BEHAVIORAL HEALTH PROVIDER AGREEMENT
(ALL LINES OF BUSINESS)

BETWEEN

INLAND EMPIRE HEALTH PLAN
AND
IEHP HEALTH ACCESS

AND

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

FOR

BEHAVIORAL HEALTH SERVICES

INLAND EMPIRE HEALTH PLAN
AND
IEHP HEALTH ACCESS
BEHAVIORAL HEALTH PROVIDER AGREEMENT

THIS BEHAVIORAL HEALTH PROVIDER AGREEMENT ("Agreement") is made and entered into this First day of _____, by and between (i) **INLAND EMPIRE HEALTH PLAN** ("IEHP"); (ii) **IEHP HEALTH ACCESS** ("Health Access"), and (iii) **SAN BERNARDINO COUNTY, DBA SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH** ("PROVIDER"), with reference to the following facts:

WHEREAS, IEHP and Health Access are each public entities that are organized and licensed as health care service plans under the laws of the State of California; and

WHEREAS, IEHP and Health Access operates a Health Maintenance Organization (HMO) that arranges for quality preventive, behavioral health, medical and hospital services to be provided to persons who are enrolled as Members in the IEHP Health Plan in a manner consistent with the laws of the United States and the State of California; and

WHEREAS, Members in Medi-Cal programs are assigned to IEHP and non-Medi-Cal Members are assigned to Health Access; and

WHEREAS, IEHP and Health Access have entered into Agreements with the California Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and the Centers for Medicare and Medicaid Services (CMS) through which IEHP and Health Access shall arrange for the provision of Health Care Services for San Bernardino and Riverside County residents who are eligible for health coverage and who enroll in the IEHP Plan; and

WHEREAS, IEHP and Health Access desire to provide a Behavioral Health Services delivery system that utilizes methods to promote the efficient delivery of Behavioral Health Services, and develop and implement health education and health maintenance for its Members; and

WHEREAS, PROVIDER has the requisite facilities, equipment and personnel necessary to deliver Behavioral Health Services, all of which are appropriately licensed in the State of California; and

WHEREAS, IEHP, Health Access and PROVIDER mutually desire to preserve and provide quality cost-effective Behavioral Health Services, compliant with the terms and conditions specified herein and to the extent permitted by law, to serve the needs of IEHP and Health Access Members.

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

1. DEFINITIONS

The following terms whenever used in this Agreement shall have the definitions contained in this Section 1. Unless otherwise indicated, all terms in any appropriate attachments, addendums and amendments hereto shall have the same meaning attributed to such terms in the body of this Agreement and references to Section numbers are to the appropriate Sections of this Agreement:

1.01 AGREEMENT – shall mean this Provider Agreement, dated as herein above stated, including all attachments, addendums and amendments hereto.

1.02 BEHAVIORAL HEALTH SERVICES – shall mean services rendered or made available to a Member for treatment of a chemical dependency or psychiatric disorder.

1.03 BEHAVIORAL HEALTH EMERGENCY – shall mean danger or harm of self or others or exhibiting potential risk of behavior which is life-threatening, destructive, or disabling to self or others.

1.04 FEE-FOR-SERVICE PAYMENTS – shall mean payments made to Provider by IEHP and Health Access on a Fee-For-Service basis for specific services performed in Attachment A, attached hereto. The specific payment rate is noted in the fee schedule in Attachment B, attached hereto.

1.05 COMMERCIAL PROGRAM – shall mean any product line in which the individuals eligible IEHP and Health Access are enrolled through Subscriber Agreement.

1.06 CO-PAYMENT – shall mean a nominal fee, approved by the applicable state and federal regulators that govern IEHP and Health Access, that is charged to Members at the time of service for designated Behavioral Health Services.

1.07 DHCS – is the Department of Health Care Services who finances and administers a number of California individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal). The DHCS works closely with health care professionals, county governments and health plans to provide health care safety net for California's low-income and persons with disabilities.

1.08 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.

1.09 EMERGENCY ADMISSION – shall mean the immediate and unscheduled admission of a Member to a Behavioral Health Services facility because the Member is experiencing a severe level of symptoms according to a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) diagnosis and is impaired in the Member's functioning to the extent that the Member presents an immediate danger of harm to self or others.

1.10 EMERGENCY ASSESSMENT – shall mean the assessment and evaluation of a Member by a licensed clinician with transition to the most appropriate level of care when the Member is experiencing a severe level of symptoms according to a DSM-IV diagnosis and is impaired in his or her functioning to the extent that the Member presents an immediate danger of harm to self or others.

1.11 EMERGENCY MEDICAL CONDITION – shall mean a medical condition that is manifested by acute symptoms of sufficient severity (including severe pain) such 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:

- placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part.

1.12 EMERGENCY SERVICES – shall mean those health services needed to evaluate or stabilize an Emergency Medical Condition.

1.13 FACILITY – shall mean a healthcare or residential facility which is duly licensed or certified by the state in which it operates to provide inpatient, residential, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of chemical dependency or psychiatric disorder.

1.14 BEHAVIORAL HEALTH SERVICES PROFESSIONAL OR PROVIDER – shall mean a psychiatrist, psychologist, licensed clinical social worker, licensed registered nurse with psychiatric background or marriage, family, or child counselor who is duly licensed or certified under the laws of this State.

1.15 HEALTH CARE SERVICES – shall mean all Medically Necessary services to which Members are entitled under IEHP and Health Access, including behavioral health services, medical, hospital, preventive, ancillary, emergency and health education services.

1.16 HEALTHY KIDS PROGRAM – shall mean the program, jointly subsidized by the Prop 10 Commission, IEHP, and other interest groups that provides insurance coverage for children of families living in Riverside or San Bernardino County earning less than a designated Federal poverty Level and are not eligible for any insurance.

1.17 IEHP-DIRECT – shall mean the department within IEHP and Health Access that administers direct contracting.

1.18 IEHP PLAN – shall mean any plan operated by IEHP and Health Access covering the provision of Behavioral Health Services to Medicare and Medi-Cal Members.

1.19 MEDI-CAL – shall mean the California name for Medicaid, the federal and state program of medical assistance for needy and low-income people.

1.20 MEDICALLY NECESSARY – shall mean reasonable and necessary services to protect life, to prevent significant illness or significant disability, to alleviate severe pain and to diagnose or treat disease, illness or injury.

1.21 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 Health Plan as outlined in Attachment E. Medicare includes IEHP Health Plan's D-SNP product as well as the Capitated Financial Alignment Demonstration, also known as the "Duals Pilot Project," which is the pilot program seeking to integrate care across delivery systems for Dual Eligible Beneficiaries, as developed by CMS and DHCS.

1.22 MEMBER – shall mean any eligible beneficiary who has enrolled in IEHP or Health Access.

1.23 OPEN ACCESS PROGRAM – shall mean the program whereby designated Members are not formally assigned to a Primary Care Physician (PCP). This program allows for Members to be treated by any contracted PCP on a Fee For Service basis. PROVIDER shall treat any Member who is enrolled in the Open Access Program once eligibility is confirmed through IEHP Health Plan.

