

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



**ITEM: 3.17
(ID # 29108)**

MEETING DATE:
Tuesday, November 04, 2025

FROM : RUHS-PUBLIC HEALTH

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM-PUBLIC HEALTH: Ratify and Approve Provider Services Agreement with Molina Healthcare of California, Inc. for Community Health Workers Services Effective as of May 1, 2024 through May 1, 2026, Renewable Annually; All Districts. [100% State]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and approve the Provider Agreement with Molina Healthcare of California, Inc. for Community Healthcare Worker Services effective May 1, 2024 through May 1, 2026, and annually renewed until terminated by either party pursuant to the requirements and conditions; and
2. Authorize the Chair of the Board to sign the Agreement on behalf of the County; and
3. Authorize the Director of Public Health, or designee, in accordance with Ordinance No. 459, and as approved to form by County Counsel, if applicable, to sign all reports, certifications, forms and subsequent amendments to the Agreement, including modifications to the statement of work that stay within the intent of the Agreement.


ACTION:Policy


Kim Saruwatari, Director of Public Health 10/22/2025

MINUTES OF THE BOARD OF SUPERVISORS

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

Ayes: Medina, Spiegel, Washington, Perez and Gutierrez
Nays: None
Absent: None
Date: November 4, 2025
xc: RUHS-PH

Kimberly A. Rector
Clerk of the Board
By: 
Deputy

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

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	\$0	\$0	\$0	\$0
NET COUNTY COST	\$0	\$0	\$0	\$0
SOURCE OF FUNDS: 100% State			Budget Adjustment: No	
			For Fiscal Year: 25/26	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The Department of Health Care Services (DHCS) added Community Health Worker (CHW) services as a Medi-Cal benefit starting July 1, 2022. CHW services are preventive health services, as defined in 42 CFR § 440.130(c), to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and efficiency. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health-related social needs.

Riverside University Health System- Public Health (RUHS-PH) will provide CHW services to Molina Healthcare of California enrolled members. These services include, but are not limited to, the control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; need for preventive services, perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention.

Impact on Residents and Businesses

Through the preventive care services provided by the CHWs, Riverside County residents enrolled in Molina Healthcare of California will be provided preventive health services to improve health outcomes, advance health equity, and reduce medical care costs.

Additional Fiscal Information

There is no cost for RUHS-PH to enter into this Agreement. RUHS-PH will be reimbursed by Molina Healthcare of California for Health Care Services provided by the CHWs to Molina Healthcare of California enrolled members.

ATTACHMENTS:

ATTACHMENT A: Participating Provider Agreement No. HSARC-25-057 with Molina Healthcare of California, Inc.


Douglas Cardonez Jr.




10/27/2025

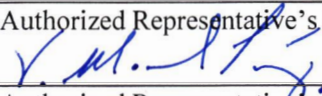
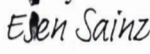

**MOLINA HEALTHCARE OF CALIFORNIA
 PROVIDER SERVICES AGREEMENT
 SIGNATURE PAGE**

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement. Each Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its respective Party. Each Authorized Representative further acknowledges and represents that they received and reviewed this Agreement in its entirety.

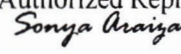
The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Provider Signature and Information.

Provider's Legal Name ("Provider") – Matching the applicable tax form (i.e., W-9, Line 1): County of Riverside, a political subdivision of the State of California, on behalf of its Riverside University Health System – Public Health.	
Authorized Representative's Signature: 	Authorized Representative's Name – Printed: V. Manuel Perez, Chair of the Board
Authorized Representative's Title: Chair of the Board of Supervisors	Authorized Representative's Signature Date: NOV 04 2025
Telephone Number: 951-358-5097	Fax Number – Official Correspondence:
Mailing Address – Official Correspondence: 4065 County Circle Drive, CA 92503	Payment Address – If different than Mailing Address:
IRS 1099 Address – If different than Mailing Address:	Tax ID Number – As listed on corresponding tax form: 95-6000930
NPI – That corresponds to the above Tax ID Number: 1124745815	Email Address – Official Correspondence: PH-Contracts@ruhealth.org (Contracts) AP@RUHealth.org (fiscal)
APPROVE AS TO FORM: Minh C. Tran, County Counsel By: Esen Sainz, Deputy County Counsel	County Counsel Signature:  ATTEST:  KIMBERLY ALARCON, Clerk By _____ DEPUTY

Health Plan Signature and Information.

Molina Healthcare of California , a California corporation ("Health Plan")	
Authorized Representative's Signature: 	Authorized Representative's Name – Printed: Sonya Araiza
Authorized Representative's Title: VP Network Mgmt & Ops	Authorized Representative's Countersignature Date: 9/29/2025
Mailing Address – Official Correspondence: Molina Healthcare of California, Inc. 200 Oceangate, Suite 100, Long Beach, CA 90802	Email Address – Official Correspondence: MHC_Contract_Terms@MolinaHealthCare.com

Attention: Contracting Department	
Effective Date of the Agreement (“Effective Date”): 5/01/2024	

PROVIDER SERVICES AGREEMENT

Provider and Health Plan enter into this Agreement as of the Effective Date. Provider and Health Plan may each be referred to herein as a “Party” and collectively as the “Parties.”

RECITALS

- A. WHEREAS, Health Plan is licensed and approved by required governmental agencies to operate a health care service plan, including to issue benefit agreements covering the provision of health care and related services and supplies to Members in accordance with Laws;
- B. WHEREAS, Provider is approved by required governmental agencies to provide health care and related services and supplies and desires to provide services to Members in accordance with Laws; and
- C. WHEREAS, the Parties intend by entering into this Agreement they will make health care and related services and supplies available to Members covered under this Agreement.
- D. WHEREAS, The parties acknowledge and agree that Provider began rendering services to Health Plan on May 1, 2024 and were accepted by Health Plan without a written services agreement. All actions taken by both the Provider and Health Plan prior to the date hereof are hereby confirmed and ratified by way of execution of this Agreement.

NOW, THEREFORE, in consideration of the promises and representations stated, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

- 1.1 Capitalized words or phrases not otherwise defined in this Agreement shall have the meanings set forth below.
 - a. **Advance Directive** means a Member’s written instruction, recognized under Laws, relating to the provision of health care when the Member is not competent to make a health care decision, as determined under Laws.
 - b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc. (“MHI”). Health Plan is an Affiliate of MHI.
 - c. **Agreement** means this Provider Services Agreement between Provider and Health Plan and all recitals, attachments, exhibits, addenda, amendments, and incorporated documents or materials.
 - d. **Appeals and Grievances Programs** mean the policies and procedures established by Health Plan to timely identify, process, and resolve Member and Provider appeals, grievances, complaints, disputes, and inquiries.
 - e. **Assigned Member** means a Member who has selected or has been assigned/attributed to Provider to receive Capitated Services. Assigned Members are a subset of Members.
 - f. **Authorization or Authorized** means the written or telephonic approval of Health Plan or its delegate for the provision or referral of Covered Services, other than Emergency Services, in accordance with the Provider Manual and this Agreement.
 - g. **California Department of Health Care Services (“DHCS”)** means the department within the State of California that administers the Medi-Cal program.

- h. **Capitation Payment** means the payment made to Provider under this Agreement for Capitated Services.
- i. **Capitated Services** mean the primary care physician (“PCP”) health care and related services and supplies for which Provider has assumed financial responsibility under this Agreement, as detailed under Attachment A. Capitated Services are a subset of Covered Services.
- j. **Centers for Medicare and Medicaid Services (“CMS”)** means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medi-Cal Plan, and the Health Insurance Marketplace.
- k. **Claim** means a bill for Covered Services provided by Provider.
- l. **Clean Claim** means a Claim for Covered Services submitted on an appropriate industry standard form, which has no defect, impropriety, lack of required substantiating documentation necessary to adjudicate the Claim, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
- m. **Covered Services** mean those health care and related services and supplies, including Emergency Services, provided to a Member that are Medically Necessary and are benefits of the Member’s Product.
- n. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that accounts for developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.
- o. **Date of Service** means (i) for outpatient services and all Emergency Services and care, the date upon which Provider delivers separately billable Covered Services to the Member or (ii) for inpatient services, the date upon which the Member was discharged from the inpatient facility.
- p. **Emergency Medical Condition** means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- q. **Emergency Services** mean Covered Services for inpatient and outpatient care furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize a Member’s Emergency Medical Condition.
- r. **Encounter Data** means the information that describes health care interactions between Members and providers relating to the receipt of any item or service by a Member under this Agreement and subject to the standards of 42 C.F.R. §§ 438.242 and 438.818.
- s. **Government Contract** means the contract between Health Plan and a governmental agency, including CMS or DHCS, for Health Plan to administer a Product.
- t. **Government Program Requirements** mean the requirements of governmental agencies for a Product, which includes the requirements set forth in the Government Contract.
- u. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, and established by Section 100500 *et seq.* of the California Government Code, including all implementing statutes and regulations.

- v. **Health Plan** means Molina Healthcare of California.
- w. **Laws** means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.
- x. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.
- y. **Medically Necessary or Medical Necessity** means health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms Consistent with California Welfare and Institutions Code Section 14059.5.
- z. **Medicare Advantage (“MA”)** means a program in which private health plans, including Health Plan, provide health care and related services and supplies through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as “**Medicare**”). Medicare Advantage also includes Medicare Advantage Special Needs Plans (“**MA-SNP**”).
- aa. **Medicare-Medi-Cal Plan (“MMP”)** means a program in which private health plans, including Health Plan, provide health care and related services and supplies to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the state, including exclusively aligned enrollment (“**EAE**”) dual special needs plans (“**D-SNPs**”) (also referred to as Medi-Medi Plans) and non-EAE D-SNPs.
- bb. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.
- cc. **Molina Fee Schedule** means the Health Plan’s fee schedule, inclusive of all reimbursement rates Health Plan is required to reimburse Provider within this Agreement.
- dd. **Molina Marketplace** means the products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.
- ee. **Overpayment** means a payment Provider receives that, after applicable reconciliation, Provider is not entitled to receive or retain pursuant to Laws, Government Program Requirements, and/or this Agreement.
- ff. **Participating Provider** means an individual or entity that is contracted with Health Plan to provide health care and related services and supplies to Members and, as applicable, is credentialed by Health Plan or Health Plan’s designee.
- gg. **Per Member Per Month (“PMPM”)** means payment amounts based on an individual Assigned Member per month basis.
- hh. **Product(s)** mean the Medicaid, MA, MMP, and/or Health Insurance Marketplace product(s) administered by Health Plan and identified in Attachment A, Products, in which Provider agrees to participate, including any successors to the health insurance programs.
- ii. **Provider** means the entity or person identified on the Signature Page of this Agreement and includes any persons or entities performing Covered Services on behalf of the entity or person identified on the Signature Page of this Agreement. Provider will ensure all persons and entities performing Covered Services comply with the applicable terms of the Agreement.
- jj. **Provider Manual** means Health Plan’s provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan’s requirements and rules that Provider is required to follow in providing services under this Agreement.

