Contract #: DD-P11-006
Budget Unit: 4012
Account String: 82-7805
Orig/Object Code: DD

HEALTH CARE SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

and

HEALTH CARE SERVICES PROVIDER

This Health Care Services Agreement is entered into this day of July 21st, 20 11, by Partnership Health Plan of California, a public entity (PARTNERSHIP) and between the **Mendocino County Health and Human Services Agency** herein referred to as PROVIDER, a medical and/or health care services, supplies, or equipment provider licensed in the State of California, as applicable, and is eligible to participate in and meets the Standards of Participation of the Medi-Cal Program to provide services under the California Medi-Cal (Medicaid) Program and meets applicable requirements under Title 22 CCR Section 51000 et. seq., Titles XVII and XIX of the Social Services Act.

IN WITNESS WHEREOF, the subsequent Agreement between PARTNERSHIP and Health Care Services Provider is entered into by and between the undersigned parties.

CONTRACTOR

Mendocino County Health and Human Services Agency

Signature: Stacy Cryer

Printed Name: Stacey Cryer

Title: Director

Date: 6-16-11

PARTNERSHIP

Partnership HealthPlan of California

Signature: Elizabeth Gibbons

Printed Name: Elizabeth Gibbons

Title: Deputy Executive Director/COO

Date: July 21, 2011

Address for Notices:

1120 South Dora Street

Ukiah, CA 95482

Attn: Stacey Cryer, Director

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

COUNTY OF MENDOCINO
HEALTH AND HUMAN SERVICES AGENCY

By _____
STACEY CRYER, HHSA Director
PAT MEEK, HHSA Assistant Director

Date: 6-16-11

PARTNERSHIP

By _____
Signature

Printed Name: Elizabeth Gibraney

Title: Deputy Executive Director/COO

Date: July 21, 2011

Budgeted: ☒ Yes ☐ No

Budget Unit: 4012

Line Item (Acct String): 82.7805

Org/Object Code: DD

Grant: ☐ Yes ☒ No

Grant No.:____

INSURANCE REVIEW:
RISK MANAGER

By _____
KRISTIN McMENOMEY, Director
General Services Agency

Date: 7/12/11

By signing above, signatory warrants and represents that he/she executed this Agreement in his/her authorized capacity and that by his/her signature on this Agreement, he/she or the entity upon behalf of which he/she acted, executed this Agreement

PURCHASING AGENT REVIEW:

KRISTIN McMENOMEY, Director
General Services Agency

By: _____
Purchasing Agent

Date: _____

COUNTY COUNSEL REVIEW:

APPROVED AS TO FORM:

JEANINE B. NADEL, County Counsel

By _____

Date: 7-11-11

EXECUTIVE OFFICE REVIEW:

APPROVAL RECOMMENDED

By _____
Carmel J Angelo, Chief Executive Officer

Date: _____

FISCAL REVIEW:

By _____
Deputy CEO/Fiscal

Date: 6-30-11

Signatory Authority: $0-25,000 Department; **$25,001- 50,000 Purchasing Agent**; $50,001+ Board of Supervisors

Exception to Bid Process Required/Completed ☐ **Exception #:** N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
HEALTH CARE SERVICES AGREEMENT

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
HEALTH CARE SERVICES AGREEMENT

RECITALS

A. WHEREAS, PARTNERSHIP has entered into and will maintain contracts with (the Medi-Cal Agreements) the State of California, Department of Health Care Services in accordance with the requirements of the Knox-Keene Care Services Plan Act of 1975 Health and Safety Code, Section 1340 et. Seq.; Title 10, CCR, Section 1300 et. Seq.; W&I Code, Section 14200 et. Seq.; Title 22, CCR, Section 53250; and applicable federal and State laws and under which Medi-Cal Beneficiaries assigned to PARTNERSHIP as Member(s) receive all medical services hereinafter defined as "Covered Services" through the PARTNERSHIP.

WHEREAS, PARTNERSHIP will arrange for Covered Services of its Medi-Cal Members under the case management of designated Primary Care Physicians chosen by or assigned to Medi-Cal Members, and all healthcare services (with the exception of emergency services) with be delivered only with authorization from the PARTNERSHIP.

B. WHEREAS, PROVIDER will to participate in providing Covered Services to Medi-Cal Members and will receive payment from PARTNERSHIP for the rendering of those Covered Services.

C. WHEREAS, PROVIDER desires to provide medical care for such Medi-Cal Members.

IN CONSIDERATION of the foregoing recitals and the mutual covenants and promises contained herein, receipt and sufficiency of which are hereby acknowledged, the parties set forth in this agreement agree and covenant as follows:

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section.

1.1 Agreement – This agreement and all of the Exhibits attached hereto and incorporated herein by reference.

1.2 Attending Physician – (a) any physician who is acting in the provision of Emergency Services to meet the medical needs of the Medi-Cal Member or (b) any physician who is, through referral from the Medi-Cal Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition or (c) any physician designated by the Medical Director to provide services for Special Case Managed Members.

1.3 California Children's Services (CCS) – A public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), Section 41800

1.4 Capitation Payment – The prepaid monthly amount that PARTNERSHIP pays to PROVIDER as compensation for capitated services.

1.5 Case Managed Members – Medi-Cal Members who have been assigned or who chose a Primary Care Physician for their medical care.

1.6 Child Health and Disability Prevention Services (CHDP) – Those health care preventive services for beneficiaries under 21 years of age provided in accordance with the provisions of Health and Safety Code Section 124025, et. Seq., and Title 17, CCR, Sections 6842 through 6852.