1.24 PARTICIPATING PROVIDER – shall mean any physician, practitioner, group practitioner, licensed Behavioral Health Services facility or other licensed behavioral health professional that is contracted with IEHP and Health Access to provide Behavioral Health Services to Members and identified in Attachment C, attached hereto and incorporated in full herein by reference.

1.25 PREPAID HEALTH PLAN – shall mean a Knox-Keene licensed health care plan holding a contract with the Department of Managed Health Care (DMHC) to provide services to beneficiaries.

1.26 PRIMARY CARE PHYSICIAN (PCP) – shall mean a physician who is responsible for supervising, coordinating and providing initial, primary and preventive care to Members, for initiating referrals, maintaining continuity of Member care, and providing health counseling and education. This means physicians who are practicing medicine in the areas of Family Practice, Pediatrics, Internal Medicine, Obstetrics-Gynecology, or General Practice.

1.27 PRIMARY CARE SERVICES – shall mean those covered services that Members are entitled to under IEHP and Health Access, which PROVIDER is required to provide or to make available to Members. Primary Care Services shall include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses. Primary care is performed and managed by the Member's assigned physician, utilizing consultation or referral as appropriate.

1.28 PRIMARY HOSPITAL – shall mean an acute care facility licensed under the laws of the State of California, is accredited by an IEHP or Health Access approved agency, and is contracted with IEHP or Health Access, at which the PROVIDER is a Member's Primary Care Physician in good standing as a part of the medical staff and to which the Member has been assigned.

1.29 PRIOR AUTHORIZATION – shall mean a formal process requiring a Behavioral Health Services provider to obtain advance approval to provide specific services or procedures.

1.30 REFERRAL – shall mean the process where PROVIDER directs a Member to a participating provider to obtain Behavioral Health Services.

1.31 STATE PROGRAM – shall mean Medi-Cal, Healthy Kids, and Open Access product lines administered through IEHP and Health Access.

1.32 SURCHARGES – shall mean an additional fee, excluding any applicable Co-payment that is charged to a Member for covered services. Surcharges are prohibited under IEHP and Health Access.

2. DUTIES OF PROVIDER

2.01 ACCESSIBILITY OF SERVICES – PROVIDER shall provide timely access to Behavioral Health Services and provide for reasonable hours of operation in compliance with IEHP and Health Access established standards for access and availability, as these services are normally made available to the general public.

2.02 ADMINISTRATIVE GUIDELINES – PROVIDER agrees to perform his/her duties under this Agreement in a manner consistent with the administrative guidelines provided by IEHP and Health Access and comply with the policies and procedures outlined in the IEHP Provider Policy and Procedure Manual.

2.03 AVAILABILITY OF SERVICES – PROVIDER agrees to provide IEHP and Health Access with current information regarding Behavioral Health Services available. PROVIDER shall notify and submit to IEHP and Health Access periodic reports that includes, but is not limited to, the identification of deletions and additions to Behavioral Health Services provided by PROVIDER.

2.04 CHANGE IN PROVIDER INFORMATION – PROVIDER shall notify IEHP and Health Access in writing, ninety (90) days prior to any change in PROVIDER's office address, telephone number, office hours, tax identification number, or license status or number.

2.05 CITATIONS – PROVIDER shall notify IEHP and Health Access in writing within fifteen (15) days of each and every report of CMS, DHCS, The Joint Commission or any other accreditation agency, which contains any citation of PROVIDER for failure to meet any required standard; any legal or government action against any of its licenses, accreditations, or certifications; or any other situation that will materially impair the ability of PROVIDER to carry out the duties and obligations under this Agreement.

2.06 CONFORMANCE TO OTHER LAW – PROVIDER certifies compliance with the Americans with Disabilities Act of 1990 (42 USC, Section 12100 *et seq*.), the Drug Free Workplace Act of 1990 (Gov. Code section 8355), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the U.S Pro-Children Act of 1994 (20 USC 6081 *et seq.*).

PROVIDER certifies awareness of Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor, the derivative Cal/OSHA Standard and laws and regulations relating thereto and shall comply therewith as to all relative elements under the Agreement.

2.07 COVERING PROVIDER – If applicable, if PROVIDER is unable to provide Behavioral Health Services when needed, PROVIDER may secure the services of a qualified covering provider. PROVIDER shall notify IEHP and Health Access as soon as reasonably possible of his/her intent to secure such services. PROVIDER may utilize only providers that have been credentialed or contracted by IEHP and Health Access. PROVIDER shall ensure that the covering provider: 1) looks solely to PROVIDER for compensation, 2) shall accept IEHP Health Plan's UM/QM and peer review processes, 3) shall not bill Members for Behavioral Health Services rendered under any circumstances, excluding that of Section 4.02 and 4) shall comply with the terms of this Agreement.

2.08 CREDENTIALING – PROVIDER shall meet IEHP and Health Access' credentialing requirements and maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities. In addition, PROVIDER shall maintain, at all times, active privileges at Primary Hospital, have written arrangements in place with a covering admitting physician approved by IEHP and Health Access, or rely on a contracted admitting physician provided by IEHP and Health Access. PROVIDER agrees that only those medical professionals who are credentialed by IEHP and Health Access shall treat Members. Hospital-based providers are not required to complete the IEHP and Health Access credentialing requirements. PROVIDER shall maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities.

2.09 FACILITY TRANSFERS – If applicable, PROVIDER agrees to notify IEHP and Health Access or designee, immediately and to assist in facilitating the transfer of Members requiring Behavioral Health Services that are not offered or available at PROVIDER'S facilities. PROVIDER agrees to cooperate and comply with IEHP and Health Access standards with respect to required referral systems for excluded (carve out) services to ensure continuity of care between IEHP , Health Access, and the local health departments or other agencies to which the Member is referred.

2.10 HOSPITAL ADMISSION – PROVIDER, or IEHP or Health Access designee, shall admit all Members with acute conditions to the Members IEHP or Health Access contracted Behavioral Health Hospital or facility only, unless an appropriate bed or service is unavailable. PROVIDER agrees to secure an authorization from IEHP or Health Access prior to admitting a Member for an elective service.

2.11 HOURS OF OPERATION AND AVAILABILITY – If applicable, PROVIDER shall make arrangements to ensure the availability of physician services to Members twenty-four (24) hours per day, seven (7) days per week. PROVIDER agrees that scheduling of appointments shall be done in accordance with IEHP and Health Access standards and to maintain weekly appointment hours that are sufficient to serve Members. PROVIDER shall be available or have designated physician back-up available, telephonically to Members after regular business hours.

2.12 IDENTIFICATION OF OFFICERS, OWNERS, STOCKHOLDERS, CREDITORS – On an annual basis PROVIDER shall identify the names of the following persons by listing them on Attachment D of this Agreement, attached hereto and incorporated by this reference, as required by DHCS and MRMIB:

A. PROVIDER officers and owners who own greater than 5% of the PROVIDER;
B. Stockholders owning greater than 5% of any stock issued by PROVIDER; and
C. Major creditors holding more than 5% of any debts owed by PROVIDER.

PROVIDER shall notify IEHP and Health Access in writing within thirty (30) days of any changes in the information provided in Attachment D.

2.13 INSURANCE – PROVIDER is an authorized self-insured public entity for purposes of General Liability, Automobile Liability, Worker's Compensation and Professional coverage and warrants that through its program of self-insurance, it has adequate coverage or resources to protect against liabilities arising out of the terms, conditions, and obligations of this agreement.

