

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



ITEM: 3.26  
(ID # 29639)

**MEETING DATE:**

Tuesday, March 03, 2026

**FROM :** RUHS-PUBLIC HEALTH

**SUBJECT:** RIVERSIDE UNIVERSITY HEALTH SYSTEM – PUBLIC HEALTH: Ratify and Approve the Agreement No. HSARC-26-051 with Inland Empire Health Plan for Lab Routine and Surveillance Services for the Period of Performance period of February 1, 2026, through January 31, 2027. All Districts [\$0]

**RECOMMENDED MOTION:** That the Board of Supervisors:

1. Ratify and approve Agreement No. HSARC-26-051 with Inland Empire Health Plan for Lab Routine and Surveillance Services for the period of performance of February 1, 2026, through January 31, 2027; 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, based on the availability of fiscal funding and as approved to form by County Counsel, to: (a) sign all subsequent amendments that exercise the options of the agreement including modifications of the statement of work that stay within the intent of the Agreement; (b) sign amendments to the compensation provisions that modify the reimbursement models; and (c) sign all certifications, assurances, reports or other related documents required; and
4. Authorize the Director of Public Health, or designee, to be charged with the responsibility of administering and implementing the Lab Routine and Surveillance Services through June 30, 2031, including to: (a) sign and execute future agreements with Inland Empire Health Plan, as approved as to form by County Counsel; and (b) sign future amendments to agreements of motion 4(a) thereto, as approved as to form by County Counsel, that (i) make modifications to the scope of work that stay within the intent of the agreement and (ii) make changes to the reimbursement models.

**ACTION:Policy**

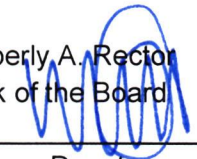
  
Kim Saruwatari, Director of Public Health 2/9/2026

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**MINUTES OF THE BOARD OF SUPERVISORS**

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

Ayes: Medina, Spiegel, Perez, and Gutierrez  
Nays: None  
Absent: Washington  
Date: March 3, 2026  
xc: RUHS-PH

Kimberly A. Rector  
Clerk of the Board  
By:   
Deputy

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

<b>FINANCIAL DATA</b>	<b>Current Fiscal Year:</b>	<b>Next Fiscal Year:</b>	<b>Total Cost:</b>	<b>Ongoing Cost</b>
<b>COST</b>	\$0	\$0	\$0	\$0
<b>NET COUNTY COST</b>	\$0	\$0	\$0	\$0
<b>SOURCE OF FUNDS: N/A</b>			<b>Budget Adjustment: No</b>	
			<b>For Fiscal Year: FY25/26 – 26/27</b>	

**C.E.O. RECOMMENDATION:** Approve

**BACKGROUND:**

**Summary**

The Riverside University Health System – Public Health Laboratory (RUHS-PHL) delivers a range of clinical diagnostic and surveillance testing services to Riverside County agencies, healthcare providers, and community partners. Testing includes infectious disease diagnostics, environmental, emerging pathogen surveillance, and specialized assays not readily available through commercial laboratories. These services play a critical role in supporting epidemiologic investigations, guiding public health interventions, and meeting statewide reporting mandates. Revenue generated through fee-for-service testing helps sustain laboratory operations and offsets Net County Cost (NCC), ensuring the County maintains a strong and responsive public health infrastructure.

**Impact on Residents and Businesses**

RUHS-PHL provides accurate, timely, and cost-effective testing that supports both individual patient care and community-level disease prevention. By maintaining local capacity for advanced testing, the laboratory helps shorten turnaround times, improve clinical decision-making, and enable swift public health response to outbreaks. This reduces the burden of disease on residents and limits operational disruptions for schools, employers, and businesses. Additionally, the availability of specialized public health testing ensures equitable access for underserved populations, enhancing overall community resilience.

**Additional Fiscal Information**

RUHS-PHL pricing is based on federal government reimbursement Medi-Cal or Medicare rates. Alternatively, fees are applied from cost study analysis to reimburse the total cost of test. There will be no county cost for any of these agreements as they are all revenue based.

**Contract History and Price Reasonableness**

This is a new contract.

**ATTACHMENTS:**

**ATTACHMENT A.** HSARC-26-051, Inland Empire Health Plan Agreement

  
Douglas Ordóñez Jr.

  
2/23/2026

  
Gregg Gu, Chief Deputy County Counsel 2/11/2026



**LETTER OF  
AGREEMENT**

This Letter of Agreement (“Agreement”) is made and entered into by and between *Inland Empire Health Plan* (referred to as “IEHP” or “PAYOR”), and **COUNTY OF RIVERSIDE, a political subdivision of the State of California, on behalf of its Riverside University Health System – Public Health Laboratory (“PROVIDER”)** for the provision of medical services to PAYOR’s Members.

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

1. **DUAL ELIGIBLE BENEFICIARY** – shall mean an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c et seq.) and Medicare Part B (42 U.S.C. § 1395j et seq.) and is eligible for medical assistance under the Medi-Cal State Plan.
2. **MEDICARE** - A benefit package that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by IEHP as outlined in Attachment C. Medicare includes the Capitated Financial Alignment Demonstration, also known as the “Duals Pilot Project,” which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and DHCS.
3. PROVIDER shall render medical services as authorized by PAYOR to Member and agrees to accept the Fee Schedule listed in Attachment A. PROVIDER shall not bill, charge or attempt to collect any payments, surcharges or other remuneration, excluding applicable copayments, from Members of HMOs or other such programs as regulated by the Knox-Keene Health Care Service Plan Act of 1975 and the Department of Health Care Services through Title 22 of the California Code of Regulations, as amended.
4. Healthcare services provided by PROVIDER under this Agreement require prior authorization. All authorizations for services are only valid for the individual PROVIDER named in the authorization and should not be considered a “Group Authorization”.
5. PROVIDER shall maintain a uniform medical record in accordance with community standards and in compliance with all applicable federal and state laws, rules and regulations for each Member. Upon request, PROVIDER shall allow IEHP, the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and all other state and federal regulatory agencies to inspect medical records for Member(s) and shall provide copies of all medical records or other medical reports, without charge. Provider shall allow IEHP to access and use PROVIDER’s practitioner performance data.