- kk. **Quality Improvement Program (“QI Program”)** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.
- ll. **Responsible Entity** means an entity, including a capitated independent practice association or any other entity capitated by Health Plan, which is financially responsible for certain Covered Services.
- mm. **State Children’s Health Insurance Program (“CHIP”)** means the program established pursuant to Title XXI of the Social Security Act, as amended.
- nn. **Subcontractor** means an individual or organization, including a Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of Provider’s obligations under this Agreement.
- oo. **Utilization Review and Management Program (“UM Program”)** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, and retrospective reviews under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 Provider Standards.

- a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider’s business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws, and Government Program Requirements.
- b. **Facilities, Equipment, and Personnel.** Provider’s facilities, equipment, personnel, technology (hardware and software), and administrative services will be at a level and quality necessary to perform Provider’s duties under this Agreement and to comply with Laws and Government Program Requirements. Provider will further ensure that its personnel comply with the applicable terms of this Agreement.
- c. **Prior Authorization.** For a Covered Service that requires a prior Authorization, Provider is required to obtain prior Authorization from Health Plan for such Covered Service. Provider will not have to obtain prior Authorizations before providing Emergency Services.
- d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior Authorization, Provider will only utilize Participating Providers to provide Covered Services. Provider will notify Health Plan so that Health Plan can determine the appropriate provider to perform the services if a Participating Provider is not available.
- e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan’s Drug Formulary/Prescription Drug List and prior Authorization and prescription policies. Provider acknowledges the authority of pharmacies to substitute generics or low-cost alternative prescriptions for the prescribed medications.
- f. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding the Member’s medical condition; Medical Necessity; appropriate treatment, care, and alternatives, including risk and benefits regardless of the provisions or limitations of a Member’s evidence of coverage; a Member’s right to appeal any adverse decisions by Health Plan; and any other communications expressly permitted under Laws.

Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

- g. **Member Eligibility Verification.** Provider will verify a Member's eligibility before providing a Covered Service, unless the situation involves the provision of an Emergency Service, and will confirm eligibility in a manner that is consistent with Laws and Government Program Requirements on redeterminations of eligibility.
- h. **Availability of Services.** Provider will meet applicable standards for timely access to care and services in accordance with Laws and Government Program Requirements. Provider will ensure the availability of Covered Services twenty-four (24) hours a day, seven (7) days a week, for those Covered Services that are required to be made available twenty-four (24) hours a day, seven (7) days a week.
- i. **Privileges.** Provider will have staff/admitting privileges with at least one (1) Health Plan-contracted hospital as necessary to provide Covered Services. To the extent permitted by Laws, Provider will authorize each hospital to notify Health Plan if disciplinary or other action of any kind is initiated against Provider that could result in the suspension, reduction, or modification of Provider's privileges. If Provider does not have privileges with at least one (1) Health Plan-contracted hospital, Provider must provide an acceptable arrangement to Health Plan that ensures Members' continuity of care.

2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Provider will participate in Health Plan's promotional activities conducted in accordance with Laws and Government Program Requirements. Neither Provider nor Health Plan will use the other Party's name, including trademarks, service marks, domain names, or logos ("**Marks**") without the prior written approval of the other Party. This Agreement does not grant either Party a license or sublicense to the other Party's Marks. However, Provider may refer to Health Plan in its listings of participating health plans. Additionally, Health Plan may use Provider's name and related information: (i) in Health Plan's filings and publications to identify Provider as a Participating Provider; (ii) in communications to identify Provider to Members; and (iii) as may be required to comply with the Laws and Government Program Requirements. Provider agrees that marketing materials related to this Agreement require Health Plan's review and prior written approval unless otherwise noted in the Agreement.

2.4 **Non-Discrimination.** Provider will not discriminate against individuals based on their status as protected veterans or because of race, color, religion, national origin, creed, ancestry, language, age, sex, marital status, sexual orientation, gender identity, health status, physical, sensory or mental handicap, disability, socioeconomic status, identification with any other persons or groups defined in California Penal Code 422.56, or participation in publicly financed programs of health care services or any other basis prohibited by Laws. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

- a. **Maintaining Records.** Provider will maintain complete and correct books and records relating to services provided under this Agreement for tax, accounting, and operation purposes. Provider will maintain medical and billing records ("**Records**") for each Member to whom Provider provides health care and related services and supplies. The Member's Records will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Records for as long as required by Laws and Government Program Requirements.

- b. **Confidentiality of Member Record.** Provider will comply with all Laws, including the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”), the Health Information Technology for Economic and Clinical Health (“**HITECH**”) Act, and the California Confidentiality of Medical Information Act (“**CMIA**”), including the implementing regulations of those laws, as well as Health Plan’s policies and procedures and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use a Member’s name, address, social security number, identity, other personal information, treatment modality, Record, or the fact that a Member is enrolled in a Product without obtaining appropriate authorization and in accordance with Laws. This section does not affect or limit Provider’s obligation to make available the Record, Encounter Data, and information concerning a Member’s care to Health Plan, a governmental agency, or another provider of health care.
- c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan’s policies and procedures, Government Program Requirements, or third-party payers, any information, statistical data, Encounter Data, or Records pertaining to a Member to the extent permitted by Laws. Provider is responsible for the costs associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a governmental agency.
- d. **Member Access to Member Record.** Provider will give each Member access to the Member’s Records and other applicable information in accordance with Laws, Government Program Requirements, and Health Plan’s policies and procedures.

2.6 **Program Participation.**

- a. **Participation in Appeals and Grievances Programs.** Provider will participate in and comply with Health Plan’s Appeals and Grievances Programs.
- b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan’s QI Program. Provider will cooperate in conducting peer reviews and audits of care and services provided by Provider.
- c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan’s UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.
- d. **Participation in Credentialing.** Provider will participate in and comply with Health Plan’s credentialing and re-credentialing program. Provider must be credentialed by Health Plan or Health Plan’s designee before providing Covered Services and must remain credentialed throughout the Term to continue to provide Covered Services. Provider will promptly notify Health Plan of any change in the information submitted or relied upon by Provider to achieve or maintain its credentialed status.
- e. **Health Education/Training.** Provider will participate in and comply with Health Plan’s provider education and training program, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

2.7 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement, as may be unilaterally updated by Health Plan as provided by Laws. Provider acknowledges the Provider Manual is available to Provider at Health Plan’s website. A physical copy of the Provider Manual is available to Provider upon request.

2.8 **Supplemental Materials.** Health Plan may issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information

(“**Supplemental Materials**”). Health Plan may issue Supplemental Materials, in a manner consistent with Laws, in an electronic format, which includes posting on Health Plan’s web-portal. Physical copies of Supplemental Materials are available to Provider upon request. Supplemental Materials become binding as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

- 2.9 **Health Plan’s Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan’s electronic processes and initiatives, including electronic submission of prior Authorization, access to electronic medical records, electronic claims filing, electronic data interchange (“**EDI**”), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan’s web-portal.
- 2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete and accurate list of its business/practice/facility locations and, as applicable, a list of each person and entity performing Covered Services, together with the specific information required for administration of this Agreement. The information includes the information required by Health Plan to produce provider directories and any subsequent changes to that information. Provider will be required to deliver to Health Plan in writing any changes as to who are the persons and entities covered under this Agreement within five (5) days. Each person or entity will only be part of this Agreement after Provider has received written approval from Health Plan, which includes confirmation that credentialing is complete, if required. Notwithstanding the above, if Laws or Government Program Requirements require the delivery of information described in this section in another manner or different timeframe, Provider will notify Health Plan in accordance with the Laws and/or Government Program Requirements. Health Plan also reserves the right to request such information at any time.
- 2.11 **Standing.**
 - a. **Licensure.** Provider represents and warrants that it has all the appropriate licenses and certifications to provide Covered Services. This includes having and maintaining a current narcotics number issued by proper authorities when appropriate. Provider will deliver evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status. Any equipment used by Provider and/or its employed and contracted personnel under the Agreement required to be licensed or registered by Laws shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law, as well. Provider will promptly notify Health Plan of changes in its licensure or certification status, including disciplinary action taken or proposed by any agency responsible for oversight of Provider. Provider shall comply with all requirements of Health & Safety Code § 1367(b)-(c) and 28 CCR § 1300.49 *et seq.*, as applicable.
 - b. **Unrestricted Status.** Provider represents and warrants that to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, contractors, or any persons or entities with an ownership or control interest in Provider as defined and set forth in 42 C.F.R. §§ 455.101 and 455.104 (collectively, “**Personnel**”) have been excluded from participation in the Medicare Program, any state, commonwealth, or the District of Columbia’s Medicaid Program, or any other federal health care program (collectively “**Federal Health Care Programs**”). Provider agrees that it must check the U.S. Department of Health and Human Services (“**HHS**”) Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government, and every state, commonwealth, and the District of Columbia’s Medicaid exclusion lists (including criminal background and registry checks) to determine whether Provider or any of its Personnel

have been excluded from participation in any Federal Health Care Programs. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Programs. Provider agrees that it is subject to 2 C.F.R. Part 376 and will require its Personnel to agree that they are subject to 2 C.F.R. Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan will issue a letter requesting payment from Provider to Health Plan of the amount imposed. If the Provider does not timely pay the amount, Health Plan may collect the amount by offsetting or recouping from any other amounts due to Provider under this Agreement or any other contract or obligation between the Parties. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements.