1.7 Contract Year – Twelve (12) month period following the effective date of this Agreement between PROVIDER and PARTNERSHIP and each subsequent 12 month period following the anniversary of the agreement. If the date of commencement of operations is later than the effective date, the PARTNERSHIP operational date will apply.

1.8 County Organized Health System (COHS) – A plan serving either a single or multiple county area.

1.9 Covered Services – Medical Management and those services set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Sections 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6842, except for excluded and limited serviced outlined in Section 3.4 of this Agreement.

1.10 DHCS – The State of California Department of Health Care Services.

1.11 Eligible Beneficiary – Any Medi-Cal Beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement between PARTNERSHIP AND DHCS, and who is certified as eligible for Medi-Cal by the State of California.

1.12 Emergency Medical Condition – A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: i) 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; ii) serious impairment to bodily functions; or iii) serious dysfunction of any bodily organ or part.

1.13 Emergency Services. Those health services needed to evaluate or stabilize a Medical Condition.

1.14 Encounter Form. The CMS-1500 claim form used by PROVIDER to report to PARTNERSHIP regarding the provision of covered services to Medi-Cal Members.

1.15 Enrollment. The process by which an Eligible Beneficiary selects or is assigned to the PARTNERSHIP.

1.16 Excluded Services. Those services for which the PARTNERSHIP is not responsible and for which it does not receive a capitation payment as outlined in Section 4 of this Agreement.

1.17 Fee-For-Service Payment (FFS). (1) The maximum Fee-For-Service rate determined by DHCS for the service provided under the Medi-Cal Program or (2) the rate agreed to by contractor and the provider. All Covered Services that are Non-Capitated Services, or authorized by the PARTNERSHIP per the PARTNERSHIP Operations Manual, and compensated by PARTNERSHIP pursuant to this Agreement will be compensated by PARTNERSHIP at the lowest allowable Fee-For-Service rate unless otherwise identified in Section 5 and of this Agreement.

1.18 Fiscal Year of Partnership HealthPlan of California. The 12 month period starting July 1.

1.19 Governmental Agencies. The Department of Managed Health Care ("DMHC"), Department of Health Care Services "DHCS", United States Department of Health and Human Services ("DHHS"), United States Department of Justice ("DOJ"), and California Attorney General and any other agency which has jurisdiction over PARTNERSHIP or Medi-Cal (Medicaid).

1.20 Hospital – Any acute general care or psychiatric hospital licensed by the DHCS.

1.21 Identification Card. The card that is prepared by the PARTNERSHIP which bears the name and symbol of PARTNERSHIP and contains: a) Member name and identification number, b) Member's Primary Care Physician, and other identifying data. The Identification Card is not proof of Member eligibility with PARTNERSHIP or proof of Medi-Cal eligibility.

1.22 Medical Director. The Medical Director of PARTNERSHIP or his/her designee, a physician licensed to practice medicine in the State of California, employed by PARTNERSHIP to monitor the quality assurance and implement Quality Improvement Activities of PARTNERSHIP.

1.23 Medically Necessary. Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. These services will be in accordance with accepted standards of medical practice and not primarily for the convenience of the Member or the participating PROVIDER.

1.24 Medi-Cal Managed Care Program. The program that PARTNERSHIP operates under its Medi-Cal Agreement with the DHCS.

1.25 Medi-Cal Provider Manual. The Allied Health or Vision Care Services Provider Manuals of the DHCS, issued by the DHCS Fiscal Intermediary.

1.26 Medical Transportation.. The transportation of the sick, injured, invalid, convalescent, infirm or otherwise incapacitated persons by ambulances, litter vans or wheelchair vans licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances or regulations. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.

1.27 Member. An Eligible Medi-Cal Beneficiary who is enrolled in the PARTNERSHIP.

1.28 Member Handbook. The PARTNERSHIP Medi-Cal Combined Evidence of Coverage and Disclosure Form that sets forth the benefits to which a Medi-Cal Member is entitled under the Medi-Cal Managed Care Program, the limitations and exclusions to which the Medi-Cal Member is subject and terms of the relationship and agreement between PARTNERSHIP and the Medi-Cal Member.

1.29 Non-Medical Transportation. Transportation services required to access medical appointments and to obtain other Medically Necessary Covered Services by Member who do not have a medical condition necessitating the use of medical transportation as defined in Title 22, CCR, Section 51323.

1.30 Non-Physician Medical Practitioner. A physician assistant, nurse practitioner, or certified midwife authorized to provide primary care under physician supervision.

1.31 Operations Manual. (also referred to as Provider Manual) The Manual of Operations Policies and Procedures for the PARTNERSHIP Medi-Cal Managed Care Program.

1.32 Other Services. Vision Care and other Covered Services, including but not limited to chiropractic; acupuncture; occupational therapy; speech pathology; audiology; podiatry; physical therapy; durable medical equipment, and medical supplies.

1.33 PARTNERSHIP. The Medi-Cal Managed Care Program governed by the Partnership Health Plan of California.

1.34 Partnership HealthPlan of California (PHC). The locally administered, prepaid Medi-Cal Managed Care program operated within Napa, Solano, Sonoma, Marin and Yolo Counties.

1.35 Physician. Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with PARTNERSHIP and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program.

1.36 Physicians' Advisory Group. The committee of physicians chosen each year from among contracting physicians by the PARTNERSHIP for the purpose of advising the PARTNERSHIP. The physicians must be Board Certified .

1.37 Physician Patient Load Limitation. The maximum number of Beneficiary Members for whom the Primary Care Physician has contracted to serve, which has been accepted by the PARTNERSHIP. The PARTNERSHIP agrees that additional Members will not be

permitted to select or be assigned to that Primary Care Physician. Such limit may be changed by mutual agreement of the parties.