MAR 03 2026

3.26

Board Approval: 09-08-2025 (IEHP: 25-188)  
WHEN DOCUMENT IS FULLY EXECUTED RETURN

**CLERK'S COPY**

to Riverside County Clerk of the Board, Stop 1010  
Post Office Box 1147, Riverside, Ca 92502-1147  
Thank you.

6. PROVIDER shall prepare and maintain such records, including books, records and papers related to medical services provided to Members, and provide access to such information to IEHP, and other applicable state and federal regulatory agencies as may be necessary to comply with federal and state laws, rules and regulations. This obligation shall survive the termination of this Letter of Agreement for a minimum of ten (10) years.
7. PAYOR shall make payments to PROVIDER in accordance with Attachment A hereto, provided the member is eligible with the PAYOR at the time services are rendered. PROVIDER shall submit claims to PAYOR for authorized covered services provided to Members within one hundred and twenty (120) days from the date of service. The claim must be submitted on a CMS 1500 or a UB-04 claim form and shall include all Member identifying information and the authorization number provided by PAYOR relating to **Laboratory Services** provided pursuant to this Agreement. A full suite of laboratory tests with the associated CPT code offered by PROVIDER can be found in Public Health Laboratory Services | Riverside University Health System (<https://www.ruhealth.org/public-health/laboratory-services>).
8. PAYOR shall compensate PROVIDER within thirty (30) working days of receipt of a complete Claim Form from PROVIDER. Any compensation disputes must be filed within 365 calendar days of payment or denial and shall be handled in accordance with Health and Safety Code § 1371 and 1371.35 et seq.
9. PAYOR and PROVIDER shall abide by any applicable State and Federal laws and regulations including, but not limited to, all provisions found in the Knox-Keene Health Care Service Plan Act of 1975, as amended. Provider agrees to comply with all applicable State and Federal laws and regulations, including without limitation those relating to Medi-Cal and Medicare and all applicable requirements of the DHCS, DMHC and CMS.
10. Throughout the term of this Agreement, PROVIDER shall maintain, at its sole cost and expense, policies for insurance providing coverage for PROVIDER's general liability and professional liability (errors and omissions), and any other insurance coverage PROVIDER deems prudent and customary in the exercise of PROVIDER's business operations, in amounts as may be necessary to protect PROVIDER and its officers, agent, and employees in the discharge of its responsibilities and obligations under this Agreement. Upon request, PROVIDER shall furnish PAYOR with evidence of such insurance coverage.
11. The term of this Letter of Agreement shall become effective as of **February 1, 2026** and shall continue in effect until **January 31, 2027**.
12. Either party may terminate this Agreement without cause by providing the other party thirty (30) working days prior written notice to terminate via Certified Mail.

13. This Agreement shall terminate immediately, upon IEHP's written notice, in the event of the occurrence of any of the following:
- a. Failure to Provide Quality Services – PROVIDER's failure to maintain the standards as provided herein.
  - b. Failure to Render Services – PROVIDER's failure to provide Health Care Services to Members as provided herein.
  - c. Breach of Material Term – PROVIDER's breach of any material term, covenant or condition of the Agreement.
  - d. Licensing – Revocation, suspension, or restriction of PROVIDER's licenses, accreditation or certification required for the performance of the duties hereunder.
  - e. Loss of Insurance Coverage – Failure by PROVIDER to maintain adequate professional liability insurance coverage, as provided herein.
  - f. Fraud – Upon IEHP's determination that PROVIDER has engaged in a fraudulent activity against the Plan or its Members.
14. Any notices required to be given herein by either party to the other shall be effected by certified letter to the appropriate address as follows:

**IEHP**

Inland Empire Health Plan  
P.O. Box 1800  
System Rancho Cucamonga, CA 91729-1800  
(909) 890-2000  
Attn: Director of Provider Contracting

**PROVIDER**

County of Riverside  
DBA Riverside University Health  
Public Health  
4065 County Circle Dr., Suite 403  
Riverside, CA 92503  
Attention: RUHS-PH Contracts Unit

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

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

16. Payment for services rendered will be sent to:

County of Riverside  
DBA Riverside University Health System Public Health  
4065 County Circle Drive, Suite 403  
Riverside, CA 92503

17. The relationship between PAYOR and PROVIDER is an independent contractor relationship. Neither PROVIDER nor its employee(s) and/or agent(s) shall be considered to be an employee(s) and/or agent(s) of PAYOR, and neither PAYOR nor any employee(s) and/or agent(s) of PAYOR shall be considered to be an employee(s) and/or agent(s) of PROVIDER. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control or employment between the parties other than that of independent parties contracting for the purposes of effectuating this Agreement.
18. This Agreement, including all attachments, which are incorporated herein by this reference, constitutes the entire agreement by and between the parties regarding the matters contemplated by this Agreement, and supersedes any and all other agreements, promises, negotiations or representations, either oral or written, between the parties with respect to the subject matter and period governed by this Agreement.
19. No alteration and/or amendment of any terms or conditions of this Agreement shall be binding, unless reduced to writing and signed by the parties hereto. Amendments required due to legislative, regulatory or other legal authority do not require the prior approval of PROVIDER and shall be deemed effective immediately upon PROVIDER's receipt of notice.
20. In the event any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.
21. The provisions of the Government Claims Act (Government Code section 900 et seq.) must be followed first for any disputes arising under this Agreement.
22. This Agreement shall be governed by and construed in accordance with the laws of the State of California. All actions and proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the counties of San Bernardino or Riverside, State of California.
23. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – IEHP PLAN and PROVIDER are subject to all relevant requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, enacted August 21, 1996, the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009 (HITECH), Public Law 111-5, enacted February 17, 2009, and the laws and regulations promulgated subsequent hereto, for purposes of services rendered pursuant to the Agreement. Both parties agree to cooperate in accordance with the terms and intent of this Agreement for implementation of relevant law(s) and/or regulation(s) promulgated under HIPAA and HITECH. Both parties further agree that it shall be in compliance with the requirements of HIPAA, HITECH and the laws and regulations promulgated subsequent hereto.