2.14 INSPECTION OF FACILITIES – Facilities used by PROVIDER to provide Health Care Services shall comply with provisions of Title 22, CCR, Section 53230 and Title 28, Section 1300.80. PROVIDER agrees to cooperate with inspections of PROVIDER facilities, as conducted by any state and federal regulatory agencies, or IEHP or Health Access staff that are required to assure compliance with required facility standards.

2.15 LABORATORY SERVICES – PROVIDER shall utilize an IEHP or Health Access designated laboratory for all laboratory services as needed for Member care. PROVIDER shall get approval and an authorization number from IEHP or Health Access prior to utilizing another laboratory.

2.16 MEMBER GRIEVANCE RESOLUTION – PROVIDER shall notify IEHP and Health Access immediately, upon knowledge of a complaint by a Member. PROVIDER agrees to cooperate with IEHP and Health Access in resolving Member grievances and agrees to participate in the grievance review procedures of IEHP and Health Access. PROVIDER and PROVIDER's staff shall comply with all final determinations of IEHP and Health Access's grievance procedures, peer reviews and QM and UM Programs. At no time shall a Member's medical condition be permitted to deteriorate because of delay in provision of care that PROVIDER disputes. Fiscal and administrative concerns shall not influence the independence of the medical decision-making process to resolve any medical disputes between Member and provider of service.

2.17 NON-DISCRIMINATION – PROVIDER represents and assures that Behavioral Health Services are provided to Members in the same manner and quality as such services are provided to PROVIDER's other patients. Members shall not be subject to any discrimination whatsoever by PROVIDER with regard to access to Behavioral Health Services. PROVIDER may not impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of the PROVIDER.

PROVIDER shall not request, demand, require or seek directly or indirectly the transfer, discharge or removal of any Member for reasons of Member's need for or utilization of Behavioral Health Services. PROVIDER shall not refuse or fail to provide Behavioral Health Services to any Member. PROVIDER agrees to comply with the provisions of Title 2 CCR, Section 8107 *et seq*., as may be amended from time to time, as incorporated by reference herein.

2.18 NON-SOLICITATION – PROVIDER shall not solicit Members on behalf of any other IPA, medical group, and HMO or insurance company. Solicitation shall mean conduct by PROVIDER, office staff, agent, or employee of PROVIDER, which may be reasonably interpreted as designed to persuade Members to discontinue their membership with IEHP and Health Access.

2.19 OTHER CONTRACTUAL COMMITMENTS – PROVIDER represents and assures IEHP and Health Access that contractual commitments to other HMOs, insurance companies, medical groups and other related entities do not restrict or impair PROVIDER from performing its duties under this Agreement and do not constitute a conflict of interest with the provision of Primary Care Services for Members.

2.20 OTHER REPORTING – If applicable, PROVIDER agrees to submit all information or reports, in a timely manner, as may be required to enable IEHP and Health Access to fulfill its reporting and other obligations under the Agreement, the Knox-Keene Act and other such applicable laws or regulations.

2.21 PHARMACEUTICAL SERVICES – PROVIDER shall provide pharmaceutical services and prescribed drugs, either directly or through subcontracts, in accordance with Title 22, CCR, Section 53854.

2.22 PRIOR AUTHORIZATION – As applicable, PROVIDER shall obtain advance authorization from IEHP and Health Access, or designee, prior to any non-emergent Behavioral Health Services provided to a Member. In the case of an emergency, PROVIDER agrees to notify IEHP and Health Access, or designee, either orally or in writing, no later than the first working day following the date of service.

2.23 PROVIDER ADVERTISING – Prior to listing or otherwise referencing IEHP and Health Access in any promotional or advertising brochures, media announcements or other advertising or marketing material, PROVIDER shall first obtain the prior written consent of IEHP and Health Access.

2.24 QUALITY MANAGEMENT (QM) AND UTILIZATION MANAGEMENT (UM) – PROVIDER shall comply with IEHP and Health Access's QM and UM Programs and any amendments to these programs as may be established or adopted by IEHP and Health Access from time to time. If a potential quality of care issue is identified based on Member complaints, or other information, IEHP or Health Access shall alert PROVIDER to initiate appropriate action. PROVIDER further agrees to assist IEHP and Health Access in the implementation of a corrective action plan.

2.25 REFERRAL PROCESS – PROVIDER understands and agrees that all specialty

consultation or care must be obtained utilizing the procedures designated by IEHP Health Plan In addition PROVIDER shall not render Primary Care Services to unassigned Members nor provide Health Care Services that fall outside those listed in Attachment A, without prior authorization from IEHP Health Plan. In the event that PROVIDER fails to comply with such procedures, IEHP and Health Access may, at their sole discretion, reimburse the provider of service and deduct such costs from any monies owed to PROVIDER.

2.26 SERVICES TO BE RENDERED – As applicable to Primary Care Providers, PROVIDER agrees to provide continuous and comprehensive Primary Care Services for all assigned Members with consideration of the physical, mental and psychosocial needs of the Members, including acute and chronic care. This includes coordinating specialty care and referrals, providing screening, counseling, preventive care services and periodic evaluation to ensure appropriate continuity of care, as outlined in Attachment A and E. As applicable to other Behavioral Health Services Providers, PROVIDER shall provide to Members those Behavioral Health Services that are Medically Necessary when such services are authorized by IEHP and Health Access, or designee, and in accordance with Attachment A and E of this Agreement. PROVIDER is responsible for coordinating the provision of Behavioral Health Services with the Member's PCP, IPA, IEHP or Health Access.

2.27 STANDARDS OF CARE – PROVIDER shall maintain the necessary registrations, accreditation, certifications and licenses required by the State of California, federal government and accreditation entities. All Behavioral Health Services shall be provided by professional personnel and at physical facilities in accordance with all applicable federal and state laws, licensing requirements and professional standards, and in conformity with the professional and technical standards adopted by IEHP and Health Access. Behavioral Health Services shall be rendered by qualified providers unhindered by fiscal and administrative management.

2.28 SKILLED NURSING FACILITY – Provider shall notify IEHP Health Plan within 24 hours or the next business day of all admissions to its facility. This requirement includes admissions of Medi-Medi members where IEHP Health Plan is the secondary payor.

3. DUTIES OF IEHP AND HEALTH ACCESS

3.01 ADMINISTRATION – IEHP and Health Access shall perform all necessary administrative, accounting and reporting requirements and other functions to state and federal regulators consistent with the administration of IEHP and Health Access and this Agreement.

3.02 ADMINISTRATION OF PAYMENTS – IEHP and Health Access agree to transmit Capitation Payments and other payments to PROVIDER in accordance with the terms and procedures set forth in this Agreement. All payments are subject to the availability of funds from payors to IEHP and Health Access, including but not limited to, Federal congressional appropriation, State and/or other payor. The State of California operates on a fiscal year from July 1 through June 30. The DHCS' funding is based on the budget and appropriations, and subject to the availability of Federal congressional appropriation of funds.