- c. **Legal Actions.** Provider will give prompt written notice to Health Plan of: (i) a legal claim asserted by a Member and information about its resolution; (ii) a criminal investigation or charge, information, or indictment filed involving Provider and information about its resolution; and (iii) a legal claim that may jeopardize financial soundness and information about its resolution.
- d. **Liability Insurance.** Provider will maintain the following insurance and additional insurance coverage consistent with industry standards and as required by Laws and Government Program Requirements.
 - i. General liability, including liability resulting from bodily injury inclusive of mental anguish, death of persons, and damage to and destruction of property arising out of or based upon any act or omission of Provider or its respective officers, directors, employees, or agents, with one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) aggregate, bodily injury and property damage combined single limit of coverage. Health Plan is to be named as an additional insured, and the insurance will evidence primary and non-contributory coverage. Subrogation rights against Health Plan are to be waived.
 - ii. Medical professional liability with limits of at least one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate for a policy year. If the coverage is claims made or occurrence reported, Provider must purchase "**Extended Reporting Period**" coverage (i.e., tail coverage) for a period of not less than three (3) years upon termination of the Provider's present or subsequent policy unless such policy covers prior acts for at least three (3) years. Subrogation rights against Health Plan will be waived.
 - iii. Umbrella liability with limits of five million dollars (\$5,000,000).

All the insurance policies referenced will be with admitted insurers having an A.M. Best rating of A-VII or better. Such insurance will be secured and maintained at Provider's own expense. Provider will furnish Health Plan with certificates of insurance completed by its respective insurance carriers: (i) certifying that minimum insurance coverage as required above is in effect; and (ii) stating that Health Plan is an additional insured for the pertinent policy. Health Plan will be given not less than thirty (30) days written notice prior to any cancellation or material change to any policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. The rights and duties of this section survive any termination as it relates to those Covered Services that Provider provided prior to the effective date of the termination.

- iv. The above requirements shall be satisfied by a self-insured program.
- 2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit the information available to Members related to Medical Necessity, appropriate treatment, or alternative care, as provided under Section 2.1(f).
- 2.13 **Laws and Government Program Requirements.**
- a. **Compliance with Laws and Government Program Requirements.** Provider will comply with the Laws that are applicable to this Agreement. Provider acknowledges Health Plan has entered into Government Contracts, and Provider agrees it will comply with the applicable Government Program Requirements for each Product. Upon written request from Provider, Health Plan will give Provider a copy of each Government Contract under which Provider is participating, redacted to remove financial and other private and trade secret information.
 - b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements relating to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. If Provider discovers an occurrence of fraud, waste, or abuse, Provider will notify Health Plan within two (2) business days. Provider will participate in and comply with investigations conducted by Health Plan or by a governmental agency. If Health Plan, DHCS, CMS, or HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate or audit Provider at any time and Provider will fully cooperate with and provide records for any such audit.
 - c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.
 - d. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the Term in accordance with Laws, including Medicaid and DHCS requirements. Provider or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the Term. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in Provider or disclosing entity also has an ownership or control interest.
- 2.14 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care and related services and supplies to Affiliates' enrollees. For Affiliates' enrollees, Provider will be compensated for Clean Claims that are determined to be payable at the rate set forth in this Agreement unless otherwise required by Laws or Government Program Requirements. Provider will follow the hold harmless provisions of this Agreement for Affiliates' enrollees.
- 2.15 **Abuse, Neglect, and Exploitation.** Provider will comply with the Laws and Government Program Requirements relating to the reporting of abuse, neglect, and exploitation.
- 2.16 **Transfer of Members.** Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.
- 2.17 **Condition Change.** Provider will promptly notify Health Plan's Care Management Team upon becoming aware of a significant change in a Member's health or functional status or death.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

- 3.1 **Health Plan Compliance.** Health Plan will comply with all Laws and Government Program Requirements that are applicable to this Agreement.
- 3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.
- 3.3 **Prior Authorization Review.** Health Plan will respond with a determination on a Prior Authorization request in accordance with the time frames required by Laws and Government Program Requirements after receiving all necessary information from Provider.
- 3.4 **Medical Necessity Determination.** Health Plan's determination regarding Medical Necessity, including determinations of level of care and length of stay, will govern. Notwithstanding, Provider may challenge Health Plan's determination through Provider Dispute Resolution.
- 3.5 **Member Services.** Health Plan will provide services to Members, including assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of 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.
- 3.6 **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.
- 3.7 **Corrective Action.** Health Plan and governmental agencies routinely monitor the level, manner, and quality of Covered Services provided, as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan to address the deficiency. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.
- 3.8 **Reassignment of Members.** Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Provider if Health Plan determines that Provider poses a threat to Members' health and safety or during a termination notice period in accordance with Laws and Government Program Requirements. Provider will ensure copies of the Member's medical records are delivered to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records. Subject to the foregoing, if Provider requests reassignment of a Member, Health Plan will consider reassignment in accordance with Laws and Government Program Requirements or, if there are no applicable Laws or Government Program Requirements, upon good cause shown by Provider.
- 3.9 **Quality Bonus Payment Program.** Health Plan may offer Provider the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). The QBPP will promote quality of care if offered. Provider must register with Health Plan's web portal and remain in compliance with this Agreement to be eligible for any QBPP. Payments under the QBPP will be based on the terms of the QBPP as set forth in the Provider Manual, in a Supplemental Material, or in an amendment to this Agreement. QBPP payments are not guaranteed payments and are paid separately from the compensation due pursuant to the terms of this Agreement.

ARTICLE FOUR – CLAIMS PAYMENT

- 4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after ninety (90) from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to Laws or Government Program Requirements. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless Health Plan is required to follow a different timeframe pursuant to Laws or Government Program Requirements. Provider will include

all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.

- 4.2 **Compensation.** Health Plan will pay Provider for Capitated Services, as applicable, and Clean Claims for Covered Services that Health Plan determines to be payable in accordance with Laws, Government Program Requirements, and this Agreement, including Attachment B. Health Plan will make payment as required by Laws or Government Program Requirements. Provider agrees to accept such payments, Member cost-sharing, coordination of benefits, and amounts due from third parties as payment in full for Covered Services under this Agreement. Provider's failure to comply with the terms of this Agreement may result in non-payment or reduced payment to Provider.
- 4.3 **Member Cost-Sharing.** Provider is responsible for the collection of co-payments, co-insurances, and deductibles, if any, from Members. Provider agrees to bill Members and collect such cost-sharing amounts from Members.
- 4.4 **Member Hold Harmless.** Provider agrees in no event, including non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or person acting on a Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services in accordance with Laws and Government Program Requirements. For the purposes of this section, non-Covered Services do not include services that have been determined to be not Medically Necessary by Health Plan. This section will survive any termination of this Agreement, regardless of the reason for the termination, including insolvency of Health Plan.
- 4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another entity is the primary payer. Provider will inquire of each Member to learn if the Member has health insurance or health benefits other than from Health Plan or is entitled to payment from: (i) another insurer or plan of any type; or (ii) a third party under any other form of compensation, including personal injury settlements in accordance with Laws and Government Program Requirements. Provider will file and make reasonable efforts to collect such potential entitlements and Provider will promptly notify Health Plan of such potential entitlement if permitted by Laws. Provider will be compensated in an amount equal to the allowable Clean Claim less the amount due from other health insurances or health benefits, insurers or plans, or third parties, not to exceed the amount specified in the Compensation Schedule in Attachment B of this Agreement.
- 4.6 **Offset.** In the event of an Overpayment, Health Plan will request in writing repayment by Provider. If the Provider does not timely repay the Overpayment, Health Plan may collect the Overpayment amount by offsetting or recouping from any other amounts due Provider under the Agreement or any other agreement between the Parties. Any offset or recoupment under this Section 4.6 will comply with Laws and Government Program Requirements, as applicable. Provider will comply with the Laws and Government Program Requirements regarding the identification and return of Overpayments and will promptly notify Health Plan of any Overpayments identified by Provider.
- 4.7 **Claim Review.** Claims will be reviewed and paid in accordance with Health Plan's policies and procedures, which are based on Health Plan's experience and industry standard billing and payment rules, including the Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT"), Healthcare Common Procedure Coding System ("HCPCS"), federal and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate

payment. Payment may exclude certain items not billed in accordance with Health Plan's policies and procedures or that do not meet Medical Necessity criteria.

- 4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will 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 will use established industry claims adjudication and clinical practices, federal and state guidelines, and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment.
- 4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to the Responsible Entity for payment for the Covered Services.
- 4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan.

ARTICLE FIVE – TERM AND TERMINATION

- 5.1 **Term.** This Agreement will commence on the Effective Date, continue in effect for one (1) year (“**Initial Term**”), and then renew for successive one (1)-year terms (each a “**Renewal Term**”) unless terminated by either Party in accordance with this Agreement. The Initial Term together with any Renewal Terms constitute the “**Term**” of this Agreement.
- 5.2 **Termination without Cause.** Either Party may terminate a Product listed under Attachment A of this Agreement without cause after the Initial Term by giving the other Party at least one hundred and twenty (120) days' prior written notice. If all Products listed in Attachment A terminate, then the Agreement shall also terminate; provided, however, that if a Party's without cause termination is due to the Parties' inability to agree to rates or other terms related to a specific Product(s), the Party may choose to only terminate Product(s) listed in Attachment A that is subject to the disagreement on rates of other contract terms.
- 5.3 **Health Plan Termination with Cause.** If Provider breaches a material provision of this Agreement, Health Plan may give Provider written notice of termination setting forth the facts underlying its breach claim. Provider will have thirty (30) days from the date of receipt of such notice to remedy or cure the breach to the satisfaction of Health Plan. During this thirty (30)-day period, the Parties agree to meet and confer as reasonably necessary to resolve the breach. If Provider has not remedied or cured the breach within such thirty (30)-day period, Health Plan may immediately terminate this Agreement or a Product under this Agreement upon expiration of the thirty (30)-day period. Notwithstanding the foregoing, Health Plan may immediately terminate this Agreement or a Product under this Agreement without providing Provider the opportunity to cure a material breach by providing written notice to the Provider should Health Plan reasonably believe the material breach of this Agreement is non-curable.
- 5.4 **Provider Termination with Cause.** If Provider claims a breach of the Agreement, Provider will give Health Plan written notice of termination setting forth the facts underlying its claim that Health Plan breached this Agreement, including to which Product(s) listed in Attachment A the breach relates. Health Plan will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of Provider. During this thirty (30)-day period, the Parties agree to meet and confer as reasonably necessary to resolve the claimed breach. If Health Plan has not remedied or cured the breach within such thirty (30)-day period, Provider may only terminate the Product(s) under this Agreement to which the breach relates upon expiration of the

thirty (30)-day period. If Provider terminates all Products listed in Attachment A in accordance with this Section 5.4, then the Agreement shall also terminate.