24. IEHP Health Plan shall provide appropriate services in support of PROVIDER for the medical care of Members, including but not limited to treatments and hospitalizations, case management and quality oversight. PROVIDER may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

IN WITNESS WHEREOF, the parties hereto have entered into this Letter of Agreement as of January 27, 2026.

**PROVIDER:**

By: Karen S. Spiegel  
Karen Spiegel

Title: Board of Supervisors, Chair

Date: MAR 03 2026

TIN#: 95-6000930

Group NPI#: 1952496010

**PAYOR**

By: Mark Bryan  
Mark Bryan

Title: Vice President, Contracting

Date: 3/27/26

**ATTEST:**

Kimberly A. Rector  
Clerk of the Board

By:   
Deputy

**APPROVED AS TO FORM:**

Minh C. Tran  
County Counsel

Esen Sainz  
By: \_\_\_\_\_  
Esen Sainz  
Deputy County Counsel

**ATTACHMENT A**

**COMPENSATION**

**COUNTY OF RIVERSIDE**

**DBA**

**RIVERSIDE UNIVERSITY HEALTH SYSTEM PUBLIC HEALTH**

Reimbursement shall be according to the following fee schedules:

**A. STATE PROGRAMS**

Reimbursement for authorized Health Care Services rendered shall be at One Hundred Percent (100 %) of the most current Medi-Cal rates, as published quarterly by DHCS.

In the event PROVIDER is authorized to provide services that have no established Medi-Cal rate, the following pricing hierarchy shall apply:

1. If Medicare or a fiscal intermediary has an established rate for the service, then 75% of the Medicare rate shall be reimbursed for the service. If no Medicare rate has been established, then;
2. IEHP HEALTH PLAN shall establish a rate based on aggregate historical Plan cost for the applicable service or item. The IEHP HEALTH PLAN established rate shall include reimbursement for delivery and setup, if applicable. The list of services with established rates can be found on the IEHP.org website.

*\*\*In the event Medi-Cal does not have an established rate for a covered code and an established Medicare rate is applied, IEHP shall continue to follow Medi-Cal billing guidelines. This rule applies, but is not limited, to the use of Procedure Code Modifiers.*

**B. MEDICARE**

Reimbursement for authorized Health Care Services rendered shall be at Eighty Percent (80%) of the most current Medicare allowable as listed in the Medicare Physician Fee Schedule, published annually by CMS (centers for Medicare and Medicaid Services).

In the event PROVIDER is authorized to provide services that have no established Medicare rate, the following pricing hierarchy shall apply:

1. When an authorized CPT/HCPCS code is not a valid Medicare code, but a valid Medi-Cal code, the services will be processed under the Medi-Cal benefit plan and IEHP Health Plan will pay one hundred fifty percent (150%) of the Medi-Cal fee schedule. If no Medi-Cal rate has been established, then;
2. IEHP HEALTH PLAN shall establish a rate based on aggregate historical Plan cost for the applicable service or item. The IEHP HEALTH PLAN established rate shall include reimbursement for delivery and setup, if applicable. The list of services with established rates can be found on the IEHP.org website.

*\*\*In the event Medicare does not have an established rate for a covered code and an established Medi-Cal rate is applied, IEHP shall continue to follow Medicare billing guidelines. This rule applies, but is not limited, to the use of Procedure Code Modifiers.*

**ATTACHMENT A**  
(Continued)  
**COMPENSATION**

**COUNTY OF RIVERSIDE**  
**DBA**  
**RIVERSIDE UNIVERSITY HEALTH SYSTEM PUBLIC HEALTH**

**C. COVERED CALIFORNIA**

Reimbursement for authorized Health Care Services rendered shall be at Eighty Percent (80%) of the most current Medicare allowable as listed in the Medicare Physician Fee Schedule, published annually by CMS (centers for Medicare and Medicaid Services).

In the event PROVIDER is authorized to provide services that have no established Medicare rate, the following pricing hierarchy shall apply:

1. When an authorized CPT/HCPCS code is not a valid Medicare code, but a valid Medi-Cal code, the services will be processed under the Medi-Cal benefit plan and IEHP Health Plan will pay one hundred fifty percent (150%) of the Medi-Cal fee schedule. If no Medi-Cal rate has been established, then:
2. IEHP HEALTH PLAN shall establish a rate based on aggregate historical Plan cost for the applicable service or item. The IEHP HEALTH PLAN established rate shall include reimbursement for delivery and setup, if applicable. The list of services with established rates can be found on the IEHP.org website.

*\*\*In the event Medicare does not have an established rate for a covered code and an established Medi-Cal rate is applied, IEHP shall continue to follow Medicare billing guidelines. This rule applies, but is not limited, to the use of Procedure Code Modifiers.*

**D. PHARMACEUTICALS**

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

Reimbursement for miscellaneous pharmaceuticals, (i.e. J3490, J3590, J9999, C9399), will be at Wholesale Acquisition Cost (WAC) + 5% (Published by First Data Bank) and require submission of National Drug Code (NDC) and the quantity.

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

Completed claims for authorized Health Care Services must be sent to:

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

**ATTACHMENT B**

**PARTICIPATING PROVIDERS**

**COUNTY OF RIVERSIDE  
DBA**

**RIVERSIDE UNIVERSITY HEALTH SYSTEM PUBLIC HEALTH**

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

<b>FACILITY NAME</b>	<b>ADDRESS</b>	<b>GROUP NPI</b>	<b>OFFICE HOURS</b>
Riverside University Health System Public Health – Laboratory	4065 County Circle Dr., Suite 106 Riverside, CA 92503	1952496010	8am – 5pm M-F
		<b>Phone/Referral Fax</b>	<b>Type</b>
		Phone: 951- 358-5070 Fax: 951-358-5015	Laboratory

## ATTACHMENT C

### MEDICARE ADVANTAGE PROGRAM

#### COUNTY OF RIVERSIDE DBA RIVERSIDE UNIVERSITY HEALTH SYSTEM PUBLIC HEALTH

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108- 173, 117 Stat. 2066 (“MMA”); and

Except as provided herein, all other provisions of the Agreement between IEHP and PROVIDER not inconsistent herein shall remain in full force and effect. This Attachment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the parties agree as follows:

#### I. DEFINITIONS

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

- 1.1. **Centers for Medicare and Medicaid Services (CMS)** means the agency within the Department of Health and Human Services that administers the Medicare program.
- 1.2. **CMS Agreement** means the Medicare Advantage contract between CMS and the MAO.
- 1.3. **Completion of Audit** means the completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.
- 1.4. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- 1.5. **Dual Eligible Beneficiary** means an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c *et seq.*) and Medicare Part B (42 U.S.C. § 1395j *et seq.*) and is eligible for medical assistance under the Medi-Cal State Plan.
- 1.6. **End Stage Renal Disease (ESRD)** means members who require kidney dialysis for the remainder of life.
- 1.7. **Final Contract Period** means the final term of the contract between CMS and the Medicare Advantage Organization.