3.03 AFTER-HOURS NURSE ADVICE LINE – IEHP and Health Access shall provide Members with access to after-hour medical advice and triage provided by licensed RNs,

PAs and NPs. This service is provided Monday-Friday from 5:00pm-8:00am and on weekends and on all State and Federal holidays, through a toll-free and TTY telephone number. The toll-free telephone number is 1-888-244-IEHP (4347), and TTY telephone number is 1-888-880-0833.

3.04 AUTHORIZATIONS – IEHP and Health Access agree to provide medical authorization access to PROVIDER for treatment and hospitalization of Members.

3.05 BENEFIT INFORMATION – IEHP and Health Access agree to apprise all Members concerning the type, scope and duration of benefits and services to which such Members are entitled under the IEHP Plan. This includes, but is not limited to, written notification to Members of Behavioral Health Services available and changes in the availability or location of Behavioral Health Services being provided by PROVIDER, and issuance of an identification card to each Member upon enrollment.

3.06 CULTURAL AND LINGUISTIC SERVICES – IEHP and Health Access agree to offer PROVIDER access to interpreter services for Members either through telephone language services or interpreters.

3.07 ELIGIBILITY INFORMATION – IEHP and Health Access shall maintain, update and distribute eligibility information to PROVIDER that contains those Members assigned to the PROVIDER within a specific month.

3.08 MARKETING ACTIVITIES – IEHP and Health Access agree to provide marketing and public relations services, advertising and marketing to potential Members. IEHP and Health Access may use PROVIDER's name, office address, telephone number, and any other demographic information in any informational material distributed to Members and for other purposes related to the administration of IEHP and Health Access.

3.09 MEDICAL MANAGEMENT – IEHP and Health Access 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.

3.10 MEMBER SERVICES – IEHP and Health Access shall provide customer service to Members, including, but not limited to, processing Member complaints and grievances, informing Members of IEHP and Health Access policies and procedures, providing Members with information about IEHP and Health Access and identifying contracted providers within IEHP and Health Access's network.

3.11 NOTIFICATION TO DHCS – IEHP and Health Access shall notify DHCS in the event of an amendment to or termination of this Agreement. Notice shall be given by properly addressed letter deposited in the U.S. Postal Service as first-class postage, prepaid registered mail.

3.12 PROVIDER ADVERTISING – IEHP and Health Access may use PROVIDER's name, office address, telephone number, and any other demographic information in any

informational material distributed to Members and for other purposes related to the administration of the IEHP Plan.

3.13 PROVIDER EDUCATION AND TRAINING – IEHP and Health Access shall provide in-service training in the IEHP Provider Policy and Procedure Manual that contains IEHP and Health Access's policies and procedures. IEHP and Health Access shall provide the necessary training on these policies and procedures when requested and in the development and initial implementation of procedures necessary to carry out the intent of this Agreement.

4. BILLING AND COMPENSATION

4.01 BILLING – In order to receive payment for Behavioral Health Services rendered, PROVIDER shall submit claims to IEHP and Health Access within one hundred and twenty (120) days from the date of service for authorized Behavioral Health Services provided to Members. The claim must be submitted using IEHP's acceptable methods of submission, IEHP web site or Provider's own EDI services, as referenced in Attachment A of this Agreement and shall include all information necessary to verify and substantiate the provision of and charges for Behavioral Health Services, including providing the authorization number, as applicable. PROVIDER shall not seek payment for claims submitted after one hundred and twenty (120) days from the date of service.

4.02 COLLECTION OF CHARGES FROM MEMBERS – PROVIDER agrees that the only charges for which a Member may be liable and be charged by PROVIDER shall be for applicable Co-payments, coinsurance and/or deductibles or for medical services not covered under the IEHP Plan. PROVIDER shall advise Member of their payment responsibility, if any, prior to rendering services that require Co-payments, coinsurance and/or deductibles. PROVIDER shall obtain a written waiver from Member prior to rendering non-covered medical services to Member. The waiver must be obtained in advance of rendering services and shall specify those non-covered services or services IEHP and/or Health Access has denied as not being Medically Necessary and shall clearly state that the Member is responsible for payment of those services.

4.03 COORDINATION OF BENEFITS – PROVIDER agrees to coordinate benefits with other programs or entitlement, excluding tort liability of a third party, and estates from deceased Members, and recognizes the other coverage as primary and IEHP and Health Access as the payor of last resort. In the case in which IEHP and Health Access are other than primary, IEHP and Health Access shall pay the lesser of the amounts which when added to the amounts received by PROVIDER from other sources equals one hundred percent of the amount required under this Agreement as specified in Attachment B. If the amount paid by the primary payer is greater than the amount that would have been paid under this Agreement, IEHP Health Plan as a secondary payer shall pay any co-pay, co-insurance, deductible or patient responsibility under the Member's coverage with the primary payor as reflected on an explanation of benefits or remittance advice from a primary payer.

Unless Member has other health insurance coverage, PROVIDER accepts payment from IEHP and Health Access for Behavioral Health Services as provided herein as full payment for such Behavioral Health Services and shall at no time seek compensation from Members, excluding

applicable Copayments for Medi-Cal, Healthy Kids Members or the State. In instances when Medi-Cal is secondary to Medicare, the contracted rate(s) herewithin shall not apply. Payment for services shall be made in accordance with CMS guidelines.

4.04 FULL COMPENSATION – PROVIDER shall accept the payments specified in Attachment B of this Agreement as payment in full for all Behavioral Health Services provided to Members and for all administrative costs incurred for providing such services. In the event IEHP and/or Health Access fails to make any payments to PROVIDER as provided herein, whether from IEHP and/or Health Access's insolvency or otherwise, Members shall not be liable for payment to PROVIDER, under any circumstances, for Behavioral Health Services.

4.05 HOLD HARMLESS – In the event IEHP and/or Health Access fail to make any payments to PROVIDER as provided herein, whether from IEHP and/or Health Access's insolvency or otherwise, Members shall not be liable to PROVIDER, under any circumstances, for Behavioral Health Services. PROVIDER further agrees to hold harmless the State of California in the event of non-payment by IEHP and/or Health Access.

4.06 POTENTIAL TORT LIABILITY – To the extent permitted by the Healthy Kids or Medicare programs, as applicable, in the event PROVIDER recovers any amount from a third party, PROVIDER shall notify IEHP and Health Access of any such recovery and shall provide IEHP and Health Access with an accounting of all such sums recovered. In the event IEHP and/or Health Access have compensated PROVIDER for such Covered Services and PROVIDER has recovered sums from a third party, PROVIDER agrees to pay such recovered sums to IEHP and Health Access up to the amounts that IEHP and Health Access paid to PROVIDER, to the extent that IEHP and Health Access have not recovered such amounts from its own third party recovery efforts. PROVIDER shall pay these amounts to IEHP and Health Access within thirty (30) days of IEHP and Health Access informing PROVIDER of the amounts IEHP and Health Access recovered from its own third party recovery efforts, if any. This section does not obligate, nor does it prohibit, either IEHP and Health Access or PROVIDER to undertake such third party recovery efforts.