- 5.5 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an individual provider under this Agreement may immediately be terminated upon written notice to the other Party in the event any of the following occurs:
- a. Provider's license or any other approval needed to provide Covered Services is limited, suspended, or revoked, a disciplinary proceeding is commenced against Provider by a governmental or accrediting agency, or an indictment is issued against Provider;
 - b. Either Party fails to maintain adequate levels of insurance;
 - c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including having or maintaining credentialing status;
 - d. Either Party 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 or Health Plan is appointed by appropriate authority;
 - e. Health Plan reasonably determines that Provider's facility, equipment, or Personnel are insufficient to provide Covered Services;
 - f. Either Party is excluded/precluded from participation in a state, commonwealth, or federal health care program;
 - g. Provider is terminated as a provider by a state, commonwealth, or federal health care program;
 - h. Either Party engages in fraud, waste, or abuse or permits fraud, waste, or abuse by another in connection with the Party's obligations under this Agreement;
 - i. Health Plan reasonably determines that Covered Services are not being properly provided or arranged for by Provider and such failure poses a threat to Members' health and safety;
 - j. Provider violates any Laws;
 - k. Provider fails to satisfy the terms of a corrective action plan issued by Health Plan under this Agreement;
 - l. Health Plan ceases to offer a Product, and any run-out period required by Laws or Government Program Requirements has expired; or
 - m. Termination is required by a governmental agency.

5.6 **Liability Limitation.** Omitted.

5.7 **Notice to Members.** In the event of any termination, Health Plan will give reasonable notice to Members who are currently receiving care, and the Parties will ensure the continuity of care in accordance with and to the extent required by Laws and Government Program Requirements.

5.8 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

5.9 **Survival.** The following sections shall survive the termination of this Agreement: Sections 2.5, 2.11(b)-(d), 2.13(b), 4.4, 4.6, 4.7, 4.8, 4.10, 6.1, 6.3, 6.6, 6.10, 6.11, 6.16 and 6.17.

ARTICLE SIX – GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from

(i) a breach of the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement or (ii) the gross negligence of willful misconduct of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives. Each Party agrees to give the other Party prompt written notice of any claim made against the other Party.

- 6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third-party to enforce this Agreement.
- 6.3 **Governing Law.** The laws of the State of California (“State”) will govern this Agreement, excluding its conflict of laws principles, to the extent such laws are not preempted by federal laws.
- 6.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Provider Manual, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.
- 6.5 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction or any governmental agency with oversight authority for this Agreement to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated because of such decision.
- 6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties’ desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word “day” means calendar day unless otherwise specified; (ii) the term “business day” means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; (v) references to any government department or agency include any successor departments or agencies; and (vi) any reference in the Agreement to “include(s)” or “including” means inclusion without limitation, unless otherwise distinguished within the text.
- 6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.
- 6.8 **Amendments.**
- a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement upon written notice to Provider to maintain consistency or compliance with applicable policy, directive, Laws, or Government Program Requirements at any time and without Provider’s consent (“Regulatory Amendment”). Such Regulatory Amendment will be binding upon Provider.

b. **Non-Regulatory Amendments.** Notwithstanding a Regulatory Amendment, any amendment of a material term to this Agreement must be in writing and executed by the Parties unless otherwise permitted by Laws.

6.9 **Delegation or Subcontract.** Provider will submit to Health Plan a list identifying Provider's Subcontractors with a description of the services each Subcontractor provides. Provider will promptly submit updates to the list to Health Plan. Provider will ensure each Subcontractor complies with the applicable terms of this Agreement. Provider's contract with a Subcontractor will be in writing and will bind the Subcontractor to the applicable terms required for compliance with this Agreement. Health Plan has the right to request Provider limit the use of a Subcontractor that does not meet the applicable terms of the Agreement, and Provider will comply with the request.

6.10 **Assignment.** Neither party may assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of other party, which it may not be unreasonably withheld. Subject to the foregoing, this Agreement is binding upon and inures to the benefit of the Parties and respective successors in interest and assignees. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

6.11 **Arbitration.**

a. **Arbitration Requirements.** Omitted.

b. **Meet and Confer.** Prior to the initiation of legal action, the Parties shall attempt to resolve any Dispute arising out of or relating to this Agreement via a good faith "**Meet and Confer**". To initiate a Meet and Confer, a Party shall deliver to the other Party a written notice of the Dispute that includes a demand to Meet and Confer. The notice shall include: (i) a statement of the Party's position and a summary of arguments supporting that position; and (ii) the name and contact information of the executive who will participate in the Meet and Confer. The Meet and Confer shall be held within forty-five (45) days of the delivery of the notice, at a mutually acceptable time and place, which may include a virtual meeting, between appropriate representatives of the Parties, including a person authorized to settle the Dispute (the "**First Meeting**"). The Parties may agree to further discussions after the First Meeting. At no time prior to the First Meeting shall either Party initiate an arbitration or litigation related to this Agreement, except to pursue a provisional remedy that is authorized by law or by JAMS Rules or by agreement of the Parties. This limitation is inapplicable to a Party if the other Party refuses to comply with the requirements of this subsection (b).

c. **Rules for Arbitration.** The Parties waive any right to trial by jury. The Parties waive any award of punitive, treble or exemplary damages. Each Party shall bear its own costs and expenses of arbitration, including its own attorneys' fees.

Litigation must be initiated within two (2) year of the earlier of the date the Dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, the Dispute will be deemed waived, and the complaining Party shall be barred from initiating litigation or other proceedings related to the Dispute, including initiating any civil action in state or federal court. The Parties expressly agree that the deadline to file litigation shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

6.12 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service ("**USPS**") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for

USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.

- b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.
- 6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.
- 6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.
- 6.15 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party if it is determined that: (i) the Party used the efforts a reasonable person would during the force majeure event to perform its duties under this Agreement; and (ii) the Party's inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event; provided, however, if the force majeure event continues for ten (10) days, the Party unaffected by the force majeure event may terminate the Agreement upon written notice to the Party unable to perform any duty under the Agreement.
- 6.16 **Confidentiality.** Any information disclosed by either Party in fulfillment of its duties under this Agreement, including health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including Member lists, QI Programs, certification/credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential by Provider. Provider will not disclose or release information to a third-party without the written consent of Health Plan. However, each Party may share information with its subsidiaries and affiliates and its respective Personnel and designees as necessary to fulfill the terms of this Agreement. Nothing in the Agreement will preclude either Party from disclosing information as required for compliance with Laws or Government Program Requirements or as required to comply with a governmental authority request provided that the information is only disclosed in a manner and to the extent required for compliance and in accordance with Laws. Provider will either return confidential information or destroy confidential information and provide confirmation of the destruction to Health Plan upon request if the Agreement terminates.

Health Plan acknowledges that Provider is a governmental entity subject to the public records and meeting laws of the State of California, including the California Public Records Act (Government Code Section 6250 et seq.) and the California Brown Act (Government Code Section 54590 et seq.). Notwithstanding any other provision contained in this Agreement, any information (including Confidential Information), communications, and documents given by Health Plan to Provider and meetings involving Provider may be subject to disclosure pursuant to the Public Records Act and Brown Act. To the extent Provider is required by law to disclose any of the above-described information, communications, and documents, Provider shall comply with such law. Provider shall

notify Health Plan of any request or demand for disclosure of information, communications and documents relating to this Agreement, in sufficient time for Health Plan to lodge a formal objection, including but not limited to, by seeking a court order, regarding any such disclosure.

- 6.17 **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this Agreement, Health Plan will be able to collect from Provider the amount imposed on or withheld from Health Plan. Health Plan will issue a letter requesting payment of the amount imposed or withheld. If Provider does not timely pay the amount, Health Plan may collect the amount by offsetting or recouping from any amounts due. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements.
- 6.18 **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.
- 6.19 **Offshore Resources.** Neither Provider nor its Subcontractors will perform any work related to the administration of the Agreement outside the United States of America without the prior written consent of Health Plan, which it may withhold in its sole discretion.
- 6.20 **Recitals and Exhibits.** The recitals and attachments to this Agreement are incorporated into the Agreement by this reference.

Community Health Worker (CHW) Services Scope of Work, Provider Requirements and Qualifications

1.1 CHW Services and Scope of Work

- 1.2 **Definition.** CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health (Title 42 Code of Federal Regulations (CFR) Section 440.130(c)). Requirements and guidelines for the CHW benefit are established by DHCS in **All Plan Letter (APL) 24-006 , CHW Services Benefit or any superseding APLs.**
- 1.3 **CHW Services.** CHW services may assist with a variety of concerns, including but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services. Additionally, CHW services can help Members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.
- 1.4 **CHW Provider Types.** CHWs may include individuals such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified in this contract. Credentialing and provider enrollment requirements for CHWs and Supervising Providers are specified in the current DHCS CHW Services APL and Medi-Cal Provider Manual. CHWs should apply for a National Provider Identifier (NPI). The NPI is a numeric identifier that is assigned to a health care provider by the Centers for Medicare & Medicaid Services (CMS). If the CHW services are provided by a provider or organization that already has a NPI, the provider or organization should ensure that the Taxonomy codes listed in the organization's NPI profile are current and include Community Health Worker (Taxonomy code 172V00000X) and other services that may be relevant to this benefit.
- 1.5 **Written Recommendation.** Since CHW services are a preventive service, there is not a required prior authorization for the first 12 units of CHW services; however, quantity limits can be applied based on goals detailed in the plan of care. CHW services require a written recommendation submitted to Molina, indicating that CHW services are ordered by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. The recommending physician/practitioner must determine whether a Member meets eligibility criteria for CHW services as set forth in the current DHCS CHW Services APL and Medi-Cal Provider Manual.
- Provider may not render CHW services without such recommendation and must provide evidence of written recommendation to Molina upon request.
- 1.6 **Documentation Requirements.** CHWs are required to document the dates and time/duration of services provided to Members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient. Documentation must be accessible to the Supervising Provider (see Section 2.5 below) and Molina upon request. Documentation should be integrated into the Member's medical record and available for encounter data reporting. CHW's National Provider Identifier (NPI) number should be included in documentation.