- 1.8. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.
- 1.9. **Medicare Advantage (MA)** means an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.
- 1.10. **Medicare Advantage Organization (MA Organization or MAO)** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.
- 1.11. **Member or Enrollee** means a Medicare Advantage eligible individual who has enrolled in or elected coverage through a MAO.
- 1.12. **Provider** means (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.
- 1.13. **Related Entity** means any entity that is related to the MA Organization by common ownership or control and (1) performs some of the MA Organization's management functions under contract or delegation; (2) furnishes services to Medicare Enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA Organization at a cost of more than \$2,500 during a contract period.

## II. ACCESS: RECORDS AND FACILITIES

Provider agrees:

- 2.1. To give the Department of Health and Human Services (HHS), Department of Justice (DOJ), Department of Managed Health Care (DMHC), DHCS, CMS and the Comptroller General or their designees the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier, Downstream, and Related Entities to the CMS Agreement through ten (10) years from the final date of the Final Contract Period or from any Completion of Audit, whichever is later. [422.504(i)(2)(ii) and (iv)]
- 2.2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 2.1 of this Attachment directly from any First Tier, Downstream, or Related Entity. For records subject to review under Section 2.1, except in exceptional circumstances, CMS will provide notification to the MA Organization that a direct request for information has been initiated. [42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)]
- 2.3. To safeguard the privacy and confidentiality of any information that identifies a particular Member, and abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. [422.118(a)]
- 2.4. To maintain the records and information of Members in an accurate and timely manner. [422.118(c)]

- 2.5. To ensure that medical information pertaining to Members is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas. [422.118(b)]
- 2.6. To comply with MAO's standards for timeliness for appointments and waiting times for each type of service. [422.112(a)(6)(i)]
- 2.7. To ensure timely access by Members to the records and information that pertain to them. [422.118(d)]

### **III. ACCESS: BENEFITS AND COVERAGE**

Provider agrees:

- 3.1. To not discriminate based on health status. [422.110(a)]
- 3.2. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for emergency and urgently needed services consistent with federal regulations, if such services are MAO's liability. [422.100(b)]
- 3.3. Unless otherwise addressed within the Agreement or its attachments, MAO is required to pay for renal dialysis services for Members temporarily outside the service area consistent with federal regulations, if such services are MAO's liability. [422.100(b)(1)(iv)]
- 3.4. To direct access to mammography screening and influenza vaccinations. [422.100(g)(1)]
- 3.5. To not collect any co-payment or other cost sharing for influenza vaccine and pneumococcal vaccines. [422.100(g)(2)]
- 3.6. To direct access to in-network women's health provider for women for routine and preventative services. [422.112(a)(3)]
- 3.7. To have approved procedures to identify access and establish a treatment plan for Members with complex or serious medical conditions. [422.112(a)]
- 3.8. To provide access to benefits in a manner described by CMS. [422.112(a)(8)]
- 3.9. To maintain procedures to ensure that Members are informed of specific health care needs that require follow-up and receive, as deemed medically necessary by Provider, training in self-care and other measures that Members may take to promote their own health. [422.112(b)(5)]

### **IV. MEMBER PROTECTIONS**

Provider agrees:

- 4.1. To work with the MAO regarding conducting a health assessment of all new Members within ninety (90) days of the effective date of enrollment. [422.112(b)(4)]
- 4.2. To provide all covered benefits in a manner consistent with professionally recognized standards of health care. [422.504(a)(3)(iii)]
- 4.3. To comply with all confidentiality and Member record accuracy requirements. [422.504(a)(13); 422.118]
- 4.4. To document in a prominent place in the medical record whether or not an individual has executed an advance directive. [422.128(b)(1)(ii)(E)]

- 4.5. To hold harmless and protect Members from incurring financial liabilities that are the legal obligation of the MAO or capitated provider organization. In no event, including but not limited to, nonpayment or breach of an agreement by the MAO, First Tier Entity, or intermediary, shall Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided.  
This provision does not prohibit collection of applicable coinsurance, deductibles, or copayments, as specified in the Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered. [422.504(g)(1)(i); 422.504(i)(3)(i)]
- 4.6. That Members eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. MAO or Provider may not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will accept the MAO payment as payment in full or bill the appropriate State source. [422.504(i)(3)(i) and 422.504(g)(1)(iii)]
- 4.7. If the CMS Agreement is terminated or is not renewed or the MAO becomes insolvent, to protect Members who are hospitalized from loss of health care benefits through the discharge date and through the period of time CMS premiums are paid. [422.504(g)(2) and (3)]
- 4.8. To provide for continuation of health care benefits for all Members for the duration of the contract period for which CMS premiums have been paid. [422.504(g)(2) and (3)]
- 4.9. To ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [422.112(a)(8)]
- 4.10. To address the special needs of Members who are members of specific ethnic and cultural populations such as, but not limited to, the Vietnamese and Latino populations. Provider shall in its policies, administration, and services practice the values of: (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive environment where difference are valued, respected and managed; (d) through cultural diversity training, foster in staff and/or providers' attitudes and interpersonal communication styles which respect Member's cultural backgrounds; and (e) referring members to culturally and linguistically appropriate community services program. In addition, Provider shall provide translation of written materials in the languages served. Written materials to be translated include, but are not limited to, signage, the member service guide, enrollee information, notices, marketing information and welcome packages. [422.112(a)(8)]
- 4.11. To educate Members regarding their health needs; share findings of the Member's medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms; recognize that the Member has the final say in the course of action to take among clinically acceptable choices.
- 4.12. To not encourage disenrollment of a Member because of the onslaught of ESRD. [422.110(b)]