1.38 Primary Care Case Management. The responsibility for primary and preventive care, and for the referral, consultation, ordering of therapy, admission to hospitals, provision of Medi-Cal covered health education and preventive services, follow-up care, coordinated hospital discharge planning that includes necessary post-discharge care, and maintenance of a medical record with documentation of referred and follow-up services.

1.39 Primary Care Physician. A physician or physicians who has/have executed an Agreement with PARTNERSHIP to provide Primary Care Services. The Physician must be duly licensed by the Medical Board of California and enrolled in the State Medi-Cal Program. The Primary Care Physician is responsible for supervising, coordinating, and providing initial and Primary Care to Members; initiating referrals; and for maintaining the continuity of care for the Members who select or are assigned to the Primary Care Physician. Primary care physicians include general and family practitioners, internists, Obstetrician-Gynecologists and pediatricians. A resident or intern will not be a Primary Care Physician.

1.40 Primary Care Services. Those services defined in the DHCS contract with PARTNERSHIP to be provided to Beneficiaries Members by a Primary Care Physician. These services constitute a basic level of healthcare usually rendered in ambulatory settings and focus on general health needs.

1.41 Primary Hospital. Any hospital affiliated with Primary Care Physician that has entered into an Agreement with the PARTNERSHIP.

1.42 Participating Referral Provider. Any health professional or institution contracted with PARTNERSHIP that meets the Standards for Participation in the State Medi-Cal Program to render Covered Services to Medi-Cal Members.

1.43 Quality Improvement Plan (QIP). Systematic activities to monitor and evaluate the clinical and non-clinical services provided to Members according to the standards set forth in statute, regulations, and PARTNERSHIP Agreement with the DHCS. The QIP consists of processes, which measure the effectiveness of care, identifies problems, and implements improvement on a continuing basis towards an identified, target outcome measurement.

1.44 Referral Authorization Form or RAF. The form or number evidencing authorization referral by PCP or Medical Director, or designee, to render specific non-emergency Covered Services to Medi-Cal Members.

1.45 Referral Physician. Any qualified physician, duly licensed in California that meets the Standards of Participation and has been enrolled in the State Medi-Cal Program in accordance with Article 3 Title 22 CCR Section 51000 et.seq. The physician has executed an Agreement with PARTNERSHIP, to whom a Primary Care Physician may refer any Member for consultation or treatment. Also called Participating Referral Physician.

1.46 Referral Services. Covered services, which are not Primary Care Services, and which are provided by physicians or healthcare service providers after authorization by the PARTNERSHIP as a non-capitated service

1.47 Special Case Managed Members. Medi-Cal Members enrolled with PARTNERSHIP who have not been assigned to a Primary Care Physician for administrative or medical reasons, e.g. CCS, ESRD, LTC, out-of-area Members, organ transplant cases, or Medi-Cal Members that the Medical Director has determined can remain unassigned to a Primary Care Physician because of a long term physician/patient relationship.

1.48 Treatment Authorization Request or TAR. "TAR" means the Treatment Authorization Request form approved by Plan for the provision of Non-Emergency Services. Those Non-Emergency Services that require a Treatment Authorization Request form approved by Plan are set forth in the Provider Manual.

1.49 Urgent Care Services. Medical services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).

1.50 Utilization Management Program. The program(s) approved by PARTNERSHIP, which are designed to review and to monitor the utilization of Covered Services. Such program(s) are set forth in the PARTNERSHIP Operations Manual.

Vision Care. Routine basic eye examinations, lenses and frames provided benefit provided every 24 months for eligible members defined by the State of California Medical-Cal Program.

SECTION 2
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

2.1 PROVIDER of Healthcare (Covered) Services is responsible for:

2.1.1 Standards of Care – Provide Covered Services for those complaints and disorders of Medi-Cal Members that are within the PROVIDER's professional competence and licensure, as applicable, with the same standards of care, skill, diligence and in the same economic and efficient manner as are generally accepted practices and standards prevailing in the professional community.

2.1.2 Licensure – Warrant that PROVIDER has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license, certification or registration in the State of California, as applicable to the Covered Services rendered. Warrant that PROVIDER has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by PARTNERSHIP. Warrant that the PROVIDER has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in the Medi-Cal Program in accordance with the program Standards of Participation contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations.

2.1.3 Covered Services – Provide the Medically Necessary Covered Services for those medical complaints and disorders as described in Attachment A of this Agreement that are within his/her professional competence and in accordance with Section 2.1.5 of this Agreement.

2.1.4 Accessibility and Hours of Service – Providing Covered Services to Medi-Cal Members on a readily available and accessible basis in accordance with PARTNERSHIP policies and procedures as set forth in the PARTNERSHIP Operations Manual during normal business hours at PROVIDERS usual place of business

Referrals – Unless otherwise agreed to by PARTNERSHIP except for Emergency Services and Urgent Care Services, provide Covered Services to Medi-Cal Members, only upon receipt of an appropriate referral to provide such services from Medi-Cal Member's Primary Care Physician Physician, PARTNERSHIP, or such other treatment authorization as described in the PARTNERSHIP Operations Manual.