CHWs should prioritize electronic tracking of members and as much as possible use Molina’s Clinical Care Advance (CCA) system for Member care management purposes. For Member referrals, CHWs should use Molina Help Finder to track and monitor community-based referrals.

1.7 Billing, Claims, and Payments

CHW services must be reimbursed through the CHW Supervising Provider or directly if the CHW is a Medi-Cal enrolled Provider. Since CHW services are a preventive service, there is not a required prior authorization for the first 12 units of CHW services; however, for services beyond the initial 12 units, quantity limits can be applied based on goals detailed in the plan of care. Members enrolled in Enhanced Care Management cannot also receive the CHW benefit. Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual. CHWs and the CHW Supervising Provider should prioritize using the 25 DHCS Priority Social Determinants of Health Codes (SDOH), based on the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), when coding for SDOH in claims and encounters to ensure correct coding and capture of reliable data. See table below. DHCS specific guidance for documentation of SDOH using Z-Codes can be found in APL 21-009: Collecting Social Determinants of Health Data or superseding APLs.

25 DHCS Priority Social Determinants of Health Z-Codes

Z code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing
Z59.3	Problems related to living in a residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance and/or death of family member
Z63.5	Disruption of family by separation and/or divorce
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other problems related to psychosocial circumstances

1.8 Plan of Care. For members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed providers, which may include the recommending provider and other licensed providers affiliated with the CHW Supervising Provider. The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the Supervising Provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other providers.

The plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Include a list of other health care professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

A licensed provider must review the Member's plan of care at least every six months from the effective date of the initial plan of care. The licensed provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition, providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

1.9 Covered CHW Services including Violence Prevention Services

CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits.

Supervising Providers should refer to the Telehealth section in Part 2 of the Provider Manual for guidance regarding providing services via telehealth (Medi-Cal Provider Manual, Medicine: Telehealth, is available at the following link:.) https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D5289F68-C42E-4FE8-B59F-FA44A06D2863/mednetele.pdf?access_token=6UyVkkRRfByXTZEWIh8j8QaYyIPyP5ULO

2.1 CHW Services include:

- **Health Education:** Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
- **Health Navigation:** Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
 - Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care
 - Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
 - Help a Member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.
- **Screening and Assessment:** Providing screening and assessment services that do not require a license and assisting a Member with connecting to appropriate services to improve their health.
- **Individual Support or Advocacy:** Assisting a Member in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

Services may be provided to a parent or legal guardian of a Member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. A service for the direct benefit of the Member must be billed under Member's Medi-Cal ID.

CHWs may render street medicine and bill for appropriate and applicable services within their scope of service.

2.2 Non-covered CHW services

- Clinical case management/care management that requires a license
- Child care
- Chore services, including shopping and cooking meals
- Companion services
- Employment services
- Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
- Delivery of medication, medical equipment, or medical supply
- Personal Care services/homemaker services
- Respite care
- Services that duplicate another covered Medi-Cal service already being provided to a Member

- Socialization
- Coordinating and assisting with transportation
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license

Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.

2.3 Required CHW Minimum Qualifications:

CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

Supervising Providers (the organizations employing or otherwise overseeing the CHWs, as described below) are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities they are serving. Supervising Providers must maintain evidence of this experience and are required to submit related documentation to Molina upon request.

CHWs must demonstrate, and Supervising Providers must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the Supervising Provider:

2.4 Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:

CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services.

Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang

intervention training from the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

CHWs must complete a minimum of six hours of additional relevant training annually. The Supervising Provider must maintain evidence of this training and submit to Molina upon request. Supervising Providers may provide and/or require additional training, as identified by the Supervising Provider.

2.5 Supervising Provider Qualifications

A Supervising Provider is the organization employing or otherwise overseeing the CHW. The Supervising Provider ensures that CHWs meet the qualifications listed in this contract and in accordance with the current DHCS CHW Services APL (referenced below). The Supervising Provider must be a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO) and must be able to:

- Demonstrate sufficient experience providing similar services within the service area;
- Submit claims or invoices using standardized protocols;
- Hold and maintain business licensing that meets industry standards;
- Comply with all reporting and oversight requirements;

Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.

Supervising Providers must provide direct or indirect oversight to CHWs. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

Supervising Providers and any Subcontractors must verify that CHWs have adequate supervision and training, and provide evidence of compliance with this requirement to Molina upon request.

2.6 Audits and Reporting

Molina will perform periodic audits on the Provider's CHW program and operations as part of the oversight process and for compliance with DHCS requirements and reporting. Program audits will include, but is not limited to, documentation requirements, the plan of care and evidence of experience/certification/training.

Provider must be able to provide reporting to Molina on CHW services as requested, in a mutually agreed upon format. Molina agrees to provide advance notice to the extent possible when conducting audits and requesting reports for CHW services.

Quarterly reporting from Providers to Molina will consist of the following data elements at minimum: Supervising Provider NPI, Name of the Supervising Provider, CHW NPI (if applicable), Name of the CHW, Full-time equivalent (FTE) for the CHW, number of Molina Members currently assigned to the CHW, estimated number of Members that the CHW can see at caseload capacity (range), demographic information for the CHW including age, race, ethnicity, sexual orientation, gender identity, languages spoken, home zip code, lived experience or specialty (if any).

Provider shall comply with all applicable requirements and guidelines indicated in DHCS All Plan Letter (APL) 22-016, CHW Services Benefit, located at the below link and any future iterations/revisions as such:

[APL 22-016 CHW Services Benefit.pdf](#)

Provider shall comply with all applicable requirements and guidelines indicated in DHCS All Plan Letter (APL) 21-009, Collecting SDoH Data, located at the below link and any future iterations/revisions as such:

[APL 21-009 Collecting SDoH Data.pdf](#)

Provider shall comply with all applicable requirements and guidelines indicated in DHCS Provider Manual, Community Health Worker (CHW) Preventive Services, located in the Inpatient/Outpatient section, under the Home Health Agencies/ Home and Community-Based Services listing and at the below link and any future iterations/revisions as such:

[Medi-Cal Provider Manual: CHW Preventive Services.pdf](#)

ATTACHMENT A

Products

This Attachment A lists the Products in which Provider will participate, as well as whether Provider is delegated to provide Capitated Services for each Product.

1. **Medicaid** – including Medi-Cal Geographic Managed Care, Medi-Cal Two Plan, and any other Medicaid programs Health Plan offers in the future.
 - Provider is delegated for Medicaid Assigned Members.

As provided in Section 5.2, Provider may terminate a Product listed under this Attachment A without cause after the Initial Term by giving Health Plan at least one hundred and twenty (120) days' prior written notice. If all Products listed in this Attachment A terminate, then the Agreement shall also terminate; provided, however, that if Provider's without cause termination is due to the Parties' inability to agree to rates or other terms related to a specific Product(s), Provider may only terminate the Product(s) listed in this Attachment A that is subject to the disagreement on rates or other contract terms.

The Parties' termination rights are set forth in full in Article Five.

PROVIDER ACKNOWLEDGEMENT:

Signature

Name



ATTACHMENT B

Compensation Schedule

[Proprietary and Confidential]

- 1.1 **Compensation for Medicaid.** With the exception of Capitated Services, Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicaid Product that are determined by Health Plan to be payable pursuant to Laws, Government Program Requirements, and this Agreement and that are submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third-parties and the Member for cost-sharing, including co-payments, deductibles, or co-insurances, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) two hundred percent (200%) of the August 2024 Medi-Cal fee schedule allowable payment rate as set forth by the State ("**Medi-Cal Rate**") or, compensation will be thirty percent (30%) of Provider's billed charges for those Covered Services where there is no -Medi-Cal Rate.

Health Plan will compensate Provider for the following specialist Covered Services provided under the Agreement at [two hundred percent (200%) of the August 2024 Medi-Cal Rate]: [Community Health Worker].

Notwithstanding any other term of the Agreement, compensation will be thirty percent (30%) of Provider's billed charges for those Covered Services where there is no Medi-Cal Rate or Medicare Rate.

Except when otherwise set forth by Laws or Government Program Requirements, Provider agrees that Health Plan will implement updates or revisions to the Medi-Cal and Medicare fee schedules on a prospective basis within sixty (60) days of the effective date of the update or revision from the appropriate governmental agency. The update or revision will be applied to all Claims received after the implementation date.

ATTACHMENT C

State Laws

Knox-Keene Act and other California Requirements

This attachment sets forth Laws or other provisions necessary to reflect compliance with State Laws. This attachment will be automatically modified to conform to subsequent changes to Laws. All provisions of the Agreement not specifically modified by this attachment remain unchanged. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Any purported modification or any provision in this attachment that is inconsistent with Laws will not be effective and will be interpreted in a manner that is consistent with the Laws. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the MMP Product to the extent such Products are preempted by federal law.

- 1.1 **Timely Access to Services.** Covered Services shall be provided in a timely manner appropriate for the Member's condition that complies with the requirements of Title 28, California Code of Regulations ("CCR"), § 1300.67.2.2 and in a manner that provides continuity of care, including the availability of primary care providers who will be responsible for coordinating the provision of health care services for each Member. When it is necessary for a Member or provider to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice, and State Laws. Provider shall ensure that its hours of operation and provision for after-hour services will be reasonable. To the extent Provider has any role in rendering Emergency Services, Provider will provide or arrange for the provision of emergency health care services twenty-four (24) hours a day, seven (7) days a week. Provider shall provide reporting required by Health Plan and the California Department of Managed Health Care ("DMHC") necessary to ensure compliance with DMHC accessibility and network adequacy standards. Provider will comply with Health Plan's system for monitoring and evaluating accessibility of care, including its system for addressing problems that develop, which shall include waiting times and appointments. [Health & Safety Code ("HSC") §§ 1367, 1367.035; 28 CCR §§ 1300.67.2(b), (c), and (f), 1300.67.2.2(c)]
- 1.2 **Coordination of Member Care.** Provider is responsible for coordinating the provision of health care services to a Member if Provider is acting as the Member's primary care physician. Provider shall maintain Member medical records in a readily available manner that permits sharing within Health Plan of all pertinent information relating to the health care of Members. [28 CCR § 1300.67.1(a), (c)]
- 1.3 **Provider Directory Information.** Provider shall inform Health Plan within five (5) business days of material changes that would affect its or its providers' listing in Health Plan's provider directory, so that Health Plan can comply with HSC § 1367.27. Material changes include, but are not limited to:
 - a. The addition or deletion of an individual provider from Provider's group of providers.
 - b. A change in a Provider or individual provider's name, practice location, contact information, practice type or specialty, board certification, NPI number, license number and type, or office email address.
 - c. Whether Provider or its individual providers are or are not accepting new patients.