## V. DELEGATION

Provider agrees:

- 5.1. To perform and maintain services or activities under the Agreement, including delegated functions, consistent and compliant with MAO's contractual obligations under the CMS Agreement. [422.504(i)(3)(iii)] If any of the MAO's activities or responsibilities under the CMS Agreement are delegated to Provider, such delegated activities and reporting responsibilities shall be specified on a delegation agreement, which shall be an attachment to the Agreement.
- 5.2. That MAO may only delegate activities or functions to a Provider, related entity, contractor or subcontractor in a manner consistent with the requirements set forth in 42 CFR § 422.504(i)(4)(i). [422.504(i)(3)(ii)]
- 5.3. To comply with MAO's policies and procedures as set forth in the Medicare Advantage Participating Provider Operations Manual, including, without limitation, provisions that require a written arrangement to: (i) specify delegated activities and reporting responsibilities; (ii) provide for revocation of the delegated activities and reporting requirements or specify other remedies in instances where CMS or MAO determines that Provider and/or delegated parties have not performed satisfactorily; (iii) specify that the performance of Provider and/or delegated parties shall be monitored by MAO on an ongoing basis and formally reviewed by the MAO at least annually; (iv) specify that the credentials of medical professionals affiliated with Provider and/or delegated parties will be either reviewed by MAO or the credentialing process will be reviewed and approved by MAO and MAO shall audit the credentialing process on an ongoing basis; and (v) specify that Provider and/or delegated parties, in the performance of such delegated activities, shall comply with all applicable Medicare laws, regulations, and CMS instructions. [422.504(i)(4)]
- 5.4. That if MAO delegates selection of providers, contractors, or subcontractors to Provider or another organization, MAO retains the right to approve, suspend, or terminate any such arrangement. [422.504(i)(5)]

## VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

- 6.1. To include, when applicable, specific payment and incentive arrangements in agreement with all Downstream Entities. [422.208]
- 6.2. That Members health services are being paid for with Federal funds, and as such, payments for such services are subject to laws applicable to individuals or entities receiving Federal funds.

MAO agrees:

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

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

## **VII. REPORTING AND DISCLOSURE**

Provider agrees:

- 7.1. To submit to MAO all data, including medical records, necessary to characterize the content and purpose of each encounter with Member. [422.310(b)]
- 7.2. To submit and certify the accuracy, completeness and truthfulness of all encounter data. [422.504(a)(8); 422.504(1)]
- 7.3. To adhere to and comply with all reporting requirements as set forth in 42 C.F.R. 422.516 and the requirements in 42 C.F.R. 422.310. [422.504(a)(8)]
- 7.4. To submit, as required by CMS, a complete and accurate risk adjustment data, and a sample of the medical records for validation of risk adjustment data. [422.310(d)(3), (4); 422.310(e)]

## **VIII. QUALITY ASSURANCE / QUALITY IMPROVEMENT**

Provider agrees:

- 8.1. To cooperate with an independent quality review and improvement organization's activities pertaining to provision of services for Members. [422.152(a)]
- 8.2. To comply with MAO's medical policy, Quality Assurance program, and Medical Management program. [422.152; 422.202(b); 422.504(a)(5)]

## **IX. COMPLIANCE**

Provider agrees:

- 9.1. That the MAO or First Tier Entity must notify any Provider, in writing, of the reason(s) for denial, suspension or termination determinations that affect health care professionals, the right to appeal the action, and the process and timing for requesting a hearing. [422.202(d)(1)]
- 9.2. That MAO and First Tier Entity must provide at least 60 days written notice to each other before terminating the contract without cause. [422.202(d)(4)]
- 9.3. With respect to Downstream Entities, to provide both the First Tier Entity and the MAO at least 60 days written notice before terminating a contract without cause. [422.202(d)(4)]
- 9.4. To comply with HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164, and Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act and the anti-kickback statute. [422.504(h)]

- 9.5. To meet the requirements of all other laws and regulation, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds.
- 9.6. To comply with (and require that all Downstream Entities comply with) all applicable MAO procedures and MAO's Medicare Advantage Participating Provider Operations Manual including, but not limited to, the accountability provisions. [422.504(i)(3)(ii)]
- 9.7. To comply with (and require that all Downstream Entities comply with) applicable state and Federal laws and regulations, including Medicare laws and regulations and CMS instructions. [422.504(i)(4)(v)]
- 9.8. To not employ or contract with (and require that all Downstream Entities not employ or contract with) individuals excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act. [422.752(a)(8)]
- 9.9. To adhere to Medicare's appeals, expedited appeals and expedited review procedures for Members, including gathering and forwarding information on appeals to MAO, as necessary. [422.562(a)]
- 9.10. To adhere to Medicare's grievance and expedited grievance procedures for Members, including gathering and forwarding information to MAO, as necessary. [422.562(a); 422.564]
- 9.11. To adhere to all guidelines and requirements for marketing as set forth by CMS. This includes, but is not limited to, discouraging Providers from [42 CFR 422.2268; 423.2268]:
  - 9.11.1 Attempting to explain MAO membership and costs;
  - 9.11.2 Being the exclusive source of membership information;
  - 9.11.3 Acting as agents of the MAO;
  - 9.11.4 Acting outside their role as medical providers of care;
  - 9.11.5 Discriminating in favor of "healthy" patients.
- 9.12. Providers may do the following:
  - 9.12.1. Display plan-marketing materials for all plans with which the Provider participates, or display materials for those plans that provide them;
  - 9.12.2. In compliance with Medicare marketing guidance and regulations, cooperatively advertise and market with MAO.