4.07 REIMBURSEMENT – IEHP and Health Access shall pay PROVIDER for authorized Behavioral Health Services in accordance with California Health and Safety Code, § 1371, *et seq*., and Attachment B of this Agreement, within forty-five (45) working days of receipt of an uncontested claim which is accurate, complete and otherwise in accordance with IEHP and Health Access standards. IEHP and Health Access shall notify PROVIDER at least forty-five (45) days prior to any material modification to IEHP and Health Access's proprietary fee schedules, claims and dispute filing guidelines or other reimbursement guidelines. IEHP and Health Access shall not be obligated to pay PROVIDER on any claim not submitted within one hundred and twenty (120) days from the date of service. If for any reason it is determined that IEHP and Health Access overpaid PROVIDER, IEHP and Health Access may deduct monies in the amount equal to the overpayment from any future payments to PROVIDER after thirty (30) days written notice. Provider is required to sign and return to IEHP the Electronic Authorization Registration form.
By signing this form, Provider acknowledges that Provider agrees to receive payment electronically in the form of an electronic fund transfer and to access the Remittance Advice from the IEHP secure website. Notwithstanding anything to the contrary set forth in this Agreement, IEHP and Health Access may reduce the rates or other compensation payable to

PROVIDER at any time or from time-to-time during the term of this Agreement as determined by IEHP and Health Access to reflect implementation of State or Federal laws or regulations, changes in the State budget or changes in DHCS or CMS policies, changes in Covered Services, or changes in rates implemented by the DHCS, CMS or any other governmental agency providing revenue to IEHP and Health Access, or any other change that results in decreases to the rates or level of funding paid to IEHP or Health Access. The amount of such adjustment shall be reasonably determined by IEHP and Health Access, and may not be in direct proportion to or in the same amount as the decrease to the rates or level of funding paid to IEHP and Health Access. All other rate changes or adjustments shall be made only if the parties have executed a formal amendment to Agreement to provide for same. Notwithstanding anything to the contrary set forth in this Agreement, IEHP and Health Access's obligation to pay PROVIDER any payment amount hereunder shall be subject to IEHP and Health Access's corresponding receipt of funding from DHCS, CMS or any other governmental agency providing revenue to IEHP and Health Access, as applicable.

4.08 REIMBURSEMENT DISPUTES – In the event PROVIDER disagrees with any payment, denial, adjustment or contest made by IEHP and Health Access, PROVIDER has 365 calendar days to submit a written dispute to IEHP Health Plan. Said dispute shall include all information necessary to verify and substantiate the dispute. IEHP and Health Access shall handle all written disputes in accordance with Health and Safety Code, § 1371 *et Seq*. (AB 1455).

4.09 SERVICE WAIVER – In the event Behavioral Health Services are not covered under IEHP and Health Access or are denied by IEHP and Health Access as not being Medically Necessary, PROVIDER shall not charge Members unless PROVIDER has obtained a written waiver from Member. The waiver must be obtained in advance of rendering services and shall specify those non-covered services or services IEHP and Health Access have denied as not being Medically Necessary and shall clearly state that the Member is responsible for payment of those services.

4.10 SURCHARGES PROHIBITED – Notwithstanding Section 4.02, PROVIDER shall in no event, including, without limitation, non-payment by IEHP Health Plan, insolvency of IEHP and Health Access, or breach of the Agreement, bill, charge, collect and deposit, or attempt to bill, charge, collect or receive any form of payment from any Member, the State, or County, for Health Care Services provided pursuant to this Agreement. PROVIDER also agrees it shall not maintain any action at law or equity against a Member to collect sums owed by IEHP and Health Access to PROVIDER. Upon receipt, by IEHP Health Plan, of notice of any Surcharge being made by PROVIDER for Behavioral Health Services, IEHP and Health Access shall take appropriate action consistent with the terms of this Agreement. PROVIDER's obligations regarding the collection of surcharges from Members shall survive the termination of this Agreement.

5. RECORDS AND CONFIDENTIALITY

5.01 ACCESS TO RECORDS – PROVIDER shall provide access at reasonable times upon demand by IEHP and Health Access, the U.S. Department of Health and Human Services, the

Department of Corporations, DMHC, DHCS or any governmental regulatory agency responsible for the administration of IEHP and Health Access, to inspect, exam or copy any books, papers and records, including but not limited to Member medical records, relating to Behavioral Health Services provided pursuant to this Agreement. Such records shall be made available at all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California. PROVIDER shall allow IEHP and Health Access to access and use PROVIDER's practitioner performance data.

5.02 CONFIDENTIALITY OF RECORDS – PROVIDER shall request from Member, or Member's legal representative, authorization for the release of the Member's medical records. Provider shall safeguard the confidentiality of Member medical records and treatments in accordance with all state and federal laws, including, without limitation, Title 42, Code of Federal Regulations, Section 431.300 *et seq*., and Section 14100.2, California Welfare and Institutions Code, the Health Insurance Portability and Accountability Act (HIPAA) and regulations adopted thereunder.

5.03 RECORDS MAINTENANCE – PROVIDER shall prepare and maintain adequate records related to Behavioral Health Services provided to each Member, in such form and containing such information as reasonably necessary for IEHP and Health Access to properly administer the IEHP Plan, consistent with state and federal law. PROVIDER shall maintain its books and records in accordance with general standards for books and record keeping. PROVIDER shall retain such records and encounter data for at least ten (10) years from the close of DHCS' fiscal year in which this Agreement is in effect. This obligation shall not terminate upon termination of this Agreement, whether by rescission or otherwise.

5.04 RECORDS RELATED TO RECOVERY FOR LITIGATION – Upon request by DHCS, IEHP and Health Access, PROVIDER shall timely gather, preserve and provide to IEHP and Health Access, in the form and manner specified by DHCS, any information specified by DHCS subject to any lawful privileges, in PROVIDER's possession, relating to threatened or pending litigation by or against DHCS. PROVIDER shall use all reasonable efforts to immediately notify IEHP and Health Access of any subpoenas, documentation production requests, or requests for records, received by PROVIDER related to this Agreement.

6. DISPUTE RESOLUTION

6.01 DISPUTE RESOLUTION – For disputes unresolved by IEHP and Health Access provider appeals process, IEHP and Health Access and PROVIDER agree to meet and confer in good faith to resolve any disputes that may arise under or in connection with this Agreement. In all events and subject to the provisions of this Section which follow, PROVIDER shall be required to comply with the provisions of the Government Claims Act (Government Code section 900, *et Seq*.) with respect to any dispute or controversy arising out of or in any way relating to this Agreement or the subject matter of this Agreement (whether sounding in contract or tort, and whether or not involving equitable or extraordinary relief) (a "Dispute").

6.02 JUDICIAL REFERENCE – At the election of either party to this Agreement (which election shall be binding upon the other party), a Dispute shall be heard and decided by a referee appointed pursuant to California Code of Civil Procedure Section 638 (or any successor provision thereto, if applicable), who shall hear and determine any and all of the issues in any

such action or proceeding, whether of fact or law, and to report a statement of decision, subject to judicial review and enforcement as provided by California law, and in accordance with Chapter 6 (References and Trials by Referees), of Title 8 of Part 2 of the California Code of Civil Procedure, or any successor chapter. The referee shall be a retired judge of the California superior or appellate courts determined by agreement between the parties, provided that in the absence of such agreement either party may bring a motion pursuant to the said Section 638 for appointment of a referee before the appropriate judge of the San Bernardino Superior Court. Any counterpart or copy of this Agreement, filed with such Court upon such motion, shall conclusively establish the agreement of the parties to such appointment. The parties agree that the only proper venue for the submission of claims to judicial reference shall be the County of San Bernardino, California, and that the hearing before the referee shall be concluded within nine (9) months of the filing and service of the complaint. The parties reserve the right to contest the referee's decision and to appeal from any award or order of any court. The designated nonprevailing party in any Dispute shall be required to fully compensate the referee for his or her services hereunder at the referee's then respective prevailing rates of compensation.