If Provider or one of its individual providers is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Provider shall direct the Member or potential Member to both Health Plan for additional assistance in finding a provider and to DMHC to report any inaccuracy with Health Plan's directories.

Provider shall provide to the Health Plan any information necessary for the Health Plan to comply with State Laws. If Provider does not comply with this provision or demonstrates a pattern of repeated failure, Health Plan may terminate the Agreement. [HSC § 1367.27]

- 1.4 **Notices to Members of Termination or Block Transfer.** Provider shall cooperate and assist Health Plan in fulfilling Health Plan's obligations under 28 CCR § 1300.67.1.3 regarding block transfer filings with the DMHC. Any written communications to Members that concern a termination of this Agreement or block transfer shall comply with the notification requirements in HSC § 1373.65(f). Health Plan shall be responsible for all notifications to Members as may be required for block transfers. [HSC § 1373.65]
- 1.5 **Continuation of Care after Termination for Certain Conditions.** If the Agreement is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, fraud, or other criminal activity, Provider will, at the request of the Member and Health Plan, continue to provide Covered Services to Members with certain medical conditions as described in and pursuant to the HSC § 1373.96, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Members with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation. Reimbursement for such services will be at the applicable rates listed in the Compensation Schedule in Attachment B. Upon termination of the Agreement, Health Plan is liable for the Covered Services rendered by Provider (other than any permissible co-payments, coinsurance, or deductibles, as set forth in the Member's evidence of coverage) to a Member who retains eligibility under the applicable evidence of coverage or by operation of law and who is under Provider's care at the time of termination of the Agreement until the Covered Services the Provider is rendering to the Member are completed or until Health Plan makes reasonable and medically appropriate provisions for the assumption of such services by another Participating Provider. [HSC §§ 1373.95, 1373.96; 28 CCR §§ 1300.67.4(a)(10), 1300.67.8(e)]
- 1.6 **Quality Assurance Program.** Health Plan will be responsible for maintaining a quality assurance program in compliance with 28 CCR §§ 1300.67.2.2(d) and 1300.70. Provider will assist Health Plan in maintaining Health Plan's quality assurance program, as applicable, and consistent with Health Plan's quality assurance program policies and procedures. 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 and so that Health Plan may comply with Laws. [28 CCR §§ 1300.51(d)J, K.2, 1300.67.2.2.(d), 1300.70]
- 1.7 **No Inducement to Deny Covered Services.** Provider acknowledges and agrees that this Agreement does *not* (i) contain any incentive or make any payment that acts directly or indirectly as an inducement to deny, reduce, limit, or delay Medically Necessary health care services, or (ii) provide monetary or other incentives to Provider to induce Provider to provide care to a Member in a manner inconsistent with coverage requirements. Provider shall ensure that its contracts with individual providers similarly comply with this Section 1.7. [HSC §§ 1348.6, 1367.2(a)(3)]
- 1.8 **Appeals and Grievances of Members.** Health Plan will be responsible for resolving Member appeals and grievances pursuant to HSC § 1368 and 28 CCR § 1300.68. Health Plan's process to resolve provider grievances are set forth in the Agreement and the Provider Manual. Provider will maintain grievance forms and a description of the grievance procedure at their facilities and will provide grievance forms to Members promptly upon request. Provider shall assist and cooperate with Health Plan in responding to Member grievances and requests for independent medical reviews consistent with Health Plan's policies and procedures, including as set forth in the

Provider Manual. [HSC § 1368; 28 CCR §§ 1300.51(d)K.2, 1300.68(a) and (b)]

- 1.9 **Language Assistance Program Standards.** Provider shall comply with the language assistance standards promulgated by the DMHC and with Health Plan’s language assistance program and shall cooperate with the Health Plan in providing any information necessary to assess compliance. [HSC § 1367.04(f); 28 CCR § 1300.67.04]
- 1.10 **No Balance Billing.** Except for applicable co-payments, co-insurance, and deductibles, Provider will not invoice or balance bill any Member for the difference between the Provider’s billed charges and the reimbursement paid by Health Plan or its capitated provider for any Covered Service. In addition, in the event Health Plan or its capitated provider fails to pay for Covered Services, Members will not be liable to Provider for any sums owed by Health Plan or its capitated provider. [HSC §§ 1379(a) and(b), 1371.9; 28 CCR §§ 1300.51(d)K.2, 1300.71(g)(4)]
- 1.11 **No Surcharges.** Neither Provider nor Provider’s agent, trustee, or assignee shall impose or collect a surcharge from a Member for services provided to the Member pursuant to the Agreement, nor shall Provider nor Provider’s agent, trustee or assignee maintain any action at law against a Member to collect sums owed by Health Plan to Provider for services provided to the Member pursuant to the Agreement. In its agreements with individual providers, Provider shall prohibit individual providers from imposing or collecting a surcharge from a Member for services provided to the Member pursuant to the agreement with Provider and prohibit the individual provider from maintaining any action at law against a Member to collect sums owed by Provider to individual provider for services provided to the Member pursuant to the agreement with Provider. Upon notice of any such action or upon notice that Provider or any individual provider has imposed surcharges for Covered Services, Health Plan will take appropriate action. As used in this attachment, the term “**surcharges**” means an additional fee that is charged to a Member for a Covered Service, but which is not approved by the Director of the DMHC (“**Director**”), provided for in the evidence of coverage. [HSC § 1379(c); 28 CCR §§ 1300.51(d)K.2, 1300.67.8(d)]
- 1.12 **Reporting or Surcharges and Cost-Sharing.** Provider will report to Health Plan in writing all surcharges, deductibles, co-payments, and co-insurance amounts paid by Members directly to Provider. [HSC § 1385; 28 CCR §§ 1300.51(d)K.2., 1300.67.8(d)]
- 1.13 **Third Party Recoveries.** Provider shall cooperate with Health Plan in identifying and providing information necessary to collect from insurers or other third parties who may be liable for injuries caused to a Member. Any recovery or assertion of a lien by Provider from such insurers or third parties shall be conducted subject to Civil Code § 3040 and other Laws.
- 1.14 **Claims Payment.** Health Plan or its capitated provider will pay claims in accordance with HSC § 1371 *et seq.* and 28 CCR § 1300.71. 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 Laws or provided by government sponsored program requirements, any Claims that are not submitted by Provider 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 shall not be eligible for payment, and Provider hereby waives any right to payment therefore. [HSC § 1371 *et seq.*; 28 CCR § 1300.71]
- 1.15 **Good Cause for Late Filing.** 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 and the demonstration of good cause for the delay, accept and adjudicate the Claim according to HSC §§ 1371, 1371.35, and 1300.67.8, whichever is applicable, and the CCR. [28 CCR §1300.71(b)(4)]

- 1.16 **Authorization of Health Plan’s Right to Offset any Uncontested Notice of Overpayment.** In the event of an Overpayment and prior to any adjustment Health Plan makes in future payments to Provider, Health Plan shall furnish Provider with a separate written notice of the Overpayment that clearly identifies the overpaid amount, claim, Member’s name, and dates of service and explains the basis of Health Plan’s request for reimbursement of the Overpayment, including interest and penalties on the claim. If Provider intends to contest Health Plan’s notice, Provider must send written notice of Provider’s intent to contest within thirty (30) business days of Provider’s receipt of Health Plan’s notice. If Health Plan does not receive a notice of intent to contest notice of the Overpayment or the requested reimbursement from Provider within the above timeframes, Provider authorizes Health Plan to offset or recoup the requested reimbursement amount from Health Plan’s payments to Provider for current or future claim submissions. [28 CCR § 1300.71(d)]
- 1.17 **Provider Dispute Resolution.** Health Plan shall establish and maintain a provider dispute resolution process to process and resolve any Provider disputes, and that process shall comply with 28 CCR § 1300.71.38 and the statutes and regulations referenced therein. Provider may obtain specific information regarding Health Plan’s provider dispute resolution process in the Health Plan policies. Provider has a right to access the Health Plan’s provider dispute resolution process. Health Plan will inform Provider of any changes to Health Plan’s provider dispute resolution procedures, including any changes to those procedures. Provider will receive the rights listed in HSC § 1375.7, as amended, if Health Plan makes any changes to the provider dispute resolution process. Provider may utilize Health Plan’s provider dispute resolution process or obtain information about the process by writing the Provider Dispute Resolution Department, P.O. Box 22722, Long Beach, CA 90801 or calling: (855) 322-4075. The Health Plan’s provider dispute resolution process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code § 809.1, *et seq.* Please see the Provider Manual for current information regarding Health Plan’s provider dispute resolution process, including additional ways to submit disputes. [HSC § 1367(h) (1) and (2); 28 CCR § 1300.71.38]
- 1.18 **Member Confidentiality.** Provider will not disclose medical information regarding a Member unless such disclosure complies with the requirements of the CMIA, including California Civil Code §§56.10, 56.104, and 56.107. Provider shall prohibit individual providers from disclosing medical information regarding a Member unless such disclosure complies with the CMIA. [HSC § 1348; 28 C.C.R. §§ 1300.51(d) K.2., 1300.67.8(a)]
- 1.19 **Maintenance and Access to Records.** This Agreement will be construed and interpreted in a manner that permits confidential treatment by the Director of payment rendered or to be rendered to Provider. Provider will prepare and maintain such records and provide such information to Health Plan or to the Director as may be necessary for Health Plan’s compliance with the provisions of the Knox-Keene Act and the rules thereunder. Such records must be maintained for at least five (5) years, except that if other regulatory requirements require a longer retention period, that longer period will apply. To the extent feasible, all such records shall be located in the State. This obligation is not terminated upon a termination of the Agreement, whether by rescission or otherwise. In addition, Provider will permit Health Plan to readily access at reasonable times, upon demand, Provider’s books, records, and documents relating to the Covered Services provided to Members, to the cost thereof, to payments Provider received from Members (or from others on their behalf) for such services unless the provider is compensated on a fee-for-service basis, and to the financial condition of Provider. Provider and its Subcontractor(s) providing health care or other services to Health Plan shall not remove books and records from this State without the prior consent of the Director. [HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.51(d)K.2, 1300.67.1(d), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