## **X. ADOPTION OF MEDICARE CONTRACT REQUIREMENTS**

Provider agrees:

- 10.1. That all contracts must be signed and dated.
- 10.2. To serve Members during the term of this Agreement.
- 10.3. To comply with the regulatory requirements and MAO's guidelines promulgated by Medicare, which are more fully documented in MAO's policies, procedures, and manuals. [422.202(b)]
- 10.4. To comply with Medicare laws, regulations and CMS instructions which are more fully documented in MAO's policies, procedures and manuals. [422.504(i)(4)(v)]
- 10.5. That any services or other activities performed by Provider in accordance with a contract between MAO and Provider are consistent and comply with MAO's obligations under the CMS Agreement. [422.504(i)(3)(iii)]

## XI. INTERPRETATION OF ATTACHMENT

Provider and MAO agree:

- 11.1. Except as provided in this Attachment, all other provisions of the Agreement between MAO and First Tier Entity not inconsistent herein shall remain in full force and effect.
- 11.2. This Attachment shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall terminate upon the termination of such Agreement.
- 11.3. For purposes of Medicare Members, the provisions of this Attachment and Federal Law shall prevail.

**ATTACHMENT D**

**COVERED CALIFORNIA PROGRAM REQUIREMENTS**

**COUNTY OF RIVERSIDE**

**DBA**

**RIVERSIDE UNIVERSITY HEALTH SYSTEM PUBLIC HEALTH**

To the extent that (i) IEHP offers any IEHP Programs under Covered California and (ii) PROVIDER is a Participating Provider in that program under this Contract, the additional terms in this Addendum I shall apply to PROVIDER and to any Subcontract under which PROVIDER and its Subcontractors render services to Members enrolled in Covered California. PROVIDER also shall comply with all applicable provisions of the Patient Protection and Affordable Care Act (and the regulations promulgated thereunder) and IEHP's Qualified Health Plan Issuer contract with Covered California ("QHP Contract").<sup>1</sup> IEHP is referred to as "Contractor" under the QHP Contract.

**I. Covered California Requirements**

1. PROVIDER agrees to comply, and to require its Subcontractors to comply, with the requirements applicable to subcontractors of IEHP under the QHP Contract and incorporate such applicable requirements in PROVIDER's contract with its Subcontractors, including but not limited to the provisions under §4.4.1(d) of the QHP Contract. [QHP Contract §1.3(b) and §4.4.1(c)]
2. All Covered Services must be provided by duly licensed, certified, or accredited Providers consistent with the scope of their license, certification, or accreditation and in accordance with the applicable laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in the QHP Contract. [QHP Contract § 4.4.1(a)]
3. PROVIDER agrees to be bound, and to bind each of its Subcontractors, by all provisions of the QHP Contract that are applicable to the Covered Services that PROVIDER and its Subcontractors provide under the Contract [QHP Contract § 4.4.1(d)], including but not limited to:
  - a. Coordination with Covered California and other programs and stakeholders.
  - b. Relationship of the parties as independent contractors [QHP Contract § 1.3(a)] and IEHP's exclusive responsibility for obligations under the QHP Contract [QHP Contract § 1.3(b)].
  - c. Participating Provider directory requirements [QHP Contract § 4.4.4].
  - d. Symphony Provider directory requirements [QHP Contract § 4.4.5].
  - e. Implementation of processes to enhance stability and minimize disruption to Provider network [QHP Contract § 4.3.5].

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<sup>1</sup> The model QHP Contract, which may be subsequently amended, is currently available at <https://www.hbex.ca.gov/insurance-companies/>.

- f. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits [QHP Contract § 4.4.3].
  - g. Provider credentialing, including maintenance of licensure and insurance [QHP Contract § 4.4.2].
  - h. Customer service standards [QHP Contract § 4.6].
  - i. Utilization review and appeal processes [QHP Contract § 5.3].
  - j. Maintenance of a corporate compliance program [QHP Contract § 1.2].
  - k. Enrollment and eligibility determinations and collection practices [QHP Contract Article 2].
  - l. Appeals and Grievances [QHP Contract §4.6.2].
  - m. Member and marketing materials [QHP Contract §2.4].
  - n. Disclosure of information required by Covered California, including financial and clinical [QHP Contract § 1.13], Quality, Network Management and Delivery System Standards [QHP Contract Article 5], and other data, books, and records [QHP Contract Article 11].
  - o. Nondiscrimination [QHP Contract § 1.11].
  - p. Conflict of interest and integrity [QHP Contract § 1.12].
  - q. Other laws [QHP Contract § 1.14].
  - r. Quality, network management and delivery system standards to the extent applicable to Participating Providers [QHP Contract Article 5], including disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 1 (“Advancing Equity, Quality, and Value”) to the QHP Contract.
  - s. Performance measures, to the extent applicable to Participating Providers [QHP Contract Article 7].
  - t. Continuity of care, coordination, and cooperation upon termination of the QHP Contract and transition of Members [QHP Contract § 4.3.5 and Article 8].
  - u. Security and privacy requirements, including compliance with HIPAA [QHP Contract Article 10].
  - v. Maintenance of books and records [QHP Contract Article 111].
4. PROVIDER agrees to comply with all applicable federal, State, and local laws, rules, and regulations [QHP Contract §§ 4.4.1(b), 4.4.1(d)(x) & (xvii), 1.14, 1.2(c)], including without limitation:
- a. The federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), known collectively as the Affordable Care Act.
  - b. The California Patient Protection and Affordable Care Act, AB 1602 and SB 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010).
  - c. The Americans with Disabilities Act of 1990 (42 U.S.C. §§ 12101 *et seq.*).
  - d. The Anti-Kickback Statute (42 U.S.C. § 1320a-7b).
  - e. The Public Contracts Anti-Kickback Act (41 U.S.C. §§ 51 *et seq.*).
  - f. The Stark Law (42 U.S.C. § 1395nn).
  - g. The Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code §§ 1340 *et seq.*) and California Insurance Code.

