect the actual revenue to be received under this Provider Services Agreement in the current fiscal year.

There is no impact to county general funds and no match requirement.

ATTACHMENTS:

ATTACHMENT A. **PROVIDER SERVICES AGREEMENT FOR THE HEALTH HOMES PROGRAM WITH MOLINA HEALTHCARE OF CALIFORNIA**

ATTACHMENT B. **HEALTH HOMES PROGRAM – BUDGET PROJECTIONS**

Gregory P. Priamos, Director County Counsel 1/27/2020

Office on Aging
Schedule A
FY 19/20

Decrease estimated revenue:		
21450-5300100000-781850	Grants-Nongovtl Agencies	$232,407
Decrease appropriations:		
21450-5300100000-510040	Regular Salaries	159,413
21450-5300100000-513000	Retirement-Misc.	34,556
21450-5300100000-513120	Social Security	9,884
21450-5300100000-513140	Medicare Tax	2,311
21450-5300100000-515040	Flex Benefit Plan	23,926
21450-5300100000-515100	Life Insurance	133
21450-5300100000-515120	Long Term Disability	405
21450-5300100000-515160	Optical Insurance	38
21450-5300100000-515220	Short Term Disability	771
21450-5300100000-515260	Unemployment Insurance	663
21450-5300100000-518010	Def Comp Ben Mgmt & Conf	247
21450-5300100000-518020	Flexible Spending Account Fees	15
21450-5300100000-518140	SEIU Training	33
21450-5300100000-518150	LIUNA Health & Safety	12
		232,407

MOLINA HEALTHCARE OF CALIFORNIA

PROVIDER SERVICES AGREEMENT FOR THE HEALTH HOMES PROGRAM

This PROVIDER SERVICES AGREEMENT FOR THE HEALTH HOMES PROGRAM ("Agreement") is entered into by and between **MOLINA HEALTHCARE OF CALIFORNIA, a California corporation** ("Health Plan"), and **_____THE COUNTY OF RIVERSIDE, a political subdivision of the state of California, on behalf of its OFFICE ON AGING** ("Provider").

RECITALS

Health Plan arranges for the provision of certain Health Care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

Health Plan arranges for the provision of certain Health Care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

Health Plan desires for Provider to serve as a Community Based-Care Management Entity (CB-CME) to render certain Health Care services to Health Plan's HHP eligible Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated :herein, Health Plan and Provider agree as follows

ARTICLE ONE - DEFINITIONS

1.1 Provider means the entity identified in Attachment A, attached hereto and .incorporated herein

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth .in Attachment B, attached hereto and incorporated herein

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall serve on Health Plan's panel of providers for the products specified in Attachment C, attached hereto and incorporated herein. Provider agrees that its practice information may be used in

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Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Practice Information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, and ability to accept new patients. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care.**

a. **Provision of Covered Services.** Provider shall provide Covered Services, described in Attachment K-1 attached hereto and incorporated herein, to Members, within the scope of Provider's business and practice, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice for case management and client contact at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **(N/A) Prior Authorization.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Member Eligibility Verification.** Provider shall verify eligibility of Members prior to rendering services.

g. **Admissions.** Provider shall cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

h. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider shall provide notification to Health Plan within twenty-four (24) hours of the referral.

i. **(N/A) Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

j. **Subcontract Arrangements.** Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.

k. **(N/A) Availability of Services.** Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services. Provider shall notify Members that any after-hour or emergency services shall be coordinated directly through Health Plan's Member Services.

l. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

2.3 **Promotional Activities.** At the request of Health Plan, and in accordance with Provider's policies and procedures, Provider may (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) may cooperate with and participate in all reasonable Health Plan's marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability, regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping.**

a. **Maintaining Member Medical Records.** Provider shall maintain a Member record for each Member to whom Provider renders Health Care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identification ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability

Act (HIPAA) of 1996, Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider shall obtain an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider shall make best efforts to report its NPI and any subparts to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider shall use its NPI to identify itself on all Claims and encounters (both electronic and paper formats) submitted to Health Plan.

e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, or claims payment. Provider shall further provide direct access at reasonable times to said patient care information as requested by Health Plan and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries. Please reference Plan Grievance Program in provider handbook.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **(N/A) Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services. If Provider is a medical group or IPA, Provider shall accept delegation of utilization management responsibilities from Health Plan at Health Plan's request. If delegation of utilization management responsibilities is revoked, Health Plan shall reduce any otherwise applicable payments owing to Provider by the Utilization Payment Reduction Amount specified in Attachment D.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or reassign Members to another provider. If Provider is a medical group or IPA, Provider shall accept delegation of credentialing responsibilities at Health Plan's request and shall cooperate with Health Plan in establishing and maintaining appropriate credentialing mechanisms within Provider's organization. If delegation of credentialing responsibilities to a group or IPA is revoked, Health Plan shall reduce any otherwise applicable payments owing to group or IPA by the Credentialing Payment Reduction Amount specified in Attachment D.

e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **(N/A) Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall ensure that Provider promptly delivers to Provider's constituent providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that staff in roles that require an active license (e.g., Licensed Clinical Social Worker and Registered Nurse)

are appropriately licensed to render Health Care services within the scope of their respective practice. Provider shall provide evidence of staff's licensure status to Health Plan upon request. Provider staff shall maintain licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in staff's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider's staff.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **(N/A) Staffing Privileges for Providers.** Consistent with community standards, every physician Provider shall have staff privileges with at least one Health Plan contracted Hospital as necessary to provide services to members under this Agreement, and shall authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of his/her hospital privileges.

e. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Provider shall maintain, at a minimum, liability insurance with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate for the policy year. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan.

2.8 **Claims Payment.**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any Claims that are not submitted by Provider to Health Plan within one hundred and eighty (180) days of providing the Covered Services that are the subject of the Claim shall not be eligible for payment, and Provider hereby waives any right to payment therefor.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations, including but not limited to the Knox-Keene Health Care Service Plan Act of 1975 and accompanying regulations, and in accordance with the compensation schedule set forth in Attachment D, attached hereto and incorporated herein.

c. **Encounter**. Means the method in which the Health Homes Program services or activity rendered to a Beneficiary will be captured.

d. **Co-payments and Deductibles.** Members with dual coverage under the Medicare and Medi-Cal program ("Medi-Medi" Members) and CFAD program Members will not be held liable by Provider for Medicare Part A and B cost sharing when the State, Health Plan or another payor such as a Medi-Cal managed care plan is responsible for paying such amounts, nor be held liable for cost-sharing that exceeds the amount such a Member would be required to pay through Medi-Cal.

e. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D.

f. **Offset.** In the event that Health Plan determines that a Claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Provider shall make repayment to Health Plan within thirty (30) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed

by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) working days notice in which to exercise Provider's appeal rights under this Agreement. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

g. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's Claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

h. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with another provider contracted with Health Plan; who receives capitation from Health Plan and is responsible for arranging for Covered Services through subcontract arrangements ("Capitated Provider"), Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

i. **No Billing of Members**. Except as specifically provided for in this section, Provider agrees to seek payment from only Health Plan or a Capitated Provider for all Covered Services provided to a Member. In no event, including but not limited to, nonpayment by Health Plan or a Capitated Provider, insolvency by Health Plan or a Capitated Provider, or breach of the Agreement, shall Provider, or any person acting on Provider's behalf, bill,

charge, collect a deposit or surcharge from, seek compensation from, or have any other recourse against a Member, or a person acting on the Member's behalf, for Covered Services provided pursuant to this Agreement.

This prohibition does not apply to the following:

i. When a Member has dual coverage, Provider may bill both payors consistent with the coordination of benefits provision in section 2.8(e) and the order of benefit determination provisions set forth in Title 28 of the California Code of Regulations, Section 1300.67.13.

ii. Provider may bill a Member for any applicable co-payment, deductible or co-insurance obligation in accordance with section 2.8(d).

iii. Provider may seek payment from Member for services that are not Covered Services under the terms of this Agreement provided the payment is not for otherwise Covered Services which Health Plan determines not to have been Medically Necessary or in keeping with Health Plan's Utilization Review and Management Program and provided the Member signs a written waiver that meets the following criteria:

(a) The waiver notifies the Member that the medical service is a non-Covered Service;

(b) The waiver notifies the Member of the medical service being provided and the date(s) of service;

(c) The waiver notifies the Member of the approximate cost of the medical service; and

(d) The waiver is signed by the Member prior to receipt of the medical service.

2.9 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act.

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to state licensing statutes and regulations set forth in Attachment E, attached hereto and incorporated

.herein, and all applicable sub-attachments to Attachment E

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment F, attached hereto and incorporated herein, and all applicable sub-attachments to Attachment F, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid .program

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the Medicare provisions set forth in Attachment H, attached hereto and incorporated herein, the effect of which provisions is limited solely to activities and Covered Services related to the .Medicare program

d. Provider acknowledges that for all Covered Services rendered to Members enrolled in a Molina Health Benefit Exchange Product, Medi-Cal statutes and regulations referenced in this Agreement are inapplicable, and Provider shall comply with all statutory and regulatory requirements of the California Health Benefit Exchange Act, California Government Code §100501, et seq.

2.10 **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another medical group, IPA, or provider without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.11 **Fraud and Abuse Reporting.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations.

2.12 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.13 **(N/A) Reciprocity Agreements.** Provider shall cooperate with Health Plan's Participating Providers and affiliates of Health Plan and agrees to provide Covered Services to Members enrolled in various government sponsored health programs and other health products, and various government sponsored health programs and other health products of affiliates, and to assure reciprocity of health care services. Without limiting the foregoing, if any Member receives services or treatment constituting Covered Services from Provider and a capitated Participating Provider is financially responsible for such services, such Participating Provider shall be solely responsible for compensating Provider for any Covered Services provided by the Provider in accordance with the applicable Payments which are the Responsibility of a Capitated Provider provisions of this Agreement. Payment by the Participating Provider shall be at; (i) the rates agreed by the Participating Provider and Provider, or (ii) if there is no applicable agreement, at the lesser of Provider's billed charges or an amount equivalent to one hundred percent (100%) of the governing rates provided by applicable State and Federal Law specific to the Member's enrolled benefit plan (i.e. Medicaid, Medicare, etc.) in place at the time services are rendered, or (iii) at the election of the Participating Provider, at the rates set forth in this Agreement. Provider agrees that the applicable provisions of the Compensation section of this Agreement shall continue to be binding upon Provider, especially in that Provider shall not balance bill Members for any Covered Services. Provider shall comply with the procedures established by Health Plan or its affiliates and this Agreement for reimbursement of such services or treatment. Provider shall not encourage Members to receive Covered Services from non-Participating Providers. Breach of this section shall constitute breach of a material term of the Agreement and will give rise to cause for termination of this Agreement pursuant to the applicable Termination with Cause provisions of this Agreement. Provider shall abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.14 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider shall forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Plan's or the Member's request to transfer the records.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of both the: (i) medical, and (ii) medically-related scientific and technical, aspects of Health Plan.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the last date indicated on the signature page of this Agreement ("Effective Date") and shall continue through June 30, 2021 or when the Health Homes Program pilot is terminated by the State, whichever comes first.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least ninety (90) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or

cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. , Provider's license or certificate to render health care services is limited suspended or revoked, or disciplinary proceedings are commenced against ;Provider by the state licensing authority

b. ;Provider fails to maintain insurance required by this Agreement

c. ;Provider loses credentialed status

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in ;bankruptcy or receiver for Provider is appointed by appropriate authority

e. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation ;methodology

f. Health Plan determines that Provider's facility and/or equipment is ;insufficient to render Covered Services to Members

g. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise ;terminated as a provider by any state or federal health care program

h. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this ;Agreement

i. Health Plan determines that health care services are not being properly ' provided, or arranged for, and that such failure poses a threat to Members .health and safety