1.20 **Amendments.**

- a. This section applies to non-institutional Providers providing Covered Services under the Medi-Cal or Healthy Families Program when Provider is compensated on a fee-for-service basis under this Agreement. Health Plan may materially amend this Agreement upon providing a minimum of ninety (90) business days' notice to Provider of its intent to change a material term of this Agreement. Provider has the right to negotiate and agree to the change within thirty (30) business days ("**Meet and Confer Period**") of Provider's receipt of the notice of the proposed material change. Provider may terminate this Agreement within the ninety (90) business day period from the date of Provider's receipt of the notice if Provider does not exercise the right to negotiate the change or no agreement is reached within the Meet and Confer Period. The material change will otherwise become effective ninety (90) business days from the date of Provider's receipt of the notice if Provider does not exercise the right to negotiate the change within the Meet and Confer Period or to terminate the Agreement within the ninety (90)-business day period.
 - b. The Provider Manual may be unilaterally amended or modified by Health Plan to maintain consistency or compliance with any Laws, policies, directives, Government Program Requirements, or requirements of an accreditation organization 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. If Provider does not deliver a written disapproval to such amendment or modification within the forty-five (45)-day period, the amendment or modification will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the forty-five (45)-day period, the Parties agree to meet and confer in good faith to determine if a revised amendment or modification can be accepted by and binding upon the Parties. If the Parties cannot agree, Provider has the right to terminate this Agreement prior to the effective date of the amendment or modification. [HSC § 1375.7]
- 1.21 **Compliance with Laws.** Health Plan is subject to the Chapter 2.2 of Division 2 of HSC and Chapter 2 of Title 28 of the CCR. Any provision of the aforementioned statutes or regulations that is required to be in this Agreement shall bind the Parties whether or not expressly set forth in this Agreement.
- 1.22 **Quality and Utilization.** Health Plan will disclose to Provider the Health Plan's QI or UM Programs and procedures at least fifteen (15) business days prior to Provider executing this Agreement. A change to the QI or UM Programs or procedures shall be made pursuant to Section 1.20 of this Attachment C. Notwithstanding the foregoing, Health Plan may make a change to the QI or UM Programs or procedures at any time if the change is necessary to comply with Laws or any accreditation requirements of a private sector accreditation organization.
- 1.23 **Data Usage.** The provisions of this section will apply only to the extent that Provider, now or in the future, acts as a "**Service Provider**" under the California Consumer Privacy Act ("**CCPA**") (Cal. Civ. Code § 1798.100 *et seq.*, § 1798.140(v) and the regulations promulgated thereunder). Provider warrants and represents that all Personal Information (as defined below) shall not be: (i) retained, used, or disclosed by Provider for any purpose other than for the specific purpose of performing the services specified in the Agreement; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Provider shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Agreement or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140(t)(1). For purposes of this section, "**Personal Information**" has the same meaning as set forth in Cal. Civ. Code § 1798.140(o).
- 1.24 **Health Care Providers' Bill of Rights.** Provider is entitled to all protections afforded to Provider

under the Health Care Providers' Bill of Rights. [HSC § 1375.7]

- 1.25 **Telehealth Services.** If Provider uses telehealth for rendering Covered Services, Provider shall obtain and document Member consent prior to providing telehealth services, as required under Business & Professions Code § 2290.5. As required by HSC § 1374.14, Health Plan shall reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of a Member appropriately delivered through telehealth services on the same basis and to the same extent that Health Plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. Additionally, a Member who is currently receiving specialty telehealth services for a mental or behavioral health condition through a third-party corporate telehealth provider has the option of continuing to receive that service with a contracted individual professional, clinic, or health facility. If Health Plan delegates responsibilities under HSC § 1374.141 to a contracted entity, the delegated entity shall comply with this section and HSC § 1374.141, as applicable, including the records access and sharing requirements. [HSC §§ 1374.14(a)-(b), 1374.141; Business & Professions Code § 2290.5]
- 1.26 **Liabilities.** Health Plan and Provider are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in the Agreement is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part Health Plan or Provider based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. [HSC § 1371.25]
- 1.27 **Reporting.** Provider agrees to submit all reports required under this Agreement or requested by Health Plan or DMHC to comply with Laws in a form acceptable to Health Plan or DMHC, including providing necessary information and reports under HSC § 1367.0061.

ATTACHMENT D

Laws and Government Program Requirements

Medicaid

This attachment sets forth Laws, Government Program Requirements, and other provisions necessary to reflect compliance for the Medicaid Product. This attachment only applies to the Medicaid Product and will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicaid Product. Any purported modification or any provision in this attachment that is inconsistent with Laws or Government Program Requirements will not be effective and will be interpreted in a manner that is consistent with Laws and Government Program Requirements. Provider must remain in compliance with this attachment and ensure its individual providers comply with this attachment. This attachment only applies to the Medicaid Product.

1.1 Definitions.

- a. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunction to any bodily organ or part; (iv) death.
- b. **Emergency Services** mean inpatient and outpatient services furnished by a provider qualified to furnish such services and that are needed to evaluate or stabilize a Member's Emergency Medical Condition.
- c. **Medically Necessary or Medical Necessity** means reasonable and necessary health care services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For Medi-Cal Members who are under the age of twenty-one (21), Medical Necessity shall also include the standards set forth in 22 CCR §§ 51340 and 51340.1.
 - i. For Members receiving Managed Long-Term Services and Supports, Medical Necessity shall be determined in accordance with Exhibit A, Attachment 21, Provision 7, Covered Services, of Health Plan's contract with DHCS to arrange for the provision of services to Medi-Cal Members ("**State Contract**").
 - ii. When determining the Medical Necessity of Covered Services for a Medi-Cal Member under the age of twenty-one (21), Medical Necessity is expanded to include the standards set forth in 42 USC § 1396d(R), and Welfare and Institutions Code § 14132(v).

1.2 **Licensure.** Provider shall furnish to Medi-Cal Members those services that Provider is authorized to provide under this Agreement, consistent with the scope of Provider's license, certification, and/or accreditation, and in accordance with professionally recognized standards.

1.3 **Compliance with Laws.** This Agreement shall be governed by and construed in accordance with all laws, regulations, and contractual obligations governing the State Contract. Provider will comply with all applicable requirements of DHCS, the Medi-Cal Managed Care Program, and all applicable requirements specified in the State Contract, Laws, and Medi-Cal Managed Care Division Policy Letters. (State Contract, Exhibit A, Attachment 6, Provisions 14.B.2 and 14.B.21; 22 CCR §§ 53250(c)(2) and 53867). Accordingly, this Agreement will comply with 42 C.F.R. § 438.230(b)(2); Welfare and Institutions Code § 14200 *et seq.*; and 22 CCR §§ 53900 and 53800 *et seq.* Specifically, Provider shall comply with all monitoring requirements in the State Contract and

assessments, team meetings and case conferences, in accordance with the Model Elements.

- X. Network Partner will ensure that Administrators:
 - A. Support the Team as appropriate;
 - B. Review annual outcome and fidelity measures to assess the status of Program implementation;
 - C. Review capacity and sustainability regularly;
 - D. Take advantage of NFP's ongoing distance learning opportunities related to Administrator education, including online learning and, when practical and appropriate, travel to Nurse-Family Partnership offices for additional training;
 - E. Make best efforts to support the Community Advisory Board ("CAB"), and
 - F. Maintain an ongoing commitment to the professional development and education of Nurse Home Visitors and provide opportunities for additional training, when applicable.

- XI. If a situation arises in which Network Partner has no openings available for Client enrollment and is maintaining a waiting list, while another Network Partner is simultaneously operating in the same geographical location and has openings, then, in accordance with the NFP goal of providing Program Benefits for the maximum number of vulnerable families, Network Partner will cooperate with the other Network Partner and will refer those unenrolled families for enrollment in the Program.

- XII. Network Partner will develop a Community Advisory Board with diverse representation (for example, health, mental health, education, criminal justice, youth, business, social services, faith-based leaders, other prominent community organization leaders) to ensure broad-based community support for Network Partner's implementation of the Program.

- XIII. NFP will periodically assess the extent to which Network Partner is implementing the Program with Fidelity to the Model. When such assessment indicates opportunities for Network Partner to improve its results by strengthening Fidelity to the Model, NFP staff will meet with Network Partner supervision and mutually develop a plan to do so.

any other monitoring requests by DHCS.

- 1.4 **Effective Dates.** This Agreement and its amendments will become effective only as set forth in the State Contract, Exhibit A, Attachment 6, Provision 14.C. Departmental Approval – Non-Federally Qualified HMOs. Except as provided in DHCS Contract Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding federally qualified health centers and rural health clinics, this Agreement shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Agreement, and has failed to approve or disapprove the proposed Agreement within sixty (60) calendar days of receipt. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Health Plan for approval.

Agreement amendments shall be submitted to DHCS for prior approval at least thirty (30) calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes that are neither approved or disapproved by DHCS, shall become effective by operation of law thirty (30) calendar days after DHCS has acknowledged receipt or upon the date specified in the Agreement amendment, whichever is later.