6.03 LIMITATIONS – Notwithstanding anything to the contrary contained in this Agreement, any suit, judicial reference or other legal proceeding must be initiated within one (1) year after the date the Dispute arose or such Dispute shall be deemed waived and forever barred; provided that, if a shorter time period is prescribed under the Government Claims Act (Government Code section 900, *et Seq*.), then, the shorter time period (if any) prescribed under the Government Claims Act shall apply.

6.04 VENUE – Unless otherwise specified in this Section, 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.

7. TERM AND TERMINATION

7.01 TERM – The term of this Agreement shall become effective on _____ and shall remain in effect for a term of five years unless earlier terminated by either party as set forth below.

7.02 DISSOLUTION OF IEHP AND/OR HEALTH ACCESS – This Agreement shall be terminated upon the dissolution of IEHP and/or Health Access by mutual action of the Riverside County and San Bernardino County Board of Supervisors. If IEHP and Health Access have incurred no obligations, either County Board of Supervisors may terminate the JPA and IEHP and/or Health Access by giving not less than sixty (60) days written notice thereof to the other party.

Also, either County Board of Supervisors may terminate the JPAs by written mutual consent, by giving twelve (12) months' written notice thereof to the other party given that the JPAs cannot be terminated until all forms of indebtedness incurred by IEHP and/or Health Access have been paid, or adequate provision for such payment shall have been made. Upon dissolution of IEHP and/or Health Access by Riverside County and San Bernardino County Board of Supervisors, this Agreement is rendered null and void. The debts, liabilities, and/or obligations of IEHP and/or Health Access are those of IEHP and Health Access alone. Neither Riverside County nor San Bernardino County assumes any of the debts, liabilities and/or obligations of IEHP and/or Health Access.

7.03 TERMINATION WITHOUT CAUSE – Either party may terminate this Agreement without cause upon providing the other party with ninety (90) days prior written notice of termination. Termination shall take effect automatically upon expiration of the ninety (90) day notice period.

7.04 TERMINATION FOR CAUSE – This Agreement shall terminate immediately, upon IEHP and Health Access's written notice, in the event of the occurrence of any of the following:

7.04.01 FAILURE TO PROVIDE QUALITY SERVICES – PROVIDER's failure to maintain the standards as provided herein.

7.04.02 FAILURE TO RENDER SERVICES – PROVIDER's failure to provide Behavioral Health Services to Members as provided herein.

7.04.03 BREACH OF MATERIAL TERM – PROVIDER's breach of any material term, covenant or condition of the Agreement.

7.04.04 LICENSING – Revocation, suspension, or restriction of PROVIDER's licenses, accreditation or certification required for the performance of the duties hereunder.

7.04.05 LOSS OF INSURANCE COVERAGE – Failure by PROVIDER to maintain adequate professional liability insurance coverage, as provided herein.

7.04.06 FRAUD – Upon IEHP and Health Access's determination that PROVIDER has engaged in a fraudulent activity against the Plan or its Members.

7.05 NOTICE OF BANKRUPTCY – Notice shall be given within ten (10) working days to the other party of any filing for bankruptcy, insolvency or for reorganization, or the appointment of a receiver, trustee or conservator, or assignment to creditors. In the event PROVIDER files for bankruptcy protection in any form, this Agreement may terminate immediately.

7.06 CONTINUING CARE RESPONSIBILITIES – In the event of termination of this Agreement, IEHP and Health Access shall be responsible to notify all Members under care prior to termination. PROVIDER shall continue to provide or arrange for Behavioral Health Services to Members until the effective date of transfer of such Members for further treatment and written notice of such transfer has been provided by IEHP and Health Access to PROVIDER.
If a Member's care cannot be transferred for medical reasons, PROVIDER shall continue to provide or arrange for treatment for the Member until IEHP and Health Access notify PROVIDER of such transfer in writing. PROVIDER shall be compensated as set forth in Attachment B for services rendered pursuant to this Agreement.

7.07 CONTINUING CARE RESPONSIBILITIES – PRIMARY CARE PHYSICIAN- In the event of termination of this Agreement, PROVIDER shall continue to provide or arrange for Primary Care Services to Members until the effective date of transfer of such Members for further treatment and written notice of such transfer has been provided by IEHP and Health Access to PROVIDER. If a Member's care cannot be transferred for medical reasons, PROVIDER shall continue to provide or arrange for treatment for the Member until IEHP and Health Access notify PROVIDER of such transfer in writing. PROVIDER shall be compensated as set forth in Attachment B for services rendered pursuant to this Agreement.

7.08 CONTINUING CARE RESPONSIBILTIES – SKILLED NURSING AND REHABILITATION FACILTIES – In the event of termination of this Agreement, PROVIDER shall continue to provide and be compensated for Behavioral Health Services under the terms of this Agreement to Members who are admitted on the date of termination until the effective date of discharge or the safe transfer of such Members to another health care facility.

7.09 MEMBER RECORDS – Upon termination of this Agreement, PROVIDER agrees to assist IEHP and Health Access in the transfer of Member medical care by making available copies of medical records, patient files and other pertinent information necessary for efficient case management of Members.

7.10 NON-PAYMENT POLICY – Notwithstanding the above, or any other provisions to the contrary, PROVIDER agrees that in the event IEHP and Health Access cease operations for any reason, including insolvency, PROVIDER shall continue to provide Behavioral Health Services for those Members who are hospitalized on an inpatient basis. PROVIDER shall not bill, charge, collect or receive any form of payment from any such Member or have any recourse against Member for Behavioral Health Services provided after IEHP and Health Access cease operation. This continuation of Behavioral Health Services obligation shall continue until Member is discharged from PROVIDER.

8. RELATIONSHIP OF PARTIES

8.01 CONFLICT OF INTEREST – The parties hereto and their respective employees or agents shall have no interest, and shall not acquire any interest, direct or indirect, which shall conflict in any manner or degree with the performance of services required under this Agreement.

8.02 NON-LIABILITY OF COUNTIES – Neither Riverside County nor San Bernardino County assumes any responsibility for any of the obligations under this Agreement.

8.03 MUTUAL INDEMNIFICATION – In connection with the obligations imposed by this Agreement, PROVIDER and **[**IEHP Health Plan**]** **[**IEHP Health Access**]** shall each indemnify and hold harmless the other, including 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 the respective party's officers, directors, agents, employees, contractors, agents and shareholders acting alone or in collusion with others. PROVIDER also agrees to hold harmless both the State and Members in the event that IEHP cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. IEHP Health Plan and PROVIDER shall promptly notify the other party hereto of any claims or demands which arise and for which indemnification is sought. The terms of this Section shall survive the termination of this Agreement."