2.1.6 Case Management – Cooperate with Medi-Cal Member's Referring Physician and PARTNERSHIP in the monitoring, coordination, and case management of the Medi-Cal Member's healthcare services. PROVIDER will promptly furnish a complete written report of the services rendered to a Medi-Cal Member to the Medi-Cal Member's Referring Physician and, upon receipt of an appropriate consent, to PARTNERSHIP, on such form as may be prescribed in the PARTNERSHIP Operations Manual.

a. PROVIDER agrees to abide by the Case Management Protocols which are included in the PARTNERSHIP Operations Manual.

b. PROVIDER agrees to abide by the PARTNERSHIP Operations Manual policies and procedures, which may be amended from time to time with thirty (30) days, notice to PROVIDER.

c. PROVIDER and any Attending Physician or Referral Physician to whom the Primary Care Physician has delegated the authority to proceed with treatment or the use of resources, will be responsible for coordinating medical services performed or prescribed through them for the Member.

d. PROVIDER acknowledges that PARTNERSHIP's Medical Director will assist in the management of Catastrophic Cases. PROVIDER will fully cooperate with PARTNERSHIP's Medical Director by providing information that may be required in the care of Catastrophic Cases, including but not limited to, prompt notification of known or suspected Catastrophic Cases.

2.1.7 Officers, Owners and Stockholders – Providing information regarding officers, owners and stockholders as set forth in Attachment C, attached to and incorporated herein.

Credentialing – Provide PARTNERSHIP with accreditation, licensure and/or certification documents, as applicable, and will use best efforts to notify PARTNERSHIP in advance of any change in such information. PROVIDER will successfully complete a facility site review, if deemed necessary by PARTNERSHIP in accordance with DHCS Medi-Cal Agreement.

2.1.9 Actions Against PROVIDER – PROVIDER will adhere to the requirements as set forth in the PARTNERSHIP Operations Manual and notify PARTNERSHIP by certified mail within five (5) days of PROVIDER's learning of any action taken which results in restrictions for a medical disciplinary cause or reason as defined in Division 3 Chapter 3 Article 3 Title 22, CCR, commencing with Sections 51000 et.seq. regardless of the duration of the restriction or excluded from participating in the Medi-Cal Program.

2.1.10 Financial and Accounting Records – Maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as will be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made hereunder or in connection herewith. Submit reports as required by PARTNERSHIP or DHCS.

2.1.11 Compliance with Member Handbook – PROVIDER acknowledges that PROVIDER is not authorized to make nor will PROVIDER make any variances, alterations, or exceptions to the terms and conditions of the Member Handbook.

2.1.12 Promotional Materials – PROVIDER will consent to be identified as a PROVIDER in written materials published by PARTNERSHIP, including without limitation, marketing materials prepared and distributed by PARTNERSHIP and, display promotional materials provided by PARTNERSHIP within his/her office.

2.1.13 Facilities, Equipment and Personnel – Provide and maintain sufficient facilities, equipment, personnel, and administrative services to perform the duties and responsibilities as set forth in this Agreement. PROVIDER agrees to provide at least 60 days notice to PARTNERSHIP prior to the opening of any new location and 90 days prior to the closing of any location.

2.1.14 PROVIDER shall provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by the Medi-Cal Agreements. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. PROVIDER shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and

Voluntary Exclusion – Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by the Medi-Cal Agreements. Such Debarment Certification and its instructions are set forth in the Provider Manual.

2.1.15 Compliance with PARTNERSHIP Policies and Procedures. PROVIDER agrees to comply with all policies and procedures set forth in the PARTNERSHIP Provider Manual. The Provider Manual is available through the PARTNERSHIP website at www.Partnershiphp.org. PARTNERSHIP may modify Provider Manual from time to time. In the even the provisions of the Provider Manual are inconsistent with the terms of this Agreement; the terms of this Agreement shall prevail.

2.1.16 Cultural and Linguistic Services. PROVIDER shall provide Services to Members in a culturally, ethnically and linguistically appropriate manner. PROVIDER shall recognize and integrate Members' practices and beliefs about disease causation and prevention into the provision of Covered Services. PROVIDER shall comply with Plan's language assistance program standards developed under California Health and Safety Code Section 1367.04 and Title 28 CCR Section 1300.67.04 and shall cooperate with plan by providing any information necessary to assess compliance. Plan shall retain ongoing administrative and financial responsibility for implementing and operating the language assistance program. PROVIDER has 24 (twenty-four) hours, 7 (seven) days a week access to telephonic interpretive services outlined in policies and procedures as set forth in PARTNERSHIP Provider Manual.

PROVIDER will verify Medi-Cal Member eligibility with PARTNERSHIP prior to rendering medical services. Referral from a Primary Care Physician is not a guarantee of Medi-Cal Member eligibility with PARTNERSHIP or eligibility in the State Medi-Cal Program.

a. Member eligibility is available via telephone or electronic media. PARTNERSHIP makes best efforts to update Medi-Cal eligibility daily from DHCS eligibility tapes.

b. PARTNERSHIP will maintain (or arrange to have maintained) records and establish and adhere to procedures as will reasonably be required to accurately ascertain the number and identity of Medi-Cal Members.

PARTNERSHIP is responsible for:

2.2.1 Member Assignment – Assigning Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician and Primary Hospital.

a. The Medi-Cal Member can select from the Primary Care Physicians contracting with PARTNERSHIP.

b. The Medi-Cal Member will seek all medical services, except those outlined in Section 4.2 from their assigned Primary Care Physician or Referring Physician.

c. If the Medi-Cal Member does not select a Primary Care Physician, PARTNERSHIP will assign Members to a Primary Care Physician in a systematic manner as the Partnership deems appropriate and/or in accordance with Medi-Cal protocols.

The Medi-Cal Member will be assigned to a Primary Hospital for inpatient and outpatient hospital services and at which the Attending Physician has medical staff privileges.