- 1.5 **Emergency Services Delegation.** Responsibility for coverage and payment of Emergency Services has not been delegated to Provider under the Agreement.
- 1.6 **Reports.** Provider agrees to submit all reports required and requested by Health Plan to comply with Laws in a form acceptable to Health Plan.
- 1.7 **Audits.** Provider agrees to 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 the Agreement, available for the purpose of an audit inspection, evaluation, examination or copying, this further includes the Access Requirements and State’s Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 20, Inspection Rights. Inspection rights: (i) by DHCS, CMS, HHS Inspector General, the Comptroller General of the United States, the Department of Justice (“**DOJ**”) bureau of Medi-Cal Fraud, the DMHC and other authorized State agencies, their duly authorized representatives or their designees, including DHCS’s External Quality Review Organization contractor; (ii) at all reasonable times at the Provider’s place of business or at such other mutually agreeable location in California; (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping; (iv) for a term of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later; (v) including all Encounter Data for a period of at least ten (10) years; (vi) if DHCS, CMS, or the HHS Inspector General determines there is reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit Provider at any time; (vii) upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate Provider from participation in the Medi-Cal program, seek recovery of payments made to Provider, impose other sanctions provided under the State Plan, and direct Health Plan to terminate this Agreement due to fraud.
- 1.8 **Subcontractors.** Provider agrees to maintain and make available to DHCS, upon request, copies of all its sub-subcontracts and Provider will ensure that all of its sub-subcontracts are in writing and Provider agrees to:
- a. Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to the contract between Health Plan and DHCS, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the HHS Inspector General, the Comptroller General, DOJ, the DMHC, or their designees; and
 - b. Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever

is later.

- 1.9 **Provider Premises.** If any inspection or evaluation is made of the premises of Provider, Provider shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.
- 1.10 **Transfer.** Provider agrees to assist Health Plan in the transfer of care in the event of: (i) termination of the State Contract for any reason in accordance to the terms of the State Contract; (ii) termination of this Agreement for any reason; or (iii) a sub-subcontract terminates for any reason.
- 1.11 **Amendment and Termination.** Health Plan agrees to notify DHCS if this Agreement is amended or terminated. For the purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.
- 1.12 **Assignment.** Provider agrees that any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the DHCS.
- 1.13 **Hold Harmless.**
 - a. PROVIDER shall indemnify and hold harmless MCP its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of PROVIDER's officers, directors, agents, employees, Providers, and agents acting alone or in collusion with others. PROVIDER also agrees to hold harmless both the State and Members in the event that MCP cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. The terms of this section shall survive the termination of this Agreement.
 - b. MCP shall indemnify and hold harmless PROVIDER its officers, directors, agents, and employees, from and against any and all loss, damage, liability, or expense (including without limitation, reasonable attorney's fees), of any kind arising by reason of the acts or omissions of MCP's officers, directors, agents, employees, providers, and agents acting alone or in collusion with others. The terms of this section shall survive the termination of this Agreement.
- 1.14 **Third-Party Tort Liability.** To the extent permitted by the Medicare programs, as applicable, in the event PROVIDER recovers any amount from a third party, PROVIDER shall notify MCP of any such recovery and shall provide MCP with an accounting of all such sums recovered. In the event MCP has compensated PROVIDER for such Covered Services and PROVIDER has recovered sums from a third party, PROVIDER agrees to pay such recovered sums to MCP up to the amounts that MCP paid to PROVIDER, to the extent that MCP has not recovered such amounts from its own third party recovery efforts. PROVIDER shall pay these amounts to MCP within thirty (30) days of MCP informing PROVIDER of the amounts MCP recovered from its own third party recovery efforts, if any. This section does not obligate, nor does it prohibit, either MCP or PROVIDER to undertake such third party recovery efforts.
- 1.15 **Records Related to DHCS Litigation.** 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: (i) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Such request shall include 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 this Agreement or the State Contract.

- 1.16 **Language Assistance.** Provider shall comply with language assistance standards developed pursuant to HSC § 1367.04. Provider agrees to arrange for the provision of interpreter services for Members at all of Provider's sites.
- 1.17 **Provider Grievances.** Provider has the right to submit a grievance through Health Plan's formal process to resolve provider grievances. Health Plan's process to resolve Provider grievances are set forth in this Agreement and the Provider Manual.
- 1.18 **Quality Assurance/Improvement.** Provider agrees to participate and cooperate in Health Plan's quality assurance and improvement and utilization management activities, including the QI Program and UM Program, as approved by DHCS and/or DMHC.
- 1.19 **Delegated Activities.** If Provider is specifically delegated by Health Plan, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Agreement. Provider agrees to revoke the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or Health Plan determine that Provider has not performed satisfactorily.
- 1.20 **Utilization Data.** To the extent that Provider is responsible for the coordination of care for Members, Health Plan agrees to share with Provider any utilization data that DHCS has provided to Health Plan, and Provider agrees to receive the utilization data provided and use it as the Provider is able for the purpose of Member care coordination.
- 1.21 **Prospective Requirements.** Health Plan will inform Provider of prospective requirements added by DHCS to the State Contract before the requirement becomes effective. Provider agrees to comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by DHCS and to the extent possible.
- 1.22 **Provider Data.** As applicable, Provider will submit to Health Plan complete, accurate, reasonable, and timely provider data needed by Health Plan to meet its provider data reporting requirements to DHCS and its operational requirements. Provider shall submit all provider data to Health Plan in the form, format, and timeframe requested by Health Plan in order to meet reporting requirements to DHCS. Provider will make corrections to provider data as requested by Health Plan. Provider data shall include all data required under the Agreement – including reports and information for Health Plan's provider directory -- that is not Encounter Data.
- 1.23 **Encounter Data.** As applicable, Provider will submit to Health Plan complete, accurate, reasonable, and timely Encounter Data needed by Health Plan in order to meet its Encounter Data reporting requirements to DHCS in compliance with applicable DHCS All Plan Letters (“**APL**”), including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to Health Plan no later than ninety (90) days from the Date of Service in the form and format as designated by Health Plan. Provider will cooperate as requested by Health Plan if corrections to Encounter Data are required for Health Plan to comply with reporting requirements to

DHCS.

- 1.24 **Prohibition of Balance Billing.** Provider will not balance bill a Medi-Cal Member.
- 1.25 **Cultural Competency, Sensitivity, and Diversity Training.** Health Plan shall provide cultural competency, sensitivity, or diversity training to staff, Provider, and Subcontractors at key points of contact. The training shall promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56.
- 1.26 **Cultural/Linguistic Training Programs.** Provider shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by Health Plan and federal and state agencies and provided or made available to Provider with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to Health Plan and federal and state agencies.
- 1.27 **Health Care Providers' Bill of Rights.** Provider is entitled to all protections afforded it under the Health Care Providers' Bill of Rights as set forth in HSC §1375.7.
- 1.28 **Public Record.** Notwithstanding any other term of the Agreement, this Agreement and all information received in accordance with the State Contract will be public record on file with DHCS, except as specially exempted by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specially exempted by Laws. 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 and major creditors holding more than five percent (5%) of the debt of Provider. For that purpose, Provider shall use the Disclosure Form, included as Attachment H to the Agreement. [Welfare and Institutions Code § 14452(a)]
- 1.29 **Disclosure Statement.** Provider shall provide Health Plan with the Medi-Cal Disclosure Statement set forth in 22 CCR Section 51000.35 prior to commencing services under this Agreement.
- 1.30 **Non-Discrimination Clause.**
 - a. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC § 4212). Such notices shall state Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
 - b. Provider will, in all solicitations or advancements for employees placed by or on behalf of

Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

- c. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
 - d. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC § 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. § 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
 - e. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. § 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders
 - f. In the event of Provider's noncompliance with the requirements of the provisions of this section, including subsections (a) through (f), or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and Provider may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. § 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
- 1.31 **Domestic Partners.** Pursuant to HSC § 1261, if Provider is licensed pursuant to HSC § 1250, Provider agrees to 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.
- 1.32 **Independent Obligations to the State of California.** Nothing in this Agreement shall be interpreted in any manner to terminate or diminish Health Plan's independent obligations to the State under one or more of its contracts with the DHCS.
- 1.33 **Lead Screening.** 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, CCR, 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 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 Member's Medical Record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement.

- 1.34 **Claims to Members.** Provider will not submit a Claim or demand, or otherwise collect reimbursement from a Medi-Cal Member or person acting on behalf of the Member for any services provided under this Agreement; provided that collection of a Claim may be made under those circumstances described in 22 CCR Sections 53220, 53222, and 53886.
- 1.35 **No Punitive Action.** Health Plan will not take punitive action against Provider if Provider requests an expedited resolution or supports a Member's appeal. Health Plan will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information the Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 1.36 **Financial Statements.** If Provider is required to file monthly financial statements with the DMHC to monitor Provider's financial viability, Provider shall file an exact copy of the monthly financial statements with DHCS. Provider shall submit monthly financial statements to the DHCS upon request, if deemed necessary, to monitor Provider's financial viability. Information submitted shall be based on current operations. Provider shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.
- 1.37 **Identifying Information.** Provider shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Provider as a result of services performed under this Agreement, except for statistical information not identifying any such person. Provider shall not use such identifying information for any purpose other than carrying out the Provider's obligations under this Agreement. Provider shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person. Provider shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by Health Plan, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager. For purposes of this provision, identity shall include name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.
- 1.38 **Laboratory Testing.** Provider agrees that if any performance under this Agreement that includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto.
- 1.39 **Excluded Services Linkages.** Provider shall cooperate and comply with any applicable policies and procedures developed by Health Plan, and provided or made available to Provider, with respect to required referral and linkage systems for mental health, dental, California Children's Services, family planning, Indian health services, and Department of Public Health Services and any other community health or excluded services in accordance with the requirements of DHCS.

- 1.40 **Performance Standards.** Provider shall comply with all applicable performance standards and applicable policies and procedures as may be required by DMHC or DHCS and are provided or made available to Provider with respect to Medi-Cal Members enrolled with Health Plan.
- 1.41 **Conflict of Interest.** Provider warrants that no part of the total compensation provided for herein shall be paid directly or indirectly to any officer or employee of the State as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to Provider in connection with any services contemplated or performed relative to this Agreement. Provider certifies that no member of or delegate of Congress, the General Accounting Office, HHS, CMS or any other federal agency has or will benefit financially or materially from this Agreement.

ATTACHMENT H

Medi-Cal Disclosure Form

DISCLOSURE FORM

(Welfare and Institutions Code Section 14452 (a))

Name of Subcontractor
Medical Group

The undersigned hereby certifies that the following information regarding (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: _____

Title: **Provider/Owner**