In the event that PROVIDER and/or IEHP are determined to be comparatively at fault for any claim, action, loss or damage which results from their respective obligations under this agreement, PROVIDER and/or IEHP shall indemnify the other to the extent of its comparative fault.

8.04 INDEPENDENT PROVIDER – It is understood and agreed that PROVIDER is an independent contractor in the business of providing Behavioral Health Services to Members and that no relationship of employer-employee exists between the parties hereto. Neither of the parties nor any of their respective officers, directors or employees shall act as, nor be construed to be, an agent, employee or representative of the other.

8.05 LIABILITY FOR OBLIGATIONS – Nothing contained in this Agreement shall cause either party to be liable or responsible for any debt, liability, or obligation of the other party or any third party, unless liability is found against either party based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law basis for liability. Each party shall be solely responsible for and shall indemnify and hold the other party harmless against any obligation for the payment of wages, salaries or other compensation (including all state, federal and local taxes and mandatory employee benefits), insurance and voluntary employment-related or other contractual or fringe benefits as may be due or payable by the party to or on behalf of such party's employees, agents and representatives.

8.06 PROVIDER PARTICIPATION – The execution of this Agreement shall qualify PROVIDER as a Participating Provider in the rendition of Behavioral Health Services to Members pursuant to the terms of IEHP and Health Access, as amended from time to time.

9. GENERAL PROVISIONS

9.01 AMENDMENT – This Agreement may be amended or modified only by mutual written consent of the parties. 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.

9.02 ASSIGNMENT – PROVIDER shall not assign or delegate any duties, rights and

obligations under this Agreement to any person or entity without first obtaining the written consent of IEHP, Health Access and DHCS. IEHP, Health Access and DHCS must approve all subcontracts between PROVIDER and other providers prior to use.

9.03 ATTORNEYS' FEES – If any action at law or in equity is necessary to enforce the terms of this Agreement, each party shall bear its own attorneys' fees and costs regardless of who prevails

9.04 CAPTIONS – Captions in this Agreement are descriptive only and do not affect the intent or interpretation of the Agreement.

9.05 CERTIFICATION OF AUTHORITY TO EXECUTE THIS AGREEMENT – PROVIDER certifies that the individual signing herein has authority to execute this Agreement on behalf of PROVIDER, and may legally bind PROVIDER, and his/her contracted physicians as listed on Attachment C, to the terms and conditions of this Agreement, and any attachments hereto.

9.06 CONTRACT REQUIREMENTS – IEHP and Health Access are subject to the provisions of sections 1340 *et Seq*. of the Health and Safety Code, sections 1300.43 of Title 28 of the California Code of Regulations and sections 2698.100 *et Seq.*, of Title 10 of the California Code of Regulations, as may be amended from time to time.

9.07 CONFIDENTIALITY OF THIS AGREEMENT – To the extent reasonably possible, each party agrees to maintain this Agreement as a confidential document and not to disclose the Agreement or any of its terms or reports without the approval of the other party, subject to the limitation of the Public Records Act and the Brown Act.

9.08 ENTIRE AGREEMENT – This Agreement, including all attachments and manuals, which are hereby incorporated in this Agreement, 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 and no other agreement, statement or promise relating to this Agreement shall be binding or valid.

9.09 GOVERNING LAW – IEHP, Health Access, PROVIDER and this Agreement are subject, and must comply with, the applicable laws of the State of California and the United States of America including, but not limited to: the California Knox-Keene Act and the regulations promulgated thereunder by the California Department of Managed Health Care, the Health Maintenance Organization Act of 1973 and the regulations and CMS instructions promulgated thereunder by the United States Centers for Medicare and Medicaid Services (CMS), and the Waxman-Duffy Prepaid Health Plan Act and the regulations promulgated by DHCS, and the State Children's Health Insurance Program (found in Title 21 of the Social Security Act). Any provision required to be in this Agreement by any of the above Acts, CMS instructions and regulations shall bind IEHP, Health Access and PROVIDER, whether or not expressly provided in this Agreement.

9.10 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – IEHP, Health Access, 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.

9.11 INVALIDITY AND SEVERABILITY – 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.

9.12 NOTICES – Any notices required to be given hereunder shall be in writing to either IEHP, Health Access or PROVIDER at the address listed below, or at such other addresses as either IEHP, Health Access or PROVIDER may hereafter designate to the other:

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

PROVIDER:
San Bernardino County
DBA San Bernardino County
Department of Public Health
351 N. Mt. View Ave.
San Bernardino, CA 92415-0010
(800) 722-4777
Attn: Office Manager

HEALTH ACCESS:
Inland Empire Health Plan
P. O. Box 1800
Rancho Cucamonga, CA 91729-1800
(909) 890-2000
Attn: CEO

All notices shall be deemed given on the date of delivery if delivered personally or on the third business day after such notice is deposited in the United States mail, addressed and sent as provided above.

9.13 IEHP PROVIDER POLICY AND PROCEDURE MANUALS – IEHP and Health Access shall develop and provide to PROVIDER and PROVIDER shall comply with IEHP Policy and Procedure Manuals that shall set forth IEHP and Health Access's administrative requirements. IEHP and Health Access may modify the Manuals from time to time by written notice to the PROVIDER. The IEHP Provider Policy and Procedure Manuals are hereby incorporated in full by reference.

9.14 TERMS – Unless otherwise indicated, all terms in any appropriate attachments, addendums and amendments hereto shall have the same meaning attributed to such terms in the

body of this Agreement and references to Section numbers are to the appropriate Sections of this Agreement.

9.15 TIME OF THE ESSENCE – Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

9.16 WAIVERS – No obligation under this Agreement or an Attachment hereto may be waived by any party hereto except by an instrument in writing, duly executed by the party waiving such obligations. All matters shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the extension of the waiver to other provisions of this Agreement unless so specified in writing.

9.17 FACSIMILE SIGNATURE – The parties agree that this Agreement may be signed and delivered via facsimile by PROVIDER, and a signature received via facsimile shall be valid and enforceable just as an original signature.

IN WITNESS WHEREOF, the parties hereto have signed this Behavioral Health Provider Agreement as set forth below.

San Bernardino County, DBA San Bernardino County Department of Public Health

TIN: 95-6002748

By:_____

Print Name and Title: James Ramos, Chairman
Board of Supervisors

Date:_____

IEHP HEALTH ACCESS:

By: _____
Bradley P. Gilbert, M.D.
Chief Executive Officer

Date: _____

By: _____
Chairperson
IEHP Health Access
Governing Board

Date: _____

Attest: _____
Secretary
Inland Empire Health Plan for IEHP Health Access

Date: _____

Approved as to Form:

By: _____
Steve J. Sohn
Staff Counsel for IEHP Health Access

Date: _____

INLAND EMPIRE HEALTH PLAN:

By: _____
Bradley P. Gilbert, M.D.
Chief Executive Officer

Date:_____

By: _____
Chairperson
Inland Empire Health Plan
Governing Board

Date: _____

Attest: _____
Secretary
Inland Empire Health Plan

Date: _____

Approved as to Form:

By: _____
Steve J. Sohn
Staff Counsel for Inland Empire Health Plan

Date: _____

ATTACHMENT A

BEHAVIORAL HEALTH SERVICES

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

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

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

Specialty Services shall include:

Behavioral Health

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

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

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

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

ATTACHMENT A
(Continued)
BEHAVIORAL HEALTH SERVICES

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

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

ATTACHMENT B

BEHAVIORAL HEALTH COMPENSATION SCHEDULE

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

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

LCSW/MFT SERVICES:

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

PSYCHOLOGIST SERVICES:

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

ATTACHMENT B
(Continued)
BEHAVIORAL HEALTH COMPENSATION SCHEDULE

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

PSYCHIATRIST SERVICES:

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

NURSE PRACTITIONER SERVICES:

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

99212	Medical/Surgical Floor Consultation (25-30 Minutes)	80% Medicare
99213	Medical/Surgical Floor Consultation (50-60 Minutes)	80% Medicare

ATTACHMENT B
(Continued)
BEHAVIORAL HEALTH COMPENSATION SCHEDULE

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

MISC. REIMBURSEMENTS ITEMS:

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

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

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

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

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

Completed claims authorized Health Care Services must be sent to:

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

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

ATTACHMENT C

PARTICIPATING PROVIDERS

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF 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 and Health Access written notification ninety (90) days prior to any changes in this Attachment C.

FACILITY NAME	**ADDRESS**	**GROUP NPI**	**OFFICE HOURS**
San Bernardino County Department of Public Health	150 E. Holt Blvd. Ontario, CA 91764	1558531707	8am – 5pm M-F
Provider Name	**License# and NPI**	**Phone/Referral Fax**	**Type**
1.Jonathan Stiansen, MFT	MFC45365/1285829382	(800) 722-4777 (909) 458-9729 Fax	MFT

FACILITY NAME	**ADDRESS**	**GROUP NPI**	**OFFICE HOURS**
San Bernardino County Department of Public Health	16453 Bear Valley Rd. Hesperia, CA 92345	1861662025	8am – 5pm M-F
Provider Name	**License# and NPI**	**Phone/Referral Fax**	**Type**
1.Jonathan Stiansen, MFT	MFC45365/1285829382	(800) 722-4777 (760) 956-4450 Fax	MFT

ATTACHMENT D

OFFICERS, OWNERS, STOCKHOLDERS AND CREDITORS

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

List, by category, all of the above:

Name	Title	*Ownership % (as applicable)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

* If corporation is publicly traded on a US stock market, indicate "Publicly Traded Corp."
Please indicate how your organization is legally organized (circle one):

Corporation Partnership Sole Proprietorship

Other (please describe): **Government Agency**

ATTACHMENT E

MEDICARE ADVANTAGE PROGRAM

SAN BERNARDINO COUNTY

DBA

SAN BERNARDINO COUNTY DEPARTMENT OF PUBLIC HEALTH

I. DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

II. ACCESS: RECORDS AND FACILITIES

Provider agrees:

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

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

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

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

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

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

III. ACCESS: BENEFITS AND COVERAGE

Provider agrees:

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

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

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

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

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

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

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

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

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

IV. MEMBER PROTECTIONS

Provider agrees:

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

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

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

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

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

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

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

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

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

4.10. To address the special needs of Members who are members of specific ethnic and cultural populations such as, but not limited to, the Vietnamese and Latino populations. Provider shall in its policies, administration, and services practice the values of: (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive environment where difference are valued, respected and managed; (d) through cultural diversity training, foster in staff and/or providers' attitudes and interpersonal communication styles which respect Member's cultural backgrounds; and (e) referring members to culturally and linguistically appropriate community services program. In addition, Provider shall provide translation of written materials in the languages served. Written materials to be translated include, but are not limited to, signage, the member service guide, enrollee information, notices, marketing information and welcome packages. [422.112(a)(8)]

4.11. To educate Members regarding their health needs; share findings of the Member's medical history and physical examinations; discuss potential treatment options, side effects and management of symptoms; recognize that the Member has the final say in the course of action to take among clinically acceptable choices.
4.12. To not encourage disenrollment of a Member because of the onslaught of ESRD. [422.110(b)]

V. DELEGATION

Provider agrees:

5.1. To perform and maintain delegated functions consistent with MAO's contractual obligations under the CMS Agreement. [422.504(i)(3)(iii)]
5.2. That MAO may only delegate activities or functions to a Provider, related entity, contractor or subcontractor in a manner consistent with the requirements set forth in 42 CFR § 422.504(i)(4)(i). [422.504(i)(3)(ii)]
5.3. To comply with MAO's policies and procedures as set forth in the Medicare Advantage Participating Provider Operations Manual, including, without limitation, provisions that require a written arrangement to: (i) specify delegated activities and reporting responsibilities; (ii) provide for revocation of the delegated activities and reporting requirements or specify other remedies in instances where CMS or MAO determines that Provider and/or delegated parties have not performed satisfactorily; (iii) specify that the performance of Provider and/or delegated parties shall be monitored by MAO on an ongoing basis and formally reviewed by the MAO at least annually; (iv) specify that the credentials of medical professionals affiliated with Provider and/or delegated parties will be either reviewed by MAO or the credentialing process will be reviewed and approved by MAO and MAO shall audit the credentialing process on an ongoing basis; and (v) specify that Provider and/or delegated parties, in the performance of such delegated activities, shall comply with all applicable Medicare laws, regulations, and CMS instructions. [422.504(i)(4)]
5.4. That if MAO delegates selection of providers, contractors, or subcontractors to Provider or another organization, MAO retains the right to approve, suspend, or terminate any such arrangement. [422.504(i)(5)]
5.5. That any contract delegating activities or functions to a Provider, related entity, contractor or subcontractor, shall include language that incorporates the Capitated Financial Alignment Demonstration product offering, also known as the "Duals Pilot Project," i.e. the definition of Medicare as specified hereinabove.
5.6. That any contract or arrangements with First Tier, Downstream and Related Entities for medical providers, shall include language that clearly states the medical provider's Emergency Medical Treatment & Labor Act (EMTALA) obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
5.7. That any contract or arrangements with First Tier, Downstream and Related Entities for medical providers, shall include language that prohibits the contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
(a) Communication with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or

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

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

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

VI. PAYMENT AND FEDERAL FUNDS

Provider agrees:

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

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

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

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

VII. REPORTING AND DISCLOSURE

Provider agrees:

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

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

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

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

VIII. QUALITY ASSURANCE / QUALITY IMPROVEMENT

Provider agrees:

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

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

IX. COMPLIANCE

Provider agrees:

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

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

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

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

9.5. To meet the requirements of all other laws and regulation, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws applicable to recipients of Federal funds.

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

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

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

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

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

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

- 9.11.1 Attempting to explain MAO membership and costs;
- 9.11.2 Being the exclusive source of membership information;
- 9.11.3 Acting as agents of the MAO;
- 9.11.4 Acting outside their role as medical providers of care;
- 9.11.5 Discriminating in favor of "healthy" patients.

9.12. Providers may do the following:

- 9.12.1. Display plan-marketing materials for all plans with which the Provider participates, or display materials for those plans that provide them;
- 9.12.2. In compliance with Medicare marketing guidance and regulations, cooperatively advertise and market with MAO.

X. ADOPTION OF MEDICARE CONTRACT REQUIREMENTS

Provider agrees:

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

XI. INTERPRETATION OF ATTACHMENT

Provider and MAO agree:

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