2.2.2 Listing – PARTNERSHIP will enter the name of each contracted PROVIDER onto a list from which Medi-Cal Members may choose to receive healthcare services. Such a list will contain the following information concerning the PROVIDER.

a. Name
b. Address(es)
c. Office hours
d. Scope of services (specialty or provider type)

2.2.3 Payment for Authorized Service Only – The PARTNERSHIP will reimburse PROVIDER for Covered Services that are authorized by the PARTNERSHIP Medical Director (or his/her Designee) or for covered services provided to a special case managed member. Payment will be made based on required authorization and claim billing requirements as identified in the PARTNERSHIP Operations Manual.

SECTION 3
SCOPE OF SERVICES

Prior Authorization(s) – With the exception of Excluded Services described in Section 4 of this Agreement, a Referral Authorization Form (RAF) from a Referring Physician and prior authorization(s) from the PARTNERSHIP's Medical Director or his/her designee is required before rendering goods and/or Covered and Limited Services in accordance with PARTNERSHIP's policies and procedures and Operations Manual to the extent permitted by the statewide Medi-Cal Program including:

3.1.1 Ambulance (Medical Transportation) Services when medically necessary and in accordance with Title 22, CCR, Section 51323 and PARTNERSHIP Operations Manual policies and procedures. Medical transportation services do not include transportation of beneficiaries by passenger car, taxicabs or other forms of public or private conveyances.

3.1.2 Other necessary durable medical equipment rental, and medical supplies determined by Referring Physician to be medically necessary for the purpose of diagnosis, management or treatment of diagnosed health impairment, or rehabilitation of the Medi-Cal Member.

3.1.3 A Treatment Authorization Request (TAR) approved by PARTNERSHIP's Medical Director shall be obtained for covered services per PARTNERSHIP's policies and procedures as outlined in the PARTNERSHIP Provider Manual. All services and goods required or provided hereunder will be consistent with sound professional principles, community standards of care, and medical necessity.

3.1.4 Interpreter Services – Arrange interpreter services as necessary for Members at all facilities.

3.1.5 Nothing expressed or implied herein shall require the PROVIDER to provide to or order on behalf of the Medi-Cal Member, Covered Services which, in the professional opinion of the Primary Care Physician or PROVIDER, are not medically necessary for the treatment of the Medi-Cal Member's disease or disability.

3.2 Prescription Drugs – Comply with the PARTNERSHIP drug formulary as approved by PARTNERSHIP policies and subject to the restrictions on the PARTNERSHIP's Drug Formulary regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals, in conformance with generally accepted medical and surgical practices and standards prevailing in the professional community.

If for medical reasons, the PROVIDER believes a generic equivalent should not be dispensed, the PROVIDER agrees to obtain prior authorization from the PARTNERSHIP Pharmacy Director.

3.2.2 PROVIDER acknowledges the authority of PARTNERSHIP's participating pharmacists to substitute generics for trade name drugs, as specified in Section 4073 of the California Business & Professions Code, and Title 22 CCR Section 51313 unless otherwise indicated.

3.2.3 The PARTNERSHIP Pharmacy and Therapeutic Committee is a professional advisory board of participating providers that meets quarterly and makes recommendations for changes to the drug formulary.

3.3 Non-Discrimination

3.3.1 Medi-Cal Members – PROVIDER will provide services to Medi-Cal Members in the same manner as such services are provided to other patients of PROVIDER,

except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of the Medi-Cal Managed Care Program. Subject to the foregoing, PROVIDER will not subject Medi-Cal Members to discrimination on the basis of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of PARTNERSHIP, or filing a complaint as a Member of PARTNERSHIP, in accordance with Title VI of the Civil Rights Act of 1964, 42 United States Code (USC), Section 2000(d), rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. Discrimination will include but is not limited to: denying any Medi-Cal Member any Covered Service or availability of a Facility; providing to a Medi-Cal Member any Covered Service which is different, or is provided in a different manner or as a different time from that provided to other Medi-Cal Members under this Contract except where medically indicated; subjecting a Medi-Cal Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; restricting a Medi-Cal Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving many Covered Services, treating a Medi-Cal Member differently from others in determining whether he or she satisfied any admission, enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Services; the assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, or the physical or mental handicap of the participants to be served.

3.3.2 For the purpose of this Section, physical handicap includes the carrying of a gene, which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse affects on the carrier. Such genes include, but are not limited to, Tay-Sach trait, sickle-cell trait, Thallassemia trait, and X-linked hemophilia.

3.3.3 General Compliance. Pursuant to the requirements of this Section of the Medi-Cal Agreement, the PROVIDER will not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual preference, national origin, age (over 40), sex, gender, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of PARTNERSHIP, or filing a complaint as a Member of PARTNERSHIP, and denial of family care leave. PROVIDER will ensure the evaluation and treatment of PROVIDER's employees and applicants for employment are free from discrimination and harassment. PROVIDER will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et.seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4,

Chapter 5 are incorporated into this Agreement by reference and made a part hereof as set forth in full. PROVIDER will give notice of his obligations under this Section to labor organizations with which he has a collective bargaining or other agreement.

3.4 Quality Improvement and Utilization Management Programs – PROVIDER agrees to cooperate and to participate with PARTNERSHIP in Quality Improvement and Utilization Management Programs including credentialing and recredentialing, peer review and any other activities required by PARTNERSHIP, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. In addition, the PROVIDER will participate in the development of corrective action plans for any areas that fall below PHC standards ensuring medical records are readily available to the PHC staff as requested.

a. PROVIDER recognizes the possibility that PARTNERSHIP, through the utilization management and quality assurance process, may be required to take action requiring consultation with its Medical Director or with other physicians prior to authorization of services or supplies or to terminate this agreement.

b. In the interest of program integrity or the welfare of Medi-Cal Members, PARTNERSHIP may introduce additional utilization controls as may be necessary.

In the event of such change, a thirty (30) day notice will be given to the PROVIDER. PROVIDER will be entitled to appeal such action to the Provider Grievance Review Committee, the Physician Advisory Group and then to the PARTNERSHIP Board of Commissions.

SECTION 4
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

4.1 Exclusions. Members in need of services, which are not Covered Services, as described in Division 3, Subdivision 1, Chapter 3, Article 4, Title 22, California Code of Regulations, will not be reimbursed by the PARTNERSHIP. The PROVIDER will not bill and expect reimbursement by the PARTNERSHIP for the following excluded services provided to Medi-Cal Members:

Services Neither Covered nor Compensated. Provider understands that Provider will not be obligated to provide Medi-Cal Members with, and the PARTNERSHIP will not be obligated to reimburse Specialist for, the following Excluded Services pursuant to this Agreement (services for which PARTNERSHIP does not receive capitation payment from the DHCS.)

(a) Dental Services, as defined in Title 22 CCR Section 51307 and Early Periodic Screening Diagnosis and Treatment supplement dental services as described in Title 22 CCR Section 51340.1(a). However, medical services necessary to support dental services are Covered Benefits for Medi-Cal Members and are not excepted;

(b) Home and community based services and Department of Developmental Services Administered Medicaid Home and Community Based Services, Multipurpose Senior Services as defined in the California Welfare and Institutions Code Section 9400 et seq., Adult Day Health Care Services as defined in Title 22 CCR Section 54001, Pediatric Day Health Care Services as defined in Title 22 CCR Section 51184(j), alcohol and drug treatment program services (including outpatient heroin detoxification), and Local Education Authority Services as defined in Title 22 CCR Sections 51360 and 51190.

(c) Short-Doyle/Medi-Cal mental health services (inpatient and outpatient), Medi-Cal specialty mental health services and services provided by specialty mental health providers (inpatient and outpatient); provided, however, the following are Covered Benefits for Medi-Cal Members and are not excepted: (i) outpatient mental health services within the PROVIDER's scope of practice, (ii) emergency room professional services except services provided by specialty mental health providers, (iii) facility charges for emergency room visits which do not result in a psychiatric admission, (iv) laboratory and radiology services necessary for the diagnosis, monitoring or treatment of a Medi-Cal Member's mental health condition, (v) emergency medical transportation for emergency mental health services, (vi) certain prescribed non-emergency medical transportation services to access mental health services, (vii) initial health history and physical assessments required upon admission for psychiatric inpatient hospital stays and consultations related to Medically Necessary Covered Services, and (viii) psychotherapeutic drugs that are covered by the Medi-Cal Program and that are not excluded by the State Medi-Cal Contract.

(d) California Children's Services ("CCS") are not covered in Sonoma and Mendocino counties as set forth in the State Medi-Cal Contract. Covered services in Napa, Marin, Solano, and Yolo counties.

(e) Services rendered in a State or Federal governmental hospital;

(f) Laboratory services provided under the State serum alphafeto protein testing program administered by the Genetic Disease Branch of the Department of Health Care Services;

(g) Fabrication of optical lenses;

(h) Targeted Case Management Services as specified in Title 22 CCR Sections 51185 and 51351;

(i) Direct Observed Therapy for tuberculosis;

(j) Personal Care Services defined in Title 22 CCR Sections 51183 and 51350;

(k) Childhood lead poising case management services provided by the Local Health Department;

(l) Certain Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency (AIDS), and psychotherapeutic drugs as set forth in the State Medi-Cal Contract; and

(m) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42

United States Code ("USC") Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.

4.3 Restricted Services/Special Reimbursement.

4.3.1 PROVIDER will ensure that services provided to Medi-Cal members will be in conformance with the limitations and procedures listed in the PARTNERSHIP Provider Manual unless PROVIDER is notified of the modification to that policy by DHCS or PARTNERSHIP.

a. Prior authorization for restricted and/or limited service will be provided only through the Medical Director of PARTNERSHIP or his/her designee.

b. The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization and is subject to the limitations specified therein.

4.3.2 Primary Care Physician Referral or prior authorization from PARTNERSHIP is not required for reimbursement by PARTNERSHIP to providers of the following services.

a. The provision and reimbursement of Limited Services will be in conformance with the policies and procedures of the Medi-Cal Fee-For-Service Program.

b. Family Planning Services are excluded from Primary Care Physician capitated services and may be obtained by patient self-referral in accordance with 42 Code of Federal Regulations Section 441.20. Family Planning services include: birth control supplies, pregnancy testing and counseling, HIV testing and counseling, STD treatment and counseling, follow-up care for complications related to contraceptive methods, sterilization, and termination of pregnancy.

4.3.3 Primary care physician referral is not required for beneficiaries designated as Special Case Managed Members.

California Children's Services (CCS) must be authorized by the respective County CCS Program.

4.3.5 Genetically Handicapped Persons Program (GHPP) services must be authorized by the GHPP program.

SECTION 5
PAYMENTS AND CLAIMS PROCESSING

5.1 Payment – PARTNERSHIP will reimburse PROVIDER for Covered Services provided which have been authorized by the PARTNERSHIP in accordance with PARTNERSHIP policies and procedures and upon submission of a complete CMS-1500 claim form along with evidence of prior authorization, if required, submission of complete data through electronic transfer, as described in Section 5.3 herein. Reimbursement will be made

within thirty (30) days of receipt by PARTNERSHIP of a "clean claim". The following conditions must be met in addition to the above requirements for reimbursement of services:

The Medi-Cal Member is eligible for Program benefits with PARTNERSHIP at the time the Covered Service is rendered by PROVIDER on the first day of the month for which PARTNERSHIP receives capitation based on the most current enrollment information from DHCS, and

5.1.2 The service is a Covered Service under the State Medi-Cal Program according to DHCS contract with PARTNERSHIP, PARTNERSHIP Operations Manual and policies and procedures, and State and federal regulations in effect at that time.

5.1.3 All CMS-1500 claim forms and/or encounter data must be submitted to the PARTNERSHIP within six (6) months of the date the service was provided

5.1.4 A summary report will accompany each check identifying Medi-Cal Members who are eligible to receive Covered Services from PROVIDER and the appropriate amount of reimbursed dispersed per Medi-Cal Member.

5.2 Entire Payment – PROVIDER will accept from PARTNERSHIP compensation as payment in full and discharge of PARTNERSHIP's financial liability. Covered Services provided to Medi-Cal Members by PROVIDER will be reimbursed as set forth in this agreement and in accordance with PARTNERSHIP's Operations Manual and policies and procedures. PROVIDER will look only to PARTNERSHIP for such compensation. PARTNERSHIP has the sole authority to determine reimbursement policies and methodology of reimbursement under this Agreement, which includes reduction of reimbursement rates if rates from the State to PARTNERSHIP are reduced by DHCS.

5.2.1 Fee-For-Service (FFS) – The PARTNERSHIP will reimburse the PROVIDER at the current State of California Medi-Cal Fee-for Service Rates for all properly documented Medi-Cal Covered Services provided to:

a. PARTNERSHIP enrolled Medi-Cal Members that present with prior authorized Covered Services, which have been properly authorized in accordance with PARTNERSHIP Operations Manual.

5.3 Claim Submission – The PROVIDER will obtain, complete, and submit CMS-1500 claim forms, or submit through electronic transfer, claims for all services rendered to Medi-Cal Members including capitated services as described in the PARTNERSHIP Operations Manual.

5.3.1 All claims for reimbursement and encounter data, if applicable as described in Section 5.3 of this Agreement, of Covered Services must be submitted to the PARTNERSHIP within six (6) months from the end of the month that service was provided as described in the PARTNERSHIP Operations Manual.

5.3.2 Upon submission of a complete and uncontested clean claim payment will be reimbursed within thirty (30) days after receipt by PARTNERSHIP. An uncontested clean claim will include all information needed to process the claim.

5.3.3 CMS-1500 forms or electronic transfer are to be used for the submission to the PARTNERSHIP of encounter data as documentation of Capitated Covered Services provided to Medi-Cal Members by the PROVIDER. The CMS-1500 forms or the submission by electronic transfer will be made by PROVIDER the 15th day of the month following the month of service during the term of this Agreement. All forms submitted should contain the data elements as Outlined in the PARTNERSHIP Operations Manual.

5.4 Medi-Cal Member Billing – PROVIDER will not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal Member, unless share of cost, or from other persons on behalf of the Medi-Cal Member, for any service included in the Medi-Cal program's Covered Services in addition to a claim submitted to the PARTNERSHIP for that service.

Coordination of Benefits – Medi-Cal is the payor of last resort recognizing Other Health Coverage as primary carrier. PROVIDER must bill the primary carrier before billing PARTNERSHIP for reimbursement of Covered Services, and, with the exception of authorized share of cost payments, will at no time seek compensation from Medi-Cal Members or the DHCS. The PROVIDER may look to the Member for non-covered services.

5.5.1 The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the PARTNERSHIP Operations Manual.

5.5.2 The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the DHCS Agreement with PARTNERSHIP.

5.5.3 PROVIDER will report to PARTNERSHIP the discovery of third party insurance coverage for a Medi-Cal Member within ten (10) business day of discovery

5.5.4 PROVIDER will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the PROVIDER, but will be reported to the PARTNERSHIP on the CMS-1500 encounter claim form or electronic transfer tape.

5.6 Third Party Liability – In the event that PROVIDER renders services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by PROVIDER pursuant to the terms of this Agreement.

5.6.1 PROVIDER will cooperate with the DHCS and PARTNERSHIP in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.

5.6.2 PROVIDER will report to PARTNERSHIP the discovery of third party tort action for a Medi-Cal Member within ten (10) business days of discovery.

5.7 Subcontracts.

All subcontracts between PROVIDER and PROVIDER's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the

Medi-Cal Agreement, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.

5.7.2 All subcontracts and their amendments will become effective only upon written approval by PARTNERSHIP and DHCS and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the PROVIDER. PROVIDER will notify DHCS and PARTNERSHIP when any subcontract is amended or terminates. PROVIDER will make available to PARTNERSHIP and Governmental Agencies, upon request, copies of all agreements between PROVIDER and Subcontractor(s) for the purpose of providing Covered Services.

5.7.3 All agreements between PROVIDER and any Subcontractor will require Subcontractor to comply with the following:

a. Records and Records Inspection – Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least seven (7) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to PROVIDER and PARTNERSHIP all reports required by PROVIDER, PARTNERSHIP or DHCS, and timely gather, preserve and provide to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recovery for Litigation.

b. Surcharges – Subcontractor will not collect a Surcharge for Covered Services for a Medi-Cal Member or other person acting on their behalf. If a Surcharge erroneously occurs, Subcontractor will refund the amount of such Surcharge to the Medi-Cal Member within fifteen (15) days of the occurrence and will notify PARTNERSHIP of the action taken. Upon notice of any Surcharge, PARTNERSHIP will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Medi-Cal Member and deducting the amount of the Surcharge and the expense incurred by

PARTNERSHIP in correcting the payment from the next payment due to PROVIDER.

c. Notification – Notify DHCS and PARTNERSHIP in the event the agreement with Subcontractor is amended or terminated. Notice will be given in the manner specified in Section 9.4 Notices.

d. Assignment – Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS and PARTNERSHIP.

e. Additional Requirements – Be bound by the provisions of Section 8.7, Survival of Obligations after Termination, and Section 7.3, PROVIDER Indemnification and Hold Harmless.

Domestic Partners – Any subcontracting of subcontracting health facility, licensed in accordance with California Health & Safety Code Section 1250 will ensure that Medi-Cal Member's are permitted to be visited by the Medi-Cal Member's domestic partner, the children of the Medi-Cal Member's domestic partner, and the domestic partner of the Medi-Cal Member's parent or child.

SECTION 6
RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

Medical Record – Ensure that a medical record will be established and maintained for each Medi-Cal Member who has received Covered Services. Each Medi-Cal Member's medical record will be established upon the first visit to PROVIDER. The record will contain information normally included in accordance with generally accepted practices and standards prevailing in the professional community.

6.1.1 PROVIDER will facilitate the sharing of medical information with other providers in cases of referrals, subject to all applicable laws and professional standards regarding the confidentiality of medical records.

6.1.2 PROVIDER will ensure records are available to authorized PARTNERSHIP personnel in order for PARTNERSHIP to conduct its Quality Improvement and Utilization Management Programs

6.1.3 PROVIDER will ensure that medical records are legible.

6.1.4 PROVIDER will maintain such records for at least seven years from the close of the State's fiscal year in which this Agreement was in effect.

6.2 Records and Records Inspection Rights.

Access to Records – PROVIDER will permit PARTNERSHIP's Medical Director, or officers or their designees, any agency having jurisdiction over PARTNERSHIP, including and without limitation the Governmental Agencies, to

inspect the premises, records and equipment of Health Care Services Provider and review all operational phases of the medical services provided to Medi-Cal Members.

a. PROVIDER or PARTNERSHIP will make all of PROVIDER's books and records, and papers ("Records") relating to the provision of, pertaining to the goods and services to Medi-Cal Members, to the cost of such goods and services, and to payments received by PROVIDER from Medi-Cal Members or from others on their behalf available for inspection, examination and copying by PARTNERSHIP and all other state and federal agencies with jurisdiction over PARTNERSHIP or this Agreement, including without limitation, Governmental Agencies, at all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California.

b. PARTNERSHIP will pay for the cost of copying Records, not to exceed $0.10 per page. The ownership of Records will be controlled by applicable law and this Agreement furnished under the terms of this Agreement, available for inspection, examination or copying.

c. PROVIDER shall permit PARTNERSHIP, Government Agencies and any other regulatory and accrediting agencies, with or without notice, during normal business hours, to interview employees, to inspect, audit, monitor, evaluate and review PROVIDER's work performed or being performed hereunder, PROVIDER's locations(s) (including security areas), information systems, software and documentation and to inspect, evaluate, audit and copy Records and any other books, accounts and materials relevant to the provisions of services under this Agreement. PROVIDER will provide all reasonable facilities, cooperation and assistance during such inspection and reviews, including for the safety and convenience of the authorized representatives in the performance of their duties. PROVIDER shall allow such inspections and reviews for the Records retention time of seven years. The State reserves the right to conduct unannounced validation reviews to verify compliance with State and federal regulations and contract requirements.

Maintenance of Records – PROVIDER will maintain records in accordance with the general standards applicable to such book and record keeping and in accordance with applicable law, and the PARTNERSHIP.

a. Records will include all encounter data, working papers, reports submitted to PARTNERSHIP, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Medi-Cal Members for a term period of at least seven (7) years.

b. PROVIDER will retain all Records for a period of at least seven (7) years from the close of the State Department of Health Care Services' fiscal year

in which this Agreement was in effect.

c. PROVIDER's obligations set forth in this Section will survive the termination of this Agreement, whether by rescission or otherwise.

d. The PROVIDER will not charge the Medi-Cal Member for the copying and forwarding of their medical records to another provider.

6.3 Disclosure to Government Officials. PROVIDER shall comply with all provisions of law regarding access to books, documents and records. Without limiting the foregoing, PROVIDER shall maintain, provide access to, and provide copies of Records, this Agreement and other information to the Director of DMHC, DHCS, External Quality Review Organizations, the State Bureau of Medi-Cal Fraud, the State Managed Risk Medical Insurance Board, the Bureau of State Audits, the State Auditor, the Joint Legislative Audit Committee, the California Department of General Services, the California Department of Industrial Relations, certified Health Plan Employer Data Information Set ("HEDIS") auditors from the National Committee on Quality Assurance, the California Cooperative Healthcare Reporting Initiative, the Counties of Solano, Napa, Sonoma and Yolo, the U.S. Department of Justice, the Secretary of the U.S. Department of Health and Human Services, the U.S. Comptroller General, the Centers for Medicare and Medicaid Services, Peer Review Organizations, their designees, representatives, auditors, vendors, consultants and specialists and such other officials entitled by law or under Membership Contracts (collectively, "Government Officials") as may be necessary for compliance by PARTNERSHIP with the provisions of all state and federal laws and contractual requirements governing PARTNERSHIP, including, but not limited to, the Act and the regulations promulgated thereunder and the requirements of Medicare and Medi-Cal programs. Such information shall be available for inspection, examination and copying at all reasonable times at PROVIDER's place of business or at some other mutually agreeable location in California. Copies of such information shall be provided to Government Officials promptly