- h. The Drug-Free Workplace Act of 1990 (Government Code §§ 8350 *et seq.*).
  - i. All applicable State and federal laws relating to child and family support enforcement, including, but not limited to, disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code.
  - j. Public Contract Code Section 10295.3 with regards to benefits for domestic partners.
  - k. Environmental laws, rules, and regulations applicable to its operations, including those relating to certifying compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with Section 42460 of the Public Resources Code, relating to hazardous and solid waste.
  - l. Any and all other State and federal laws, rules, and regulations, applicable to the operation of Covered California, and PROVIDER's provision of services under the Contract and the QHP Contract.
5. PROVIDER recognizes that the performance of services under the QHP Contract depends upon the joint effort of Covered California, IEHP, PROVIDER, and any other authorized Subcontractors. PROVIDER shall coordinate and cooperate with IEHP and such Subcontractors to the extent necessary to promote compliance with the terms set forth in the QHP Contract. PROVIDER shall also coordinate and comply with requirements of other State agencies that affect the Members, including DHCS, regarding the development and implementation of CalHEERS with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other laws, rules, regulations, or program instructions. [QHP Contract §§ 4.4.1(d)(i), 1.7]
6. PROVIDER shall exercise due diligence in the selection of any Subcontractors that are permitted under the QHP Contract, subject to any IEHP approval requirement, and in the monitoring of services provided by Subcontractors for compliance with the terms of the QHP Contract and applicable laws, rules, regulatory requirements, and orders. [QHP Contract §§ 1.3(b), 4.4.1(d)(ii)]
7. Nothing in the QHP Contract or Contract shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and PROVIDER or IEHP and PROVIDER. The parties acknowledge that they are independent contractors. [QHP Contract §§ 4.4.1(d)(ii), 1.3(a)]
8. PROVIDER shall provide information to IEHP to allow IEHP to comply with its provider directory obligations under the QHP Contract. PROVIDER acknowledges that Covered California may use PROVIDER's data for any noncommercial purposes. [QHP Contract §§ 4.4.1(d)(iii), 4.4.4]

9. PROVIDER shall comply with applicable laws, rules and regulations governing liability of Members for Covered Services provided to Members, including those relating to holding a Member harmless from liability if IEHP fails to pay an amount owed by IEHP to PROVIDER. PROVIDER shall inform every Member in a manner that allows the Member the opportunity to act upon a PROVIDER's proposal or recommendation regarding (i) the use of a non-Participating Provider or (ii) the referral of a Member to a non-Participating Provider for proposed non-Emergency Services. PROVIDER shall disclose to a Member considering accessing non-Emergency Services from a Participating Provider if a non-Participating Provider will be used as part of the Participating Provider's plan of care. PROVIDER is responsible for complying with the provider manual and may rely upon the provider directory of IEHP in fulfilling its obligation under this provision. [QHP Contract §§ 4.4.1(d)(vi), 4.4.3]
10. If PROVIDER is delegated activities relating to credentialing and re-credentialing, the process used by PROVIDER must be reviewed and approved by IEHP and as otherwise required by DMHC or any other applicable regulator. [QHP Contract §§ 4.4.1(d)(vii), 4.4.2]
11. PROVIDER shall cooperate and comply with and participate in the utilization management program established by IEHP in compliance with applicable laws, rules and regulations, including Health and Safety Code § 1367.01. [QHP Contract §§ 4.4.1(d)(ix); 5.3]
12. PROVIDER shall comply with all Covered California eligibility and enrollment determinations and shall provide required assistance to IEHP in its efforts to comply with the terms relating to eligibility, enrollment, and Member marketing materials from the QHP Contract. [QHP Contract §§ 4.4.1(d)(xi), Article 2]
13. PROVIDER shall cooperate and comply with the internal review process established by IEHP to resolve Member's written or oral Grievances and Appeals, including those involving expressions of dissatisfaction regarding PROVIDER. PROVIDER shall comply with State and federal laws, rules, and regulations relating to the external review process, including independent medical review, available to Members for Covered Services. [QHP Contract §§ 4.4.1(d)(xii), 4.6.2(a)]
14. Except with respect to any longer periods that may be required under applicable laws, PROVIDER shall maintain a medical record documentation system adequate to fully disclose and document the medical condition of each Member and the extent of Covered Services provided to each Member by PROVIDER. Clinical records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by applicable law, if an audit, litigation, research, evaluation, claim or other action involving the foregoing records has not concluded before the end of the seven (7) year minimum retention period, PROVIDER shall retain the clinical records until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(i) & (xxii), 11.1]

15. Except as otherwise required to be maintained for a longer period by law or the QHP Contract, financial records, supporting documents, statistical records, and all other records pertinent to amounts paid to or by IEHP in connection with the QHP Contract shall be retained by PROVIDER for at least ten (10) years from the date of the final claims payment. PROVIDER shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with the requirements of the QHP Contract as applicable to PROVIDER. This shall include adequate data customarily maintained and reasonably necessary to properly document each of its transactions with IEHP during the period the QHP Contract remains in force and records of claims, including medical review and high dollar special audit claims. [QHP Contract §§ 1.13, 4.4.1(d)(xiv), (xxii), 11.2(a), 11.2(b)]
16. PROVIDER shall cooperate with IEHP's obligations under the QHP Contract to maintain historical claims data and other records and data relating to the utilization of Covered Services by Members online for two (2) years from date that the QHP Contract is terminated with respect to Covered Services provided to Members during the terms of the QHP Contract. These records shall include, but are not limited to, the data elements to produce specific reports mutually agreed upon by Covered California and IEHP and in such form reasonably required by Covered California that is consistent with industry standards and requirements of DMHC or any other applicable regulator regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductible, out-of-pocket, and other cost sharing for each claim. [QHP Contract §§ 4.4.1(d)(xiv) and (xii), 11.2(c)]
17. PROVIDER agrees that Covered California, the California Department of General Services, California State Auditors, or their designated representatives shall, subject to applicable State and federal laws regarding the confidentiality and release of Protected Health Information of Members, have the right to review and to copy any records and supporting documentation pertaining to the performance of the QHP Contract. PROVIDER agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is otherwise required. PROVIDER agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. [QHP Contract §§ 4.4.1(d)(xxii), 11.5(c)]
18. PROVIDER and its agents and employees shall not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. §§ 2000d *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681 *et seq.*), the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101 *et seq.*), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), or subject to any other applicable laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through Covered California. [QHP Contract §§ 4.4.1(d)(xi), 1.11(a)]