ARTICLE FIVE - GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, agencies, districts, special districts,

departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and reasonable attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan and listed in Attachment C, the contract between the Department of Health Care Services and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive agreement between Health Plan and Provider. Nor shall it be deemed to be an agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 **Amendment.** Health Plan may, without Provider's consent, amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for compliance. Should Provider disagree with the changes, or be unable to comply with the changes to the Agreement, notwithstanding any other

provision in this Agreement, Provider may terminate the Agreement upon forty-five (45) days' notice to Health Plan. Health Plan may otherwise materially amend this Agreement only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by an amendment being executed by each party hereto.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Dispute Resolution.** Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy shall be submitted to non-binding arbitration administered by the American Arbitration Association ("AAA") in accordance with its Commercial Arbitration Rules then in effect by a single arbitrator in Riverside County, CA; provided, however, that arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters. If possible, the arbitrator shall be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor shall the arbitrator have the authority to award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees of arbitration. The use of arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.9 **Governing Law and Venue.** This Agreement shall be governed by the laws of the state of California. Any legal action related to the performance or interpretation of this Agreement shall be filed only in the Superior Court of the state of California located in Riverside, California, and the parties waive any provision of law providing for a change of venue to another location.

5.10 **Attachments.** Each of the Attachments identified below is hereby made a part of this Agreement:

Attachment A	Provider Identification Sheet
Attachment B	Definitions

Attachment C	Products/Programs
Attachment D	Compensation
Attachment E	Health Care Service Required Provisions
Attachment F	DHCS Provisions
Attachment G	Acknowledgment of Receipt of Provider Manual & Health Homes Program Guide
Attachment H	Disclosure Form
Attachment I	Certificate of Ownership
Attachment J	Provider Scope of Responsibility
Attachment K-1	Provider Scope of Service
Attachment L	Business Associate Agreement
Attachment M	Delegation Services Addendum

5.10 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:
Molina Healthcare of California
9275 Sky Park Court, Suite 400, San Diego, CA 92123
Attention: President/CEO

If to Provider:
Riverside County Office on Aging
P.O. Box 2099, Riverside, CA 92516
Attention: Gary Robbins

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.11 **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product shall govern.

SIGNATURE AUTHORIZATION

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth below. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

County of Riverside		**Molina Healthcare of California**	
Provider Signature:		Molina Signature:	
Tax ID Number (TIN):		Signatory Name (Printed):	Paul Van Duine
Signatory Name (Printed):	V. MANUEL PEREZ	Signatory Title (Printed):	VP of Provider Network and Ops
Signatory Title (Printed):	Chairman, Board of Supervisors	Signature Date:	1/8/2020
Signature Date:	2/4/2020		

FORM APPROVED COUNTY COUNSEL
BY: _____ 1/27/20
DANIELLE D. MALAND DATE

ATTEST:
KECIA R. HARPER, Clerk
By _____
DEPUTY

ATTACHMENT A
Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

	Primary Care Physician
Y	**Health Homes Program**
N/A	Group/IPA (a list of constituent members with their License No., UPIN, and DEA numbers is attached and incorporated herein)
N/A	Other: type N/A

Please enter "N/A" for the following if not applicable or not available:

Provider Name	County of Riverside, Office on Aging	Billing Address: PO Box 2099 Riverside, CA 92516
Telephone No.	951-867-3800	
Facsimile No.	951-867-3830	
Tax I.D. No. (TIN)	95-6000930	
License No.		
Billing NPI	1457782773	Physical Address: 3610 Central Avenue Riverside, CA 92506
Individual NPI	1457782773	
DEA No.		

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

_____
Provider Signature

Jewel Lee
Signatory Name (Printed)

Director
Signatory Title (Printed)

_____
Signature Date

ATTACHMENT A
Provider Identification Sheet (Continuation Page)

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN and/or billing address. Please enter "N/A" for the following if not applicable or not available:

Provider Name		Billing Address:
Telephone No.		
Facsimile No.		
Medicaid ID No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.		
NPI (or UPIN if NPI not yet designated)		
DEA No.		

Provider Name		Billing Address:
Telephone No.		
Facsimile No.		
Medicaid ID No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.		
NPI (or UPIN if NPI not yet designated)		
DEA No.		

Provider Name		Billing Address:
Telephone No.		
Facsimile No.		
Medicaid ID No.		
Email Address		
Tax I.D. No.		Physical Address (if different than above):
License No.		
NPI (or UPIN if NPI not yet designated)		
DEA No.		

ATTACHMENT B
DEFINITIONS

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

2. **Agreement** means this Provider Services Agreement for the Health Homes Program, all attachments, and incorporated documents or materials.

3. **Capitated Financial Alignment Demonstration (CFAD) Product, or the Medicare and Medicaid Program** means the managed care program established by the Centers for Medicare and Medicaid Services (CMS) through the capitated financial alignment demonstration in which the state, CMS and Health Plan will enter into a three-way contract that will allow the health plan to provide care to beneficiaries eligible for both Medicaid and Medicare.

4. **Claim(s)** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.

5. **Clean Claim** means a claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim. For the Molina Health Benefit Exchange Product, Clean Claim shall have the same meaning as the definition of 'complete claim' set forth in Title 28, California Code of Regulations §1300.71(a)(2).

6. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

7. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.

8. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan affiliate's product which covers the Member.

9. **Credentialing Payment Reduction Amount** means that amount by which payments otherwise owing to Provider are reduced in the event Provider is dedelegated responsibility for credentialing.

10. **Emergency Services** are Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (a) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid / Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114.

11. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.

12. **Health Benefit Exchange** means the California Health Benefit Exchange established by Section 100500 of the California Government Code.

13. **Health Plan** means Molina Healthcare of California.

14. **HEDIS Studies** means Health Employer Data and Information Set.

15. **IPA** means Independent Practice Association.

16. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

17. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

18. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D Services.

19. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

20. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to receive Covered Services.

21. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Where Provider is a Group/IPA or Hospital, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Group/IPA or Hospital. All of said persons are bound by the terms of this Agreement.

22. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan or mutually amended or modified from time to time by the parties, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

23. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

24. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

25. **Utilization Payment Reduction Amount** mean that the amount by which payments otherwise owing to Provider are reduced in the event that Provider is de-delegated responsibility for utilization management.

27. **Contractor** means the person(s) and/or entity identified in Attachment A to this Agreement.

28. **Subcontract** means a written agreement entered into by the Contactor with any of the following:

    A. A Provider of health care services who agrees to furnish Covered Services to Members.

    B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor obligations to Health Plan under the terms of this Contract.

ATTACHMENT C

Products/Programs

Provider hereby elects to participate as a panel provider for each of the following Health Plan products as offered and applicable to Health Homes.

Y Medi-Cal Managed Care

Health Plan shall maintain any applicable benefit and Covered Services descriptions in its Provider Manual and Health Homes Program Guide.

ATTACHMENT D

COMPENSATION

Health Plan agrees to reimburse Provider for Health Homes Services at the rates outlined below.

I. Rates:

1.1. Rate shall commence after Molina receives a qualified HCPCS code (applicable "G" code) from the Provider. Molina agrees to compensate Provider 95% of DHCS premium rate in effect for the applicable coverage month for the Health Homes Program. Compensation is contingent upon submission of at least one HCPCS code (applicable "G" code) with a valid modifier each month, in accordance with the guidelines specified below.

1.2. **Codes: HCPCS and Modifiers.** DHCS selected HCPCS code (applicable "G" code) for HHP. The definition of "G" code is as follows: Comprehensive assessment of and care planning for patients requiring chronic care management services.

HCPCS code along with seven (7) different modifiers are listed in the table below for the HHP services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, and Referral to Community and Social Supports). This coding scheme uses HIPAA compliant HCPCS code and modifier combinations to identify clinical and non-clinical services, distinguishes between in-person and telephonic/telehealth 'visits', and allows other HHP services such as case notes, case conferences, tenant supportive services, driving to appointments, etc. to be codified. In addition, there is a designated modifier for engagement services. The HHP coding scheme is as follows:

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	Applicable "G" code	U1	15 minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	Applicable "G" code	U2	15 Minutes equals 1 UOS; Multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	Applicable "G" code	U3	15 Minutes equals 1 UOS; Multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	Applicable "G" code	U4	15 Minutes equals 1 UOS; Multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	Applicable "G" code	U5	15 Minutes equals 1 UOS; Multiple UOS allowed

Other Health Home Services: Provided by Non-Clinical Staff	Applicable "G" code	U6	15 Minutes equals 1 UOS; Multiple UOS allowed
HHP Engagement Services	Applicable "G" code	U7	15 Minutes equals 1 UOS; Multiple UOS allowed

Rates: At least one (1) HCPCS code submission with a valid modifier is required for each HHP Member at minimum every ninety days. If more than one (1) HCPCS code submission is submitted for each HHP Member at minimum every ninety days, only one encounter/ encounter code per HHP Member will be accepted per month for payment. The payment Provider shall receive for the one encounter/encounter code that is accepted is 95% of the DHCS premium rate in effect for the applicable coverage month for the Health Homes Program. Provider is responsible for reporting all encounters data back to the Health Plan.

1.3 **Reimbursement Limitations**

1. HHP Members may opt out of the program at any time and as a result, Members will be considered disenrolled from the program.

2. Payments will cease when HHP Member is determined to be ineligible for HHP as follows:
   i. No longer eligible with Health Plan Medi-Cal program;

   ii. HHP Member is determined through further assessment to be sufficiently well managed through self-management or through another program, or the HHP Member is otherwise determined to not fit the high-risk eligibility criteria;

   iii. HHP Members whose condition management cannot be improved because the HHP Member is uncooperative;

   iv. HHP Members whose behavior or environment is unsafe for Provider staff;

   v. HHP Members determined to be more appropriate for an alternate care management program;

   vi. HHP Member enters or is found to be in a 1915(c) Home and Community Based (HCBS) waiver program: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), Pediatric Palliative Care (PPC);

   vii. Member is managed by County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);

viii. Member becomes a resident at a Skilled Nursing Facility (SNF) with a duration longer than the month of admission and the following month; or

ix. Member is enrolled or becomes enrolled in Hospice.

x. Member opts out of program they are considered disenrolled in the HHP program.

3. Provider shall be eligible for payment for HHP engagement services prior to a completed HAP. Prior to a completed HAP, Provider will be paid for engagement services provided for up to ninety (90) days. Notwithstanding any other provision, Provider will no longer be eligible for payment if HHP Member does not have a completed HAP within 90 days of becoming a HHP Member, regardless of whether a valid HCPCS code and modifier combination is submitted. If a HAP is delayed, but completed, payment will begin the following month.

1.4 Billing and Payment Terms

1. The CB-CME shall promptly submit encounters to the Health Plan. The CB-CME will submit an encounter to Health Plan for the encounters completed that month, using the appropriate HHP encounter code for the care coordination encounter type provided. Preferred submission is through the Health Plan Provider Services Portal.
2. Encounters will be submitted for each individual HHP Member based upon the provision of an eligible HHP Service. While multiple encounters can be submitted, only one encounter/encounter code per HHP Member will be accepted per month for payment.
3. The CB-CME shall ensure that documentation supporting the delivery of one of the HHP Services is collected for each submitted encounter.
4. CB-CME providing Health Homes Program Services upon submittal of a valid encounter shall receive payment for one HHP Member per month.
5. Health Plan shall render payments pursuant to this attachment within thirty (30) days of Health Plan's acceptance of CB-CME's successfully submitted encounter.

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REQUIRED PROVISIONS
(HEALTH CARE SERVICE PLANS)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. Any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

DMHC Provisions

1. In the event that Health Plan fails to pay Provider for Covered Services, the Member or subscriber shall not be liable to Provider for any sums owed by Health Plan. Provider shall not collect or attempt to collect from a Member or subscriber any sums owed to Provider by the Health Plan. Provider may not and will not maintain any action at law against a Member or subscriber to collect sums owed to the Provider by Health Plan. (Health and Safety Code section 1379)

2. To the extent that any of Health Plan's quality of care review functions or systems are administered by Provider, Provider shall deliver to Health Plan any information requested in order to monitor or require compliance with Health Plan's quality of care review system. (Rule 1300.51, J-5)

3. Provider is responsible for coordinating the provision of Health Care Services to Members who select Provider if Provider is a primary care physician. (Rule 1300.67.1(a))

4. Provider shall maintain Member records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. (Rule 1300.67.1(c))

5. Provider shall maintain reasonable hours of operation and make reasonable provisions for after-hour services. (Rule 1300.67.2(b))

6. To the extent Provider has any role in rendering Emergency Services, Provider shall make such Emergency Services available and accessible twenty-four (24) hours a day, seven days a week. (Rule 1300.67.2(c))

7. Provider shall participate in Health Plan's system for monitoring and evaluating accessibility of care including but not limited to waiting times and appointment availability, and addressing problems that may develop. Provider shall timely notify Health Plan of any changes to address or inability to maintain Health Plan's access standards. (Rule 1300.67.2(f))

8. Health Plan is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975. A provision that (i) the plan is subject to the requirements of

Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California Code of Regulations, and (ii) any provision required to be in the contract by either of the above shall bind the plan whether or not provided in the contract. (Rule 1300.67.4(a)(9)).

9. Upon the termination of this Agreement, Health Plan shall be liable for Covered Services rendered by Provider (other than for copayments as defined in subdivision (g) of Section 1345 of the Health and Safety Code) to a subscriber or Member who retains eligibility under the applicable plan contract or by operation of law under the care of Provider at the time of termination of the Agreement until the services being rendered to the subscriber or Member by Provider are completed, unless the Health Plan makes reasonable and medically appropriate provision for the assumption of services by a contracting provider. (Health and Safety Code section 1373.96) (Rule 1300.67.4(a)(10))

10. Any written communications to Members that concern a termination of this Agreement shall comply with the notification requirements set forth in Health and Safety Code section 1373.65(f).

11. Provider shall maintain all records and provide all information to the Health Plan or the DMHC as may be necessary for compliance by the Health Plan with the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended and any regulations promulgated thereunder. To the extent feasible, all such records shall be located in this state. Provider shall retain such records for at least two years: this obligation shall not terminate upon termination of the Agreement, whether by rescission or otherwise. (Health and Safety Code section 1381) (Rule 1300.67.8(b))

12. Provider shall afford Health Plan and the DMHC access at reasonable times upon demand to the books, records and papers of Provider relating to health services provided to Members and subscribers, to the cost thereof, to payments received by Provider from Members and subscribers of the Health Plan (or from others on their behalf), and, unless Provider is compensated on a fee-for-services basis, to the financial condition of Provider. Provider shall promptly deliver to Health Plan, any financial information requested by Health Plan for the purpose of determining Provider's ability to bear capitation or other applicable forms of risk sharing compensation. (Rule 1300.67.8(c))

13. Provider shall not and is hereby prohibited from demanding surcharges from Members for Covered Services. Should Health Plan receive notice of any such surcharges by Provider, Health Plan may take any action it deems appropriate including but not limited to demanding repayment by Provider to Members of any surcharges, terminating this Agreement, repaying surcharges to Members and offsetting the cost of the same against any amounts otherwise owing to Provider. (Rule 1300.67.8(d))

14. Upon Health Plan's request, Provider shall report all co-payments paid by Members to Provider. (Health and Safety Code section 1385)

15. To the extent that any of Health Plan's quality assurance functions are delegated to Provider, Provider shall promptly deliver to Health Plan all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions. (Rule 1300.70)

16. Provider may utilize Health Plan's Provider Dispute Resolution Process by phoning or writing the Provider Services Department, Molina Medical Centers, Third Floor, One Golden Shore Drive, Long Beach, CA 90802 (800) 526-8196, ext. 1249. The Provider Dispute Resolution Process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Health and Safety Code Section 809, et. seq. Please see the Provider Manual for more information regarding the dispute resolution process. (Health and Safety Code Section 1367(h).) (Rule 1300.71.38)

17. Provider shall display in each reception and waiting area a notice informing Members how to contact their health plan, file a complaint with their plan, obtain assistance from the DMHC, and seek an independent medical review. (Rule 1300.68(b))

18. A written contract shall be prepared or arranged in a manner which permits confidential treatment by the Director of payment rendered or to be rendered to the Provider without concealment or misunderstanding of other terms and provisions of the contract. (Rule 1300.67.8(a))

19. Provider shall provide grievance forms and assist Members in filing grievances. Provider shall participate in the Health Plans grievance system and cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews. (Rule 1300.68)

20. In the event a Member seeks and obtains a recovery from a third party or a third party's insurer for injuries caused to that Member, and only to the extent permitted by the Member's evidence of coverage and by California law, Provider may have the right to assert a third party lien for and to recover from the Member the reasonable value of Covered Services provided to the Member by Provider for the injuries caused by the third party. Health Plan shall similarly have the right to assert a lien for and recover for payments made by Health Plan for such injuries. Provider shall cooperate with Health Plan in identifying such third party liability claims and in providing such information. Pursuit and recovery of under third party liens shall be conducted in accordance with California Civil Code section 3040.

21. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement upon forty-five (45) business days' notice to Provider unless a shorter timeframe is necessary for

compliance. Health Plan may otherwise materially amend the Provider Manual only after forty-five (45) business days prior written notice to Provider and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party.

22. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider is not the primary payer under coordination of benefits, Provider may submit Claims to Health Plan or Health Plan's capitated provider within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer. Except as otherwise provided by law or provided by government sponsored program requirements, any Claims that are not submitted by Provider to Health Plan within ninety (90) days from the date of payment or date of contest, denial or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

23. Notwithstanding any other provision in this Agreement, if Health Plan or Health Plan's capitated provider denies a claim because it was filed beyond the claim filing deadline, Health Plan will, upon Provider's submission of a provider dispute pursuant to Title 28, California Code of Regulations, section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to California Health & Safety Code section 1371 or 1371.35, whichever is applicable, and the California Code of Regulations.

24. Provider shall inform Health Plan within five business days when either of the following occur (Health and Safety Code Section 1367.27):
    a) Provider is not accepting new patients; or
    b) If Provider was previously not accepting new patients, but Provider is currently accepting new patients.

25. Provider shall provide to Health Plan any information necessary in order for the Health Plan to comply with Health and Safety Code Section 1367.27. In the event Provider does not comply with this provision and demonstrates a pattern of repeated failure, Health Plan may terminate the Agreement.

ATTACHMENT F
DHCS PROVISIONS

The following provisions apply exclusively to Covered Services provided and activities engaged in pursuant to Medicaid Program:

1. All Medicaid covered services are set forth in Attachment C and the Provider Manual as set forth in this Agreement. (Rule 53250(c)(1))

2. This Agreement shall be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Health Plan. (Rule 53250(c)(2))

3. This Agreement shall become effective upon approval by the Department of Health Care Services ("DHCS") in writing, or by operation of law where the DHCS has acknowledged receipt of this Agreement and has failed to approve or disapprove the Agreement within 60 days of receipt. (Rule 53250(c)(3))

4. Amendments to this Agreement shall be submitted to the DHCS, for prior approval, at least thirty (30) days before the effective date of any proposed changes governing compensation, services or term. Proposed changes which are neither approved nor disapproved by the DHCS, shall become effective by operation of law thirty (30) days after the DHCS has acknowledged receipt, or upon the date specified in the Amendment, whichever is later. (Rule 53250(c)(3))

5. Provider agrees to submit all reports required and requested by Health Plan, in a form acceptable to Health Plan. (Rule 53250(c)(5))

6. Provider shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of this Agreement, available for the purpose of an inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor:

    a. By the DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, DMHC, Department of Justice (DOJ), or their designees;

    b. At all reasonable times, at Provider's place of business or at such other mutually agreeable location in California;

    c. In a form maintained in accordance with the general standards applicable to such book or record keeping;

    d. For a term of at least ten years from the final date of the Agreement period or from the date of completion of any audit, whichever is later;

e. Including all encounter data for a period of at least ten years. (Rule 53250(e)(1))

f. If DHCS, CMS or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

g. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Subcontract due to Fraud.

7. Provider agrees to notify the DHCS in the event that this Agreement is amended or terminated. Notice to the DHCS shall be considered given when properly addressed and deposited in the United States Postal Service as First Class Registered Mail, postage attached. (Rule 53250(e)(4))

8. Provider shall maintain and make available to the DHCS, upon request, copies of all sub-subcontracts and shall ensure that all sub-subcontracts are in writing and require that the Provider:

   a. Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Agreement, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees.

   b. Retain all records and documents for a minimum of 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. (Rule 53250(e)(3))

9. Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS in those instances where prior approval by the DHCS is required. (Rule 53250(e)(5))

10. Provider agrees to hold harmless both the State of California and Health Plan members in the event that Health Plan cannot or will not pay for services performed by Provider pursuant to this Agreement. (Rule 53250(e)(6))

11. Provider shall assist Health Plan in the transfer of care in the event Health Plan's Two-Plan Model and Geographic Managed Care (GMC) Model Contracts with the DHCS expires or terminates. Providers shall assist Health Plan in the transfer and care in the event of sub-subcontract termination for any reason.

12. Provider shall not attempt recovery in circumstances involving casualty insurance, tort liability or workers' compensation. Provider shall report to the DHCS within ten (10) days after discovery any circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation award. (Rule 53222(b))

13. Provider shall disclose the names of the officers and owners of Provider, stockholders owning more than ten percent (10%) of the stock issued by Provider, if any, and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form made available by Health Plan. (W&I Code section 14452(a))

14. Provider acknowledges that Health Plan bears significant risk by assuming financial responsibility for all in-patient hospitalization expenditures, including expenditures for services connected with the period of hospitalization. (Rule 53251(c) & (e))

15. Non-Discrimination Clause.
    a. During the performance of this Agreement, Provider and Provider's subcontractors will not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including cancer), age (over 40), marital status, and denial of family care leave. Provider and Provider's subcontractors will ensure the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. Provider and Provider's subcontractors will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et. seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 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 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider and Provider's subcontractors as the case may require will give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

    b. Provider shall permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

16. Provider agrees to arrange for the provision of interpreter services for Members at all provider sites.

17. Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State of California under one or more of its contracts with the Department of Health Care Services.

18. Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, California Code of Regulations, Division 1, Chapter 9, commencing with Section 37000. Provider shall document and appropriately follow up on blood lead screening test results.

    Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's Medical Record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent(s) or guardian shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Members Medical Record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

19. Provider shall provide Health Plan with the Disclosure Statement set forth in Title 22, California Code of Regulations Section 51000.35 prior to commencing services under this Agreement.

20. Upon request by DHCS, Provider shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to lawful privileges, in Provider's possession, related to threatened or pending litigation by or against DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify DHCS and Health Plan of any subpoenas, document production requests, or requests for records, received by Provider related to Health Plan's contract with DHCS. Provider shall be reimbursed by DHCS for the services necessary to comply with this requirement under the reimbursement terms specified in Health Plan's contract with DHCS.

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ATTACHMENT G

Acknowledgement of Receipt of Provider Manual & Health Homes Program Guide

Provider hereby acknowledges receipt of Health Plan's Provider Manual and Health Homes Program Guide.

Medi-Cal:
http://www.molinahealthcare.com/providers/ca/medicaid/Pages/home.aspx

http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

Date of receipt: _____

Initials of authorized
Representative of Provider: _____

ATTACHMENT H

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))

Name of Subcontractor
COUNTY OF RIVERSIDE, OFFICE ON AGING

The undersigned hereby certifies that the following information regarding **COUNTY OF RIVERSIDE, OFFICE ON AGING** (the "Organization") is true and correct as of the date set forth below.

1. Officers/Directors General Partners:

2. Co-Owner(s):

3. Stockholders owning more than five percent (5%) of the stock of the Organization:

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

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

6. If not already disclosed above, is Organization, either directly or indirectly, related to or affiliated with the Contracting Health Plan? Explain:

Date: _____ By: _____

Print Name: **Jewel Lee**

Title: **Director**

ATTACHMENT I

CERTIFICATE OF OWNERSHIP

I, _____, an authorized representative of **COUNTY OF RIVERSIDE, OFFICE ON AGING,** do certify that, to the best of my knowledge, the individuals or entities listed below have a five percent or more ownership, direct or indirect, or control interest in the aforementioned entity as defined under 42 U.S. C. Section 1320 a 3 (2).

Name of Individual/Entity	Employer Identification Number	Social Security Number

☐ No one is listed because there are no individuals or entities with a five percent (5%) or more interest.

X No one is listed because the Provider is under government ownership.

☐ No one is listed because the Provider of services is a non-profit, public benefit corporation for which there are no outside controlling interests.

_____ _____

Signature of Authorized Representative and Title Date

ATTACHMENT J

Provider Scope of Financial Responsibility

The following attachment outlines the division of financial responsibility between Health Plan and Provider ("Provider Scope of Financial Responsibility"), the intent being to clarify Covered Services categories in order to provide for accurate administration of this Agreement. For services not specifically listed, each sub-attachment serves as a model under which broad service categories suggest the appropriate financial responsibility. The applicable provisions and attachments of this Agreement, including Health Plan's Provider Manual, should be consulted for an accurate and complete description of Covered Services. Member benefit information and eligibility shall be verified by Provider prior to the provision of any services. The following sub-attachments are included in this Agreement, referenced hereto and incorporated herein:

Attachment K-1 (Medi-Cal Programs)

ATTACHMENT K-1

MEDI-CAL PROGRAM

PROVIDER SCOPE OF SERVICE

ATTACHMENT K-1

MEDI-CAL PROGRAM HEALTH HOME PROGRAM SCOPE OF WORK

Provider shall provide Health Home Program (HHP) Services to eligible Health Plan Beneficiaries identified for participation in the HHP. In the event there is a conflict between the terms of this Attachment and other provisions in the Agreement, this Attachment will control for HHP Services. For purposes of this Attachment, Provider will be referred to as a Community Based Care Management Entity (CB-CME).

I. DEFINTIONS

1.1 **Beneficiary** means a person who is eligible to receive HHP Services.

1.2 **Community Based-Care Management Entity (CB-CME)** means an organization within the qualified Health Homes Program network that is responsible for delivering Health Homes Program Services to the HHP Member.

1.3 **Health Action Plan (HAP)** means a documented care plan that incorporates the HHP Member's needs in the areas of physical health, mental health, substance abuse disorder community-based LTSS, palliative care, trauma-informed care needs, social supports, and as appropriate for individuals experiencing homelessness, housing.

1.4 **Health Homes Program (HHP)** means the program in which community based care management entities or CB-CMEs, qualified by the state, provide Health Homes Program Services to eligible Beneficiaries.

1.5 **Health Homes Program Members (HHP Member)** means a person who is eligible for HHP Services and who has agreed to take part in HHP Services as demonstrated by completion of the HAP and consent to participate in the HHP.

1.6 **Health Homes Program Services (HHP Services)** means services that coordinate care across several domains, as defined under Section 2703 of the Affordable Care Act of 2010. The purpose is to coordinate the full breadth of clinical and social service expertise for high cost/ high risk Beneficiaries with complex Chronic Conditions, mental health, and substance use disorder issues and/or long-term service needs and supports.

1.7 **Health Plan HHP Policy** refers to Health Plan policies that reference HHP roles, division of labor & delegation, provides Health Home oversight as far as staffing, case management processes, discharge planning, and housing.

1.8 **Individual Housing Transition Services** means services that assist HHP Members with obtaining housing, such as individual outreach and assessments, and includes services as defined in the DHCS Health Homes Program Guide.

1.9 **Individual Housing and Tenancy Sustaining Services** means housing and tenancy sustaining services as described in the DHCS Health Homes Program Guide, such as tenant and landlord education and tenant coaching, that support HHP Members in maintaining tenancy once housing is secured.

II. GENERAL PROGRAM REQUIREMENTS

2.1 The CB-CME will serve as the frontline provider of HHP Services, subject to the Health Plan's review, certification and oversight process. In order for the Provider to be a CB-CME, Provider must meet the qualifications outlined below. In the event Health Plan determines the Provider ceases to meet the qualifications below or Provider notifies Health Plan that it ceases to meet the qualifications below, Provider will no longer be considered a CB-CME and will not receive compensation for performing HHP Services.

1. Experience serving Medi-Cal members and ensuring compliance with W&I Code HHP requirements, as appropriate for their assigned HHP Member population, including but not limited to high-risk members such as individuals who are experiencing homelessness.

2. Strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls.

3. Capacity to provide appropriate and timely in-person care coordination activities, as needed. If in-person communication is not possible in certain situations, alternative communication methods such as tele-health or telephonic contacts may also be utilized, if culturally appropriate and accessible for the HHP Member, to enhance access to services for HHP Members and families where geographic or other barriers exist and according to HHP Member choice.

4. Capacity to accompany HHP Members to critical appointments, when necessary, to assist in achieving HAP goals.

5. Agrees to accept any enrolled HHP Members assigned by the Health Plan, per this Agreement.

6. Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and/or processes, to collaborate on care coordination.

7. Use tracking processes to link HHP Services and share relevant information between the CB-CME and Health Plan and other providers involved in the HHP Member's care.

2.2 CB-CME is responsible for compliance with all HHP requirements in the DHCS HHP Guide, DHCS contract for Health Homes and Health Plan's policies and procedures. CB-CME agrees to comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program.

CB-CME policies and procedures must be compliant with regulatory requirements and Health Plan HHP Policies and will be reviewed at scheduled Health Plan audits. In the event that there are any changes to these documents after the Effective Date of this Agreement, the CB-CME will adopt and adhere to any changes in these documents. The CB-CME will receive prompt notification from Health Plan of any change in the DHCS Health Homes Program Guide or DHCS Health Homes contract that impact the Health Homes Program Services.

2.3 Health Plan and CB-CME acknowledge and agree that Beneficiaries have the right to request a new CB-CME or to prospectively discontinue receiving Health Home Services at any time.

2.4 Health Plan and CB-CME will coordinate HHP Services for HHP Members to ensure referrals for Covered Services are directed to Health Plan's participating network providers whenever possible. Whenever possible, HHP Member relationships with current community based organizations and providers will be maintained.

2.5 Health Plan has the right to determine if a HHP Member meets an exclusion criteria for HHP and notify the CB-CME of HHP Member disenrollment.

III. CB-CME HEALTH HOME PROGRAM REQUIREMENTS

3.1 The CB-CME is responsible for providing HHP Services. These services are defined by the DHCS Health Homes Program Guide as a set of six (6) specific care coordination services: 1) Comprehensive Care Management, 2) Care Coordination, 3) Health Promotion, 4) Comprehensive Transitional Care, 5) Individual and Family Support, and 6) Referral to Community and Social Support Services. The CB-CME is required to coordinate and integrate care across the continuum of services for the provision of HHP services as follows:

1. **Comprehensive Care Management:** activities related to engaging Beneficiaries to participate in the HHP and collaborating with Beneficiaries and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP). Comprehensive care management may include case conferences to ensure that the HHP Member's care is continuous and integrated among all service providers. Comprehensive care management services include, but are not limited to:
   i. Engaging the HHP Member in HHP and in their own care.

   ii. Assessing the HHP Member's readiness for self-management using screenings and assessments with standardized tools.

   iii. Promoting the HHP Member's self-management skills to increase their ability to engage with health and service providers.

   iv. Supporting the achievement of the HHP Member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines.

   v. Completing a comprehensive health risk assessment to identify the HHP Member's physical, mental health, substance use, palliative, and social service needs.

vi. Developing a HHP Member's HAP and revising it as appropriate

vii. Reassessing a HHP Member's health status, needs and goals.

viii. Coordinating and collaborating with all involved parties to promote continuity and consistency of care.

ix. Clarifying roles and responsibilities of the multi-disciplinary team, providers, and HHP Member and family/support persons.

2. **Care Coordination:** services to implement the HHP Member's HAP. Care coordination services begin once the HAP is completed. HHP care coordination services will integrate with Health Plan's current care coordination activities, but will require a higher level of service than current Health Plan requirements. Care coordination may include case conferences in order to ensure that the HHP Member's care is continuous and integrated among all service providers. All program staff who provide HHP services are required to complete state and health plan mandated CB-CME/care coordinator training. Care coordination services address the implementation of the HAP and ongoing care coordination and include, but are not limited to:

   i. HHP Member Support:

      1. Working with the HHP Members to implement their HAP.

      2. Assisting the HHP Member in navigating health, behavioral health, and social services systems, including housing.

      3. Sharing options with the HHP Member for accessing care and providing information to the HHP Member regarding care planning.

      4. Identifying barriers to the HHP Member's treatment and medication management adherence.

      5. Monitoring and supporting treatment adherence (including medication management and reconciliation).

      6. Assisting in attainment of the HHP Member's goals as described in the HAP.

      7. Encouraging the HHP Member's decision making and continued participation in HHP.

      8. Accompanying HHP Members to appointments as needed.

   ii. Coordination:

      1. Monitoring referrals, coordination, and follow ups to ensure needed services and supports are offered and accessed.

2. Sharing information with all involved parties to monitor the HHP Member's conditions, health status, care planning, medications usages and side effects.

3. Creating and promoting linkages to other services and supports.

4. Helping facilitate communication and understanding between HHP Members and healthcare providers.

iii. CB-CMEs must develop and ensure the implementation of policies and procedures to support coordination efforts to:

1. Maintain frequent, in-person contact between the HHP Member and the care coordinator when delivering intensive care coordination services.

2. The CB-CME must maintain adequate staffing ratios that account for varying degrees of HHP Member touch based on risk level and tiering, following recommended staffing models as recommended or required by DHCS and the Health Plan.

3. Ensure availability of support staff to complement the work of the care coordinator.

4. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions.

5. Link HHP Members who are homeless or experiencing housing instability to permanent housing, such as supportive housing.

6. Identify and take action to address HHP Member gaps in care through:

a. Assessment of existing data sources for evidence of care appropriate to the HHP Member's age and underlying chronic conditions

b. Evaluation of HHP Member perception of gaps in care.

c. Documentation of gaps in care in the HHP Member case file.

d. Documentation of interventions in HAP and progress notes.

e. Findings from the HHP Member's response to interventions.

f. Documentation of discussions of HHP Members care goals.

g. Documentation of follow-up actions, and the person or organization responsible for follow-up.

3. **Health Promotion:** services to encourage and support HHP Members to make lifestyle choices based on healthy behavior, with the goal of motivating HHP Members to successfully monitor and manage their health. HHP Members will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions. Health promotion services include, but are not limited to:

    i. Encouraging and supporting health education for the HHP Member and family/support persons.

    ii. Assessing the HHP Member's and family/support persons' understanding of the HHP Member's health condition and motivation to engage in self-management.

    iii. Coaching HHP Members and family/support persons about chronic conditions and ways to manage health conditions based on the HHP Member's preferences.

    iv. Linking the HHP Member to resources for: smoking cessation; management of HHP Member chronic conditions; self-help recovery resources; and other services based on HHP Member needs and preferences.

    v. Using evidence-based practices, such as motivational interviewing, to engage and help the HHP Member participate in and manage their care.

4. **Comprehensive Transitional Care:** services to facilitate HHP Members' transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable HHP Member admissions and readmissions. Agreements and processes to ensure prompt notification to the HHP Member's care coordinator and tracking of HHP Member's admission or discharge to/from an ED, hospital inpatient facility, residential/treatment facility, incarceration facility, or other treatment center are required. Additionally, CB-CMEs must provide information to hospital discharge planners about HHP. Comprehensive transitional care services include, but are not limited to:

    i. Providing medication information and reconciliation.

    ii. Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners.

    iii. Collaborating, communicating, and coordinating with all involved parties.

    iv. Easing the HHP Member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management.

    v. Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.

vi. Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures.

vii. Developing and facilitating the HHP Member's transition plan.

viii. Preventing and tracking avoidable admissions and readmissions.

ix. Evaluating the need to revise the HHP Member's HAP.

x. Providing transition support to permanent housing.

5. **Individual and Family Support:** activities that ensure that the HHP Member and family/support persons are knowledgeable about the HHP Member's conditions with the overall goal of improving their adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the HHP Member and family/support persons to manage the HHP Member's condition and assisting them to access these support services. Individual and family support services may include, but are not limited to:

i. Assessing the strengths and needs of the HHP Member and family/support persons.

ii. Linking the HHP Member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management.

iii. Connecting the HHP Member to self-care programs to help increase their understanding of their conditions and care plan.

iv. Promoting engagement of the HHP Member and family/support persons in self-management and decision making.

v. Determining when HHP Member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices.

vi. Advocating for the HHP Member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals.

vii. Accompanying the HHP Member to clinical appointments, when necessary.

viii. Identifying barriers to improving the HHP Member's adherence to treatment and medication management.

ix. Evaluating family/support persons' needs for services.

6. **Referral to Community and Social Support Services**: determining appropriate services to meet the needs of HHP Members, identifying and referring HHP Members to available community resources, and following up with the HHP Members. Community and social support referral services may include, but are not limited to:

    i. Identifying the HHP Member's community and social support needs.

    ii. Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the HHP Member.

    iii. Providing HHP Member with information on relevant resources, based on the HHP Member's needs and interests.

    iv. Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports.

    v. Following up with the HHP Member to ensure needed services are obtained.

    vi. Coordinating services and follow-up post engagement.

    vii. Checking in with HHP Members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require.

    viii. Providing Individual Housing Transition Services, including services that support each HHP Member's ability to prepare for and transition to housing.

    ix. Providing Individual Housing and Tenancy Sustaining Services, including services that support the HHP Member in being a successful tenant in their housing arrangement and thus able to sustain tenancy.

3.2 Health Action Plan. The CB-CME will adhere to the requirements for the HAP in accordance with the DHCS Health Homes Program guide and Health Plan's policies and procedures:

1. The CB-CME will develop a HAP using a standardized format as specified by Health Plan, within 90 days of Beneficiary enrollment into HHP.

2. The HAP must be created and maintained for each HHP Member assigned to the CB-CME.

3. The HAP must incorporate the HHP Member's needs in the areas of physical health, mental health, SUD, community-based LTSS, palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencing homelessness, housing.

4. The HAP is based on the needs and desires of the HHP Member and will be reassessed based on the HHP Member's progress or changes in their needs.

5. The HAP must track referrals.

6. Updates to the HAP must be recorded in the Health Plan's care management platform and/or exchanged in alternate format as otherwise specified and agreed upon by the plan and CB-CME.

7. CB-CME will ensure the HHP Member's HAP is under the direction of a dedicated Health Homes care coordinator who is accountable for facilitating access to medical, behavioral health care, long-term services and support and community social supports and coordinating with entities that authorize these services as necessary to support the achievement of individualized health action goals.

IV. PROGRAM EXCLUSIONS AND DISENROLLMENT

CB-CMEs must assess and identify HHP Members that should be excluded from the HHP. The CB-CME must report these findings to the Health Plan in a timely, mutually agreed upon frequency.

4.1 Non-duplication of services: CB-CMEs must ensure non-duplication by identifying HHP Members who are already receiving services from another program for exclusion from HHP. Exclusions for non-duplication include but are not limited to:

1. Participation in any of the following 1915(c) Waiver Programs: 1915(c) Home and Community Based (HCBS) waiver program, HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), Pediatric Palliative Care (PPC);

2. Members managed by County Targeted Case Management (TCM) (excluding Specialty Mental Health TCM);

3. Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month,

4. Hospice residents

5. Cal MediConnect members.

4.2 Disenrollment from HHP: CB-CMEs may identify HHP Members for exclusion based on HHP Member assessment and through ongoing care coordination activities and follow up for the following reasons:

1. HHP Members determined through further assessment to be sufficiently well managed through self-management or through another program, or the HHP Member is otherwise determined to not fit the high-risk eligibility criteria.

2. HHP Members whose condition management cannot be improved because the HHP Member is uncooperative.

3. HHP Members whose behavior or environment is unsafe for CB-CME staff.

4. HHP Members determined to be more appropriate for an alternate care management program.

5. CB-CMEs must notify the Health Plan upon knowledge of HHP Member's disenrollment or Death.

6. HHP Member decides to opt out of the program and is disenrolled.

V. REPORTING

5.1 CB-CME shall submit reports to the Health Plan in an agreed upon manner, following a standardized template and format provided by the Health Plan, on a mutually agreed upon frequency and/or ad-hoc request. The CB-CME understands that metrics and measures are subject to change at the Health Plan's discretion, depending on state requirements. At a minimum, the CB-CME will report the following metrics on a quarterly basis:

1. HHP Members eligible for housing services.

2. HHP Members who received housing service after referral.

3. HHP Members who are homeless, but who are receiving supportive housing.

4. HHP Members eligible for supportive housing.

5.2 CB-CME shall help to obtain and coordinate quality of care for HHP Members on an annual basis. Specific quality reporting requirements include, but are not limited to, the following and subject to change:

1. Screening for Clinical Depression and Follow-Up Plan (CDF)

2. Control of blood pressure

VI. CB-CME HEALTH HOMES PROGRAM RESPONSIBILITIES

6.1 CB-CMEs are be expected to perform the following duties/responsibilities to support HHP requirements:

1. Be responsible for care team staffing, according to HHP required staffing ratios determined by DHCS, and oversight of direct delivery of the core HHP services;

2. Implement systematic processes and protocols to ensure HHP Member access to the multi-disciplinary care team and overall care coordination

3. Ensure person-centered health action planning that coordinates and integrates all of the HHP Member's clinical and non-clinical physical and behavioral health care related needs and services, and social services needs and services;

4. Coordinate with authorizing and prescribing entities as necessary to reinforce and support the HHP Member's health action goals, conducting case conferences as needed in order to ensure that the HHP Member care is integrated among providers;

5. Provide evidence-based care;

6. Monitor referrals, coordination, and follow-up to needed services and supports; actively maintain a directory of community partners and a process ensuring appropriate referrals and follow-up;

7. Support HHP Members and families during discharge from hospital and institutional settings, including providing evidence-based transition planning;

8. Accompany the HHP Member to critical appointments (when necessary and in accordance with Health Plan's HHP policy);

9. Provide service in the community in which the HHP Member lives so services can be provided in-person, as needed;

10. Coordinate with Health Plan's nurse advice line, which provides 24-hour, seven day a week availability of information and emergency consultation services to HHP Members; and

11. Provide quality-driven, cost-effective HHP Services in a culturally competent and trauma-informed manner that addresses health disparities and improves health literacy.

6.2 The CB-CME will not proactively encourage Beneficiaries to change health plans or primary care providers. This does not limit the ability of the CB-CME and the CB-CME sub-contractors from providing information about how to change health plans or to assist them with changing primary care providers if the Beneficiary expresses her or his own desire to make such a change, as long as it is performed in ordnance with any state or federal laws.

6.3 Documentation and Record Keeping. CB-CME will complete and maintain adequate and proper medical and coding documentation with respect to all HHP Members in the HHP. Such documentation will be in accordance with all legal, accreditation, regulatory and third party payer requirements. The CB-CME will provide access to medical records and documentation within the timeframe requested by Health Plan. The CB-CME staff enters all HHP Members information into Health Plan's care management platform. This includes all information pertinent to Health Homes and care coordination services provided to HHP Members. The CB-CME will utilize the care management platform to document and update the HAP and other assessment tools, record all HHP Member and provider interactions, monitor progress of care

and outcomes, initiate recommended changes in care as necessary, and address achievement of health action goals, including the HHP Member's preferences and identified needs.

6.4 Outreach and Engagement: Opt-In Activities. Health Plan will be responsible for enrolling Beneficiaries, using state-determined, Centers for Medicare & Medicaid Services (CMS)-approved criteria unless those duties are passed to the CB-CME with mutual agreement. Opt-In activities conducted by the CB-CME will follow Health Plan's policies and procedures on outreach methodology for HHP. Upon HHP Member consent to be enrolled into the program, Health Plan is responsible to assign HHP Members to the CB-CME based on available data and provide the assignment HHP membership list. All HHP Members may opt out of the program at any time and for any reason.

6.5 Referral List and Program Engagement. The referral list will contain HHP Members who have opted-in to HHP assigned to the CB-CME. The CB-CMEs will begin attempts to engage the Beneficiary by phone, by mail, or in person within five (5) business days of receipt of referral list in order to conduct HHP Member assessments and create the HAP.

1. If CB-CME is unable to contact a referred Beneficiary within thirty (30) days following assignment, or if the Beneficiary declines to participate in HHP, the CB-CME will notify the Health Plan in accordance with the disenrollment protocols established in Health Plan's HHP policies and procedures.

6.6 The CB-CME will collaborate, coordinate and communicate with Health Plan's case managers/care coordination staff as needed to facilitate ongoing coordination of health care needs for HHP Member.

6.7 Reassess the HHP's progress towards meeting patient-centered health action goals in the HAP every six (6) months, or sooner depending on changes in the HHP's health status or a change in the HHP's needs or preferences.

ATTACHMENT L

Business Associate Addendum

With respect to the creation, receipt, maintenance, or transmission of Protected Health Information in the performance of certain delegated functions on behalf of Health Plan ("Molina Healthcare") in accordance with the term and conditions set forth in this Agreement, Provider agrees that it is Health Plan's business associate ("Business Associate") with all the rights and obligations set forth in this Attachment.

RECITALS

WHEREAS, the Parties have engaged or intend to engage in one or more agreements (each, an "Agreement" and collectively, the "Agreements") which may require the use or disclosure of PHI in performance of services described in such Agreement or Agreements (the "Services") on behalf of the Company;

WHEREAS, the Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") and any regulations promulgated thereunder (collectively the "HIPAA Rules"); and

WHEREAS, this BAA, in conjunction with the HIPAA Rules, sets forth the terms and conditions pursuant to which protected health information (in any format) that is created, received, maintained, or transmitted by, the Business Associate from or on behalf of the Covered Entity, will be handled between the Business Associate and the Covered Entity and with third parties during the term of the Agreement(s) and after its termination.

NOW THEREFORE, the Parties agree as follows:

1. DEFINITIONS

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the first party listed in the first paragraph of this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as

applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CRF 160.103, and in reference to the party to this BAA, shall mean the second party listed in the first paragraph of this BAA.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by the Business Associate to the under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. GENERAL PROVISIONS

2.1 Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by the Company to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2 Amendment. The Company may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon forty-five (45) business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. The Company may otherwise materially amend this BAA only after forty-five (45)

business days prior written notice to the Business Associate and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the Business Associate's receipt of the Company's written notice to amend this BAA, the Company shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of the Company.

3. SCOPE OF USE AND DISCLOSURE

3.1 The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s), if such use or disclosure of PHI would not violate the Privacy Rule.

3.2 The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by the Company, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and

b. to provide Data Aggregation services relating to the Health Care Operations of the Company if required under the Agreement.

3.3 The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or

b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4 The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, the Company, is as between the parties, the sole property of the Company.

3.5 The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of the Company in each instance.

4. OBLIGATIONS OF THE BUSINESS ASSOCIATE

The Business Associate shall:

4.1 Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2 Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Company. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4 Promptly report to the Company any unauthorized use or disclosure of PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such Breach or Security Incident. The Business Associate shall indemnify the Company against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI or Breach of Unsecured PHI including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5 The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify the Company of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than thirty (30) days after the discovery of the Breach. The notification by the Business Associate to the Company shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that the Company is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;

b. a description of the types of Unsecured PHI that were involved in the Breach; and

c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf

of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7 Within ten (10) days of receiving a request, make available PHI in a Designated Record Set to the Company as necessary to satisfy the Company's obligations under 45 CFR 164.524.

4.8 Within fifteen (15) days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by the Company pursuant to 45 CFR 164.526.

4.9 Maintain and make available to the Company, within twenty (20) days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy the Company's obligations under 45 CFR 164.528.

4.10 Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of the Company available to the Company or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11 To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of the Company, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12 To the extent the Business Associate is to carry out one or more of the Company's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Company in the performance of such obligation(s).

5. MISCELLANEOUS

5.1 Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4 Governing Law and Venue. This BAA shall be governed by California law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by Molina.

5.5 Notices. Any notices to be given hereunder to a Party shall be made via certified U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below:

If to Business Associate, to:	**If to the Company, to:**
County of Riverside, Office of Aging	Molina Healthcare, Inc.
P.O. Box 2099	200 Oceangate, Suite 100
Riverside, CA 92516	Long Beach, CA 90802
Attn: Privacy Official	Attn: Privacy Official
Fax:	Fax: 562-499-0789

6. TERM AND TERMINATION OF BAA

6.1 Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date the Company terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2 Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), the Company may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if the Company determines, in its sole discretion, that Business Associate has violated a material term of this BAA .

6.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to the Company or, if agreed to by the Company, destroy all PHI received from the Company, or created, maintained, or received by Business Associate on behalf of the Company, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide the Company with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required By Law. If return or destruction of all PHI, and all copies of PHI, received from the Company, or created, maintained, or received by Business Associate on behalf of the Company, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI.

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

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ATTACHMENT M
MOLINA HEALTHCARE OF CALIFORNIA, INC.
DELEGATION SERVICES ADDENDUM

Provider desires to perform certain delegated functions for Health Plan and Health Plan desires that Provider perform such functions in accordance with the terms and conditions set forth in this Delegation Services Addendum ("Addendum") to the Provider Services Agreement for the Health Homes Program ("Agreement"). This Addendum supersedes all previous Delegation Agreements, Attachments, Exhibits and/or Addendums. In the event requirements and expectations identified in the Statement of Work (SOW) differ from the Addendum, Provider will be held to the requirements and expectations identified in the Addendum Provider shall begin performing the specific function delegated as of the date indicated by the Health Plan in its notice to Provider of its approval of delegation (the "Start Date"). The parties agree that the Start Date may be different for each specific delegated function.

ARTICLE ONE - DEFINITIONS

1.1 Unless otherwise defined in this Addendum, capitalized terms used in this Addendum shall have the same meanings ascribed to them in the Agreement.

1.2 Capitalized terms specific to this Addendum shall have the meaning set forth below:

A. **Claims Administration Services** means the process of receiving and processing claims for covered services from Participating Providers and Noncontracted/nonpar Providers.

B. **Corrective Action Plan (CAP)** means a document that identifies area(s) of deficiency. Deficiencies are most often identified through, but are not limited to, pre assessment or annual assessment activities, report monitoring activities, and/or member or Participation Provider complaint monitoring activities.

C. **Centers for Medicare and Medicaid Services (CMS)** means the administrative agency of the United States Government, responsible for administering the Medicare program.

D. **Credentialing** means the process of verifying through primary sources, information on a physician or other health care provider, to determine if they meet participation criteria.

E. **Delegation** means the formal process by which Health Plan gives Provider the authority to perform certain functions as outlined in Article Four (Delegated Activities) of this Addendum on behalf of Health Plan. While Health Plan delegates these certain functions, it maintains the responsibility for ensuring that the function meets or exceeds all applicable state and federal requirements as well as the established policies and procedures as set forth by the Health Plan for that certain function.

F. **National Committee for Quality Assurance (NCQA)** means a not for profit organization that performs quality oriented accreditation reviews of managed care health plans.

G. **Noncontracted/nonpar Provider** means a practitioner who does not have a current contract with Molina Healthcare or Provider.

H. **Organizational Providers** means all facilities that provide Covered Services to Members on behalf of Provider pursuant to contractual agreements by and between Provider and such facility. This includes, but is not limited to, hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies.

I. **Oversight** means the monitoring of delegated activities by the Health Plan to ensure the maintenance of agreed upon standards of performance, reporting, and compliance with improvement activities. Oversight may result in commendation or CAP up to and including revocation of the delegated function.

J. **Participating Provider** means all persons or entities, including Organizational Providers and Practitioner Providers, providing Covered Services for or on behalf of Provider pursuant to contractual agreements by and between Provider and such persons or entities.

K. **Practitioner Provider** means all persons that provide Covered Services to Members on behalf of Provider pursuant to contractual agreements by and between Provider and such persons. This includes, but is not limited to, physicians, and, when applicable, physician assistants and nurse practitioners.

L. **Primary Care Provider (PCP)** means a nurse practitioner, physician (MD/DO), or in some circumstances a physician assistant, who practices within the specialties of Adult Medicine, Family Medicine, Geriatric Medicine, Internal Medicine, Pediatrics, or Women's Healthcare. Members are assigned a PCP from which they received routine or preventive care.

M. **Protected Health Information (PHI)** means information defined as such in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

N. **Quality Data (QD)** means data gathered on Participating Providers as a part of the recredentialing process that compares individual performance against that of a group. This can include, but is not limited to, authorization data, immunization data, prescribing data, admission data, or other data gathered as part of a larger quality improvement initiative.

O. **Utilization Management (UM)** means the process for determining benefit coverage and medical necessity for procedures requested by a Practitioner.

ARTICLE TWO – GENERAL TERMS AND CONDITIONS

2.1 **Delegation.** Subject to satisfactory completion of the pre-delegation assessment requirements set forth in Section 2.3 (Pre-Delegation Assessments) of this Addendum, below, Health Plan agrees to delegate to Provider performance of the functions identified in Article Four (Delegated Activities) of this Addendum as of the Start Date. Provider agrees to accept such delegation under the terms and conditions of this Agreement. Notwithstanding such delegation, Health Plan shall remain accountable for the performance of all such functions. Delegated functions shall be determined by Health Plan's network needs and Provider's ability to perform those functions. The specific activities assigned to Provider in connection with each delegated function, and any requirements specific to such function, are set forth, as outlined in Article Four (Delegated Activities) of this Addendum.

2.2 **Policies and Procedures**

A. Provider's policies and procedures shall comply with all NCQA, CMS, state Medicaid and Health Plan policies as applicable, as well as any state regulations.

B. Provider shall make best efforts to notify Health Plan of any significant revisions to policies or procedures previously approved by Health Plan at least sixty (60) days prior to implementation of the revision or amendment unless earlier implementation is required to effect compliance with any applicable statute or regulation or to protect the rights, health or safety of Health Plan Member. For examples of significant revisions to policies or procedures see Article 4, Delegated Reporting Requirements.

C. Provider policies and procedures must be in compliance with regulatory requirements and Health Plan HHP Policies and will be reviewed at scheduled c audits.

2.3 **Pre-Delegation Assessment**

A. Prior to delegating functions to Provider, Health Plan shall conduct a comprehensive pre-delegation assessment of Provider's ability and administrative capabilities to perform each delegated function, including a review of Provider's policies and procedures, committee minutes, and files as applicable. Upon mutual agreement of date and time, Provider shall provide Health Plan representatives with access to any office or location where each such function will be performed, to personnel directly responsible for performing such function, and to all other relevant and necessary information pertaining to Provider's ability and capacity to perform such function. Except as provided in paragraph (C) below, performance by Provider of any delegated function shall commence only upon completion, to Health Plan's sole satisfaction, of the pre-delegation assessment for that function.

B. The appropriate Health Plan shall, in its discretion, issue a decision whether or not to accept the proposed delegation agreement. The decision will be based off the results of the pre-delegation assessment. Health Plan will provide a written report to Provider of all pre-delegation assessment results, with a request for follow-up if appropriate, and the status of the decision to delegate each function.

C. In circumstances where a previous contract exists between Health Plan and Provider that included delegation of specific function(s), the pre-delegation requirements of Section 2.3 (Pre-Delegation Assessment) of this Addendum shall be waived with respect to only that particular function(s). Such waiver shall not affect the application of such function to all other terms and conditions of this Addendum.

D. In the event Provider has NCQA accreditation/certification at the time of delegation, on-site review and assessment requirements may be modified. However, current policies and procedures and an NCQA accreditation/certification letter must be forwarded to Health Plan, along with other requested pre-delegation materials. Documentation of NCQA accreditation/certification does not preclude the standard submission of reports and activities as required by this Addendum.

2.4 **Health Plan Ongoing Review and Assessment**

A. Health Plan shall perform annual audits of Provider's performance of each delegated function within fourteen (14) months of the previous assessment date. At a minimum, annual assessments will include review of current functional policies and procedures, and appropriate file reviews. If state laws dictate, or as described below in Section 3.1.A (Corrective Action), more frequent reviews may be necessary. Additionally, and in states where collaborative assessment efforts exist, Health Plan may complete an annual assessment with the collaborative as long as six (6) months or more has passed since the previous assessment.

When appropriate, and with agreement from Provider, Health Plan has the right to conduct any such reviews or assessments electronically. However, Health Plan maintains the right to conduct any review or assessment on site.

B. For on-site reviews and assessments, Provider shall provide Health Plan representatives with reasonable access to; (1) any office or location where such function is performed, (2) personnel directly responsible for performing such function, and (3) all other relevant and necessary information pertaining to Provider's performance under this Addendum.

C. Upon approval by the Health Plan of each review and assessment, Health Plan shall provide Provider with a copy of its written report of such assessment, along with any feedback, recommendations and requests; and if applicable, any CAP required to be taken pursuant to the terms of this Addendum.

D. In the event that Provider has or earns NCQA accreditation/certification during the tenure of delegation, on-site review and assessment requirements may be modified. However, current policies and procedures and an NCQA accreditation/certification letter must be forwarded to Health Plan on an annual basis and as otherwise requested. Documentation of NCQA accreditation does not preclude the standard submission of reports and activities as required by this Addendum.

2.5 **Sub-Delegation**

A. Provider shall not further sub-delegate the performance of any delegated activity as identified in Article Four (Delegated Activities) of this Addendum to another organization without the prior written consent of Health Plan. If sub-delegation of any activity is approved, Provider shall remain accountable to Health Plan for the performance of such activity and shall be solely responsible for insuring that its sub-delegate fulfills all obligations of Provider. Approval of any sub-delegation by Health Plan shall not be construed to relieve Provider of any obligation under this Addendum or to deprive Health Plan of the right to enforce such obligation against Provider.

B. Provider shall not further delegate the performance of any delegated activities to any sub-delegate that employs, consults with or has an independent contractual relationship with any person who has been convicted of crimes specified in Sections 1128 or 1128A of the Social Security Act, or with any individual subject to civil penalties specified in Sections 1128 or 1128A of the Social Security Act.

C. Provider shall not further delegate the performance of any delegated activities to any offshore entity. This includes, but is not limited to, companies located in Canada and Mexico.

2.6 **Delegate Reporting Requirements.** Provider shall comply with all reporting requirements and frequency identified in Article Four (Delegated Activities) of this Addendum for the functional area(s) delegated. All reports shall be submitted to the Health Plan's Delegation Oversight Manager.

2.7 **Encounter Data Files.** Encounter Data files should be submitted to Health Plan contacts on a monthly basis, including all Claims processed for the previous month. Files are due to identified Health Plan contacts no later than due dates identified on the current Statement of Work (SOW). Files must be submitted using a mutually agreeable format. File formats that are not agreed to by Health Plan will not be accepted.

Provider must maintain encounter inventory of ninety-eight percent (98%) accuracy. Accuracy rates will be calculated by dividing the number of accepted encounters by the total number of encounters submitted. While encounter data records may meet Health Plan accuracy requirements, records are not deemed accurate until they are accepted by state and/or federal regulators. In the event regulators identify required revisions, Health Plan will notify Provider of needed revisions and due date for adjustment records.

2.8 **Health Plan Reporting Requirements.** Notwithstanding any reporting requirements set forth elsewhere in this Addendum, all information required to be submitted by Health Plan to applicable state and federal agencies, unless otherwise specified by state and/or federal law or government sponsored program requirements shall be submitted directly by the Health Plan.

2.9 **Participation in Health Plan Audits.** The functions delegated to Provider in Article 4 are reviewable during Health Plan's performance audits conducted by NCQA, CMS, DMHC, and any other state Medicaid audits. Provider agrees to supply copies of requested files and/or records as necessary to facilitate Health Plan's audit process. Health Plan agrees to provide Provider with notice of a file request within one (1) business day of receiving the request from the regulator, and Provider shall deliver to Health Plan the requested file within two (2) business days of receipt, unless such regulator has indicated a shorter timeframe for delivery is required which Health Plan will include in written request. Non-compliance with submitting files requested for Health Plan audits may result in immediate termination of applicable delegated function(s). Department of Managed Health Care (DMHC) has the authority to review and audit enrollee records. The Health Plan, state and federal regulatory and/or enforcement agencies, with the appropriate authority, may audit or request for and review all records, books, reports, papers minutes of medical staff meetings, peer review, and quality of care review records, duty rosters of medical personnel, correspondence and any other records or documents of the Provider and its sub-delegates that pertains to a Health Plan enrollee.

2.10 **Medicaid Managed Care Final Rule Compliance.** In accordance with 42 CFR 438 et seq., Provider agrees:

i. upon Health Plan's written request, to report to Health Plan on Provider's performance of the delegated activities or obligations;
ii. to perform the delegated activities and obligations in compliance with Health Plan's state contract obligations;
iii. to allow Health Plan to revoke the delegation of the activities or obligations if Provider has not performed satisfactorily;
iv. to comply with all applicable Medicaid laws, regulations, regulatory guidance and contract provisions;
v. that the state, CMS, U.S. Health and Human Services ("HHS") Inspector General, U.S. Government Accountability Office Comptroller General, or their designees, have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of Provider, or of Provider's contractors, that pertain to any aspect of the services and activities performed, or determination of amounts payable under Health Plan's contract with the state;

vi. to make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to any Medicaid enrollees;

vii. to allow the right for said audit through ten (10) years from the final date of the Agreement or from the date of completion of any audit, whichever is later; and

viii. that if the state, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS, or the HHS Inspector General may inspect, evaluate, and audit Provider at any time.

2.11 **Protected Health Information (PHI) provisions**

A. Health Plan and Provider staff shall coordinate activities and share information as necessary to provide timely access to quality services for Health Plan Members. Such information shall be maintained and treated in a confidential manner, consistent with federal and state law.

B. Provider will give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with applicable law, applicable government sponsored health programs, and Health Plan's policies and procedures. This section shall survive the termination of this Agreement.

C. To the extent Provider uses, discloses, creates or maintains PHI in its performance of delegated activities on behalf of Health Plan, Provider agrees to abide by the terms of the Business Associate Agreement, separately executed and incorporated by reference, with respect to all such PHI.

ARTICLE THREE – REMEDIES FOR NON-PERFORMANCE

3.1 **Corrective Action**

A. If through report monitoring, including compliance with report content and reporting frequency, assessment activities, including timely response to a CAP, or member complaint information, Health Plan has reason to believe that Provider is not carrying out any delegated activity in accordance with the terms of this Addendum or the Attachments incorporated herein; Health Plan may, at its sole discretion, either revoke the Provider's right to perform any delegated function or activity or require CAP by:

1. Undertaking a focused audit of Provider's performance of any or all delegated activities. Health Plan shall provide Provider with fifteen (15) calendar days' prior written notice, unless a shorter timeframe is required by a regulator, of any such audit; and/or
2. Requiring Provider to respond and submit, within the time period specified by Health Plan, a CAP to address any deficiency identified by Health Plan; and/or
3. Requiring Provider to, within the time period specified by Health Plan, provide a CAP response approved by Health Plan. The time period allowed for correcting any deficiency shall be determined by Health Plan, taking into account the severity and impact of the deficiency; and/or
4. Taking such other steps as Health Plan deems reasonable and prudent to effect corrected performance on the part of Provider.

3.2 **Revocation**

A. Health Plan may, at its sole discretion send Provider a written notice of intent to revoke a delegated activity(s) for failure to correct the identified deficiency(s) as outlined in

the CAP within thirty (30) calendar days; unless Health Plan determines that continued delegation:

1. Presents an imminent or significant risk to harm to Health Plan and/or its Members;
2. Represents a pattern of noncompliance or nonperformance, whether of the same deficiency or not; in any of which cases the delegated activity(s) may be revoked immediately or on such lesser notice as Health Plan, in its sole discretion, deems appropriate.

B. If any delegated function or activity is revoked, Provider shall deliver to Health Plan the information and data specified in Article Four (Delegated Activities) of this Addendum applicable to such delegated function(s); including the information outlined in the Performance Standards within the time periods set forth by Health Plan. Provider shall otherwise cooperate in transferring such function or activity back to Health Plan, so as to eliminate or minimize any impact on Health Plan's Members.

C. If Health Plan delegates more than one function to Provider, revocation of any one function shall not, in and of itself, mean revocation of any/all other functions.

D. Provider shall not have the right to appeal Health Plan decision to revoke any and all delegated functions.

E. If a delegated function is revoked, Provider must wait twelve (12) months before re-applying for delegation of the revoked function. At that time, Health Plan's initial delegation process is initiated.

F. In the event of termination of delegated function(s) on the part of Provider or Health Plan, Provider agrees to maintain all records associated with delegated function(s) for a minimum of two years (2).

G. Health Plan or Provider may request that delegation of function(s) be revoked without cause with ninety (90) calendar days advanced notice. With the exception of Claims Administration and Utilization Management Services, termination of one function does not necessarily mean termination of all delegated functions. If Provider is delegation for multiple functions, the termination request should state specifically which function(s) are being terminated.

ARTICLE FOUR – DELEGATED ACTIVITIES

4.1 SANCTION MONITORING

A. Delegation. Health Plan hereby delegates to Provider, and Provider hereby agrees to perform, Sanction Monitoring activities as described below in Section 4.1.B (Delegated Responsibilities), for Provider's staff and employees at all levels. Health Plan Sanction Monitoring requirements are established by CMS and Health Plan business needs, and apply to Medicare line of business only. Current delegation requirements are summarized below, and are identified in the Sanction Monitoring Delegation Requirements policy, DO008. Health Plan retains the right, at its sole discretion, to change or modify its delegation policies, procedures and assessment program documents.

B. Delegated Responsibilities. Provider is specifically delegated for the following Sanction Monitoring functions:

1. Review of Provider staff and employees at all levels against Office of Inspector General (OIG) and System for Award Management (SAM) exclusion lists prior to date of hire/effective/contract;
2. Review of Provider staff and employees at all levels against OIG and SAM exclusion lists within thirty (30) calendar days of new information being released from the source;
3. Retention of Sanction Monitoring documentation for no fewer than ten (10) years;
4. Oversight of any external entity used for Sanction Monitoring processes to ensure compliance with numbers one (1) and two (2) above, as applicable. Oversight should including ensuring external entity has a Sanction Monitoring process for their staff and employees at all levels, that meets Health Plan requirements; and
5. Oversight of Sanction Monitoring activities for any sub-delegation of healthcare services to a sub-delegate that has been previously approved by Health Plan. Oversight should include ensuring the sub-delegate's compliance with the Sanction Monitoring process as described above in numbers one (1) through three (3). Provider agrees to not further sub delegate any Sanction Monitoring activities without written agreement from Health Plan.

C. Sanction Monitoring Program. Provider shall be responsible for maintaining a Sanction Monitoring process in full compliance with CMS and Health Plan requirements. Health Plan requirements include, but are not limited to:

1. Policies describing process to ensure that prospective staff and employees at all levels are screened against the OIG and SAM exclusion lists prior to hire/effective dates;
2. Policies describing process to ensure that staff and employees are monitored against all new OIG and SAM information, within thirty (30) days of updated information being released from the source;
3. Policies describing step(s) taken if OIG or SAM exclusion is discovered for staff or employee at any level;
4. Policies describing process for notifying Health Plan if any staff or employee is identified as having a OIG or SAM sanction;
5. Policies describing process for notifying Health Plan if staff or employee is removed from OIG or SAM sanction lists;
6. Policies describing retention of Sanction Monitoring documents for no fewer than ten (10) years;
7. If Provider uses an external entity to complete Sanction Monitoring screening, policies describing oversight of external entity, including how external entity ensures that their staff and employees at any level do not have OIG or SAM Sanctions; and
8. If Provider has sub-delegated functions for Medicare Part C or D services or healthcare services, policies describing how Provider monitors sub-delegate's Sanction Monitoring process including how external sub-delegate ensures that their staff and employees at any level do not have OIG or SAM Sanctions.

D. Sanction Monitoring Reporting Requirements. In addition to reporting requirements described in other sections of this Addendum, Provider shall submit the following reports:

1. Completion of the annual OIG/SAM Exclusions Attestation form, submitted to the Health Plan Medicare Compliance team, due no later than December 31st of each year; and
2. Within five (5) business days of discovery, notify the identified Health Plan contact(s) of any OIG or SAM exclusions for any staff or employee. Provider agrees to work with Health Plan to guarantee that the excluded individual is not assigned to any Health Plan activities or projects.

E. Performance Standards. Provider will be evaluated on an ongoing and annual basis against current Sanction Monitoring requirements. Ongoing evaluation of annual attestations as identified above in Section D.1 (Sanction Monitoring Reporting Requirements) will be completed to determine compliance with reporting requirements. CAP will be implemented for any deficiencies identified in annual attestations, including non-submission of attestations or late submission of attestations.

Tri-annual assessments will include a review of policies and procedures and staff and employee files. Provider will be evaluated against current Sanction Monitoring requirements as dictated by CMS and Health Plan requirements and placed on CAP for any missing policy or documentation requirement or any file element that scores less than ninety-six percent (96%).

F. Health Plan Responsibilities. In addition to other Health Plan identified responsibilities Health Plan shall retain the following Credentialing functions:

1. Reporting to CMS of any excluded individual used for Health Plan activities or projects.

4.2 CREDENTIALING SERVICES

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.3 CLAIMS ADMINISTRATION SERVICES

A. Encounter Data. In addition to reporting requirements described in other sections of this Delegation Addendum, Provider shall furnish Health Plan with encounter data for all Covered Services provided, in accordance with all state and federal requirements. Data will be provided in a format approved by Health Plan and will include all information required by Health Plan. Required data will be delivered by Provider monthly to Health Plan not later than thirty (30) days following the end of each month, or such earlier time as may be required by applicable law, policy and procedure, or government contract.

4.4 CALL CENTER SERVICES

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.5 HEALTH HOMES

A. Delegation. Health Plan hereby delegates to Provider, and Provider hereby agrees to perform, all Community Based-Care Management services as described below in Section B (Delegated Responsibilities) for all Covered Services provided to Members by Health Plan or Provider's Participating Providers. Health Homes program requirements are established by Federal and State laws, State Medicaid requirements

and guidelines and Health Plan business needs. Current delegation requirements are summarized below, and are outlined in the Health Plan's policy and procedures. Health Plan retains the right, at its sole discretion, to change or modify its delegation policies, procedures, and assessment program documents.

B. Delegated Responsibilities. Provider is specifically delegated for the following Health Home functions for Covered Services:

1. Development and maintenance of the Provider's Health Homes program description, annual Health Homes work plan, use of Qualified consultants, and Health Homes policies and procedures;
2. Annual evaluation of Health Homes Program Description, including identification of program strengths and weaknesses, and opportunities for improvement, Health Homes work plan, and Health Homes policies and procedure;
3. Develop and maintain a comprehensive care management process that engages members and their family/support persons to actively participate in the Health Home Program;
4. Develop and maintain systematic processes and protocols to ensure Member's access to the Multi-Disciplinary care team and overall care coordination for needed services;
5. Develop and maintain process and tools for developing the Members' Health Action Plan (HAP) and reinforcing, implementing and reassessing, as appropriate, in collaboration with the Member, to accomplish stated goals;
6. Continuity and consistency of comprehensive care coordination for individual Members, including but not limited to medical health, behavioral health, community and social support, transportation and housing support;
7. Identifying, developing or promoting additional services in support of the Health Home Program;
8. Coordinate with authorizing and prescribing entities to reinforce and support Member's health action goals, conducting case conferences as needed;
9. Monitor and ensure all Providers participating in the Health Homes Program are properly credentialed based on State and Federal laws and accreditation standards.
10. Communication about the Health Homes Program to Members, staff and contracted Practitioner Providers;
11. Monitoring referrals, coordination and follow-up to ensure needed services and supports are offered and accessed;
12. Monitoring of the quality and timeliness of service;
13. Identification of potential Member fraud, waste, or abuse.
14. Support Health Plan Appeals and Grievance process including investigations scientific and technical review aspects, and communicating with Provider's sub contracted network; and
15. Provider agrees to not further sub delegate CB-CME responsibilities without Health Plan approval. All pre assessment documents completed by Provider must be submitted to Health Plan Delegation Oversight staff for review and approval, prior to sub-delegation effective date. Health Plan maintains the right to require

Provider to modify pre assessment documents, and or pre assessment processes, to ensure that Health Plan requirements and state and federal standards applicable to sub delegation are met.

C. Health Homes Program. Provider shall be responsible for maintaining a Community-Based Care Management Entity that is in full compliance with Health Plan requirements. Health Plan requirements include, but are not limited to:

1. Policies identifying the levels of staff, and the functions each staff level is qualified complete;
2. Policies describing the process of outreaching to Health Homes eligible members;
3. Policies describing the process of ensuring Members see their Primary Care Physician (PCP) within 60 days of enrollment into a Health Homes Program;
4. Policies establishing minimum standard for in-person visits per calendar quarter;
5. Policies establishing staffing ratios for support staff, Care Coordinator and providers to appropriately support the Program and in accordance with Program required staffing ratios determined by DHCS;
6. Process for identifying and ensuring availability of providers with experience working with people who are chronically homeless;
7. Policies describing process to support screening, referral and co-management of individuals with both behavioral health and physical health conditions;
8. Policies describing how Members can speak with or leave a message for Program staff;
9. Policies describing the communication process for Members who have hearing problems, or who need translation services;
10. Policies describing the process to coordinate eligible individuals who are homeless or experiencing housing instability to permanent housing;
11. Policies describing the process of screening, referral and co-management of individuals with behavioral health and physical health conditions;
12. Policies describing the Health Education and Promotion program of Health Homes, including member material, coaching for chronic conditions, and connecting members to community resources;
13. Policies describing the Comprehensive Transitional Care process for Members transitioning from and among treatment facilities, including any agreements and processes to ensure Member's care coordinator is notified timely;
14. Policies describing the processes in place to ensure that Health Insurance Portability and Accountability Act (HIPAA) defined Protected Health Information (PHI) is kept confidential, and the process for notifying Health Plan of unauthorized use or disclosure of Member PHI;
15. Policies describing process for identification of potential Member or Participating Provider fraud, waste, and abuse;
16. Policies describing how Provider will comply with Health Plan fraud, waste, and abuse processes;
17. Policies describing the Member and family support services, community and social support services offered; and

18. Policies describing process for coordinating transportation services for the Member:

D. State Medicaid Requirements. In addition, the following provisions are required for delegation in the state of California:
   1. Meet all CB-CME qualifications as outlined in state and federal laws and the DHCS Health Homes Program Guide;
   2. Identified as a CB-CME certified organization type as outlined in state and federal laws and DHCS Health Homes Program Guide;

E. Health Plan Participating Providers. In the absence of a direct contract between Provider and any Health Plan contracted provider, Provider is required to follow Health Plan's contracted terms and conditions for authorization and payment of services with such provider. Health Plan will provide Provider with all necessary information to comply with this requirement. Provider shall keep all such information confidential and shall not be used for purposes other than the payment of Health Plan specific Claims.
   1. Provider must use Health Plan's contracted rates, even if they exceed the rates set by the DOI for fee-for-service medical assistance programs; and
   2. Provider's authorization guidelines may not be more restrictive than Health Plan's for any specific service.

F. Health Homes Program Reporting Requirements. In addition to reporting requirements described in other sections of this Addendum, Provider shall provide Health Plan with the following information necessary for the oversight of delegated Health Homes Program activities. All reports are due on or before the 15th of the month following the close of the month (e.g. March reports are due on or before April 15th):
   1. A log of Health Homes members (enrolled, disenrolled, pending) on a quarterly basis. From these logs, up to five percent (5%) of members will be selected for complete file review. Health Plan staff will identify files selected, and the following information should be submitted within five (5) business days:
      a. Member case file;
      b. Member's Health Assessment Plan;
      c. Multi-Disciplinary team participants;
      d. Member and provider notification(s);
      e. Relevant clinical information gathered and used to make decision; and
      f. Other information relevant in determining Program compliance.
   2. The list of required reports may be revised by Health Plan to include additional report as required by state and Federal Medicaid requirements. Health Plan will provide Provider with a minimum of sixty (60) days advanced written notice of additional reports, unless a shorter timeframe is required by state or federal regulators. Furthermore, any ad-hoc reports shall be provided to Health Plan in the mutually agreed upon timeframe and format at the time of the report request.

G. Performance Standards. Provider will be evaluated on an ongoing and annual basis against current Health Homes Program requirements. Ongoing evaluation of monthly

reports as identified above in Section F (Health Homes Program Reporting Requirements) will be completed to determine compliance with program requirements. CAP will be implemented for any deficiencies identified in monthly reports, untimely decision making, missing information from member notification, or incomplete or inaccurate Health Homes Program Report information.

Annual assessments will include a review of policies and procedures and Care Coordination files as applicable. Provider will be evaluated against current Program requirements as dictated by NCQA, CMS, state Medicaid, and Health Plan as applicable and placed on CAP for any missing policy or documentation requirement or any file element that scores less than ninety-six percent (96%).

4.6 **UTILIZATION MANAGEMENT SERVICES**

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.7 **CARE MANAGEMENT**

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.8 **NURSE ADVICE LINE SERVICES**

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.9 **BEHAVIORAL HEALTH CRISIS LINE SERVICES**

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.10 **NON EMERGENT MEDICAL TRANSPORTATION SERVICES**

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.11 **RISK ASSESSMENT SERVICES**

THIS FUNCTION INTENTIONALLY NOT DELEGATED

4.12 **MEMBER APPEALS AND GRIEVANCE SERVICES**

THIS FUNCTION INTENTIONALLY NOT DELEGATED