19. PROVIDER and its agents and employees shall not unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. PROVIDER and its agents and employees shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. PROVIDER and its agents and employees shall comply with the provisions of the Fair Employment and Housing Act (Government Code, §§ 12900, *et seq.*) and the applicable regulations promulgated thereunder (2 CCR §§ 7285.0, *et seq.*). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, § 12990, set forth in CCR Chapter 5 of Division 4 of Title 2, including, 2 CCR §§ 8103 *et seq.*, are incorporated into the QHP Contract by reference and made a part hereof as if set forth in full. PROVIDER shall give written notice of its nondiscrimination obligations under this clause to labor organizations with which it has a collective bargaining or other agreement. [QHP Contract §§ 4.4.1(d)(xv), 1.10(b)]
20. PROVIDER agrees to be free from any conflicts of interest with respect to Covered Services provided under the QHP Contract. PROVIDER and its personnel shall not currently have, and shall not have throughout the term of the Contract, any direct interest which may present a conflict in any manner with the performance of services required under the QHP Contract. PROVIDER represents that it is not aware of any conflict of interest or any basis for potential violations with respect to applicable laws that govern referrals required for the provision of certain Covered Services, including federal and State anti-kickback and anti-self-referral laws, rules, and regulations. [QHP §§ 4.4.1(d)(xvi), 1.11]
21. PROVIDER shall cooperate and comply with programs established by IEHP consistent with its quality, network management, and delivery system standards obligations under the QHP Contract, including Covered California quality initiatives, the quality rating system, transparency and quality reporting, and quality improvement strategy. This obligation shall include the provision of necessary information to IEHP to ensure IEHP's compliance with its required reporting obligations pursuant to Attachment 1 of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xviii), 5.2]
22. PROVIDER shall comply with all applicable QHP Contract customer service standards that are applicable to PROVIDER. [QHP Contract §§ 4.4.1(d)(viii), 4.6]
23. PROVIDER shall comply with all applicable QHP Contract performance standards that are applicable to PROVIDER. [QHP Contract §§ 4.4.1(d)(xix), Article 7]
24. PROVIDER shall comply with applicable QHP Contract Member and marketing requirements applicable to PROVIDER. [QHP Contract §§ 4.4.1(d)(xiii), 2.4]

25. PROVIDER agrees to comply with policies and procedures implemented by IEHP to enhance stability and minimize disruption to IEHP's provider networks. PROVIDER shall provide IEHP with the information necessary to comply with notice and other requirements in the cases of block transfers (Health and Safety Code § 1373.65) and network disruptions (Health and Safety Code §§ 1373.23 and 1366.1 and Insurance Code § 10199.1). In the event of a change related to network disruption, block transfers, or other similar circumstances, PROVIDER shall cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under applicable laws, rules, and regulations, including those relating to continuity of care set forth at Health and Safety Code § 1373.95 and as otherwise set forth in the QHP Contract. In the event of a termination of the QHP Contract or decertification of one or more of IEHP's qualified health plans, PROVIDER shall cooperate fully with IEHP and Covered California to assure the continuity of care for Covered Services. [QHP Contract §§ 4.4.1(d)(v), 4.4.1(d)(xx), 4.3.5, Article 7]
26. PROVIDER agrees to comply with applicable provisions of HIPAA, including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d *et seq.*, the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and any current and future regulations promulgated under HITECH or HIPAA, all as amended from time to time and collectively referred to herein as the "HIPAA Requirements." PROVIDER agrees not to use or further disclose any PHI, other than as permitted or required by the HIPAA Requirements and the terms of this Contract and the QHP Contract. Terms utilized in this Section 26 that are not otherwise defined in the Contract shall have the meanings set forth in the HIPAA Requirements. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(a)]
- a. PROVIDER shall maintain technology policies and procedures acceptable to IEHP that provide reasonable safeguards to protect PHI and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by PROVIDER and its Subcontractors. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(e)]
  - b. PROVIDER shall mitigate to the extent practicable, any harmful effect that is known to PROVIDER of any Security Incident related to PHI and/or Personally Identifiable Information or of any use or disclosure of PHI and/or Personally Identifiable Information by PROVIDER in violation of the requirements of the QHP Contract or applicable privacy and security laws and regulations and agency guidance. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(f)]
  - c. PROVIDER shall comply with all applicable Covered California Protection of Information policies, in accordance with the terms and conditions set forth in the QHP Contract and as detailed in Section 9.2 of the QHP Contract, Protection of Information Assets, including, but not limited to, executing non-disclosure agreements and other documents required by such policies. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(h), 10.2]

- d. PROVIDER shall cooperate with Covered California in investigating the Breach and/or successful Security Incident involving PHI and/or Personally Identifiable Information and in meeting Covered California's obligations, if any, under applicable State and federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or the successful Security Incident involving PHI and/or Personally Identifiable Information is attributable to PROVIDER, PROVIDER shall be responsible for Breach notifications and reporting as required under applicable federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with Covered California and IEHP. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(e)(iii)]
  - e. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of IEHP, PROVIDER agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 CFR. Part 162. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(iv)]
  - f. PROVIDER shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of PHI and/or Personally Identifiable Information by PROVIDER or its Subcontractors or agents, including, without limitation, (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the QHP Contract requirements, or (c) California law, and (2) the costs of Covered California's actions taken to: (a) notify the affected Individual(s) and other entities of and to respond to the Breach; (b) mitigate harm to the affected Individual(s); and
  - (c) respond to questions or requests for information about the Breach or other impermissible use or disclosure of PHI and/or Personally Identifiable Information. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(vi)]
27. Books and records shall be kept in a secure location at the PROVIDER's office(s), and books and records related to the QHP Contract shall be available for inspection and copying by Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours and upon reasonable notice. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10) year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(xxii), Article 11]
28. PROVIDER shall promptly notify IEHP in writing of any inquiry, audit, investigation, litigation, claims, examination, or other proceeding involving PROVIDER that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability of IEHP to perform in accordance with the terms set forth in the QHP Contract. [QHP Contract §§ 4.4.1(d)(xxii), Article 11]

29. PROVIDER shall maintain compliance and provide IEHP with a description of its fraud, waste, and abuse detection and prevention programs and its other compliance programs to ensure compliance of its obligations and IEHP's reporting obligations under the QHP Contract. [QHP Contract § 1.15]
30. PROVIDER shall maintain insurance commensurate with the nature of its work and all coverage shall be subject to the requirements set forth in the QHP Contract and applicable laws, rules, and regulations. [QHP Contract § 9.1.]







# [202573025] HSARC-26-051, IEHP, Medical Services

Final Audit Report

2026-01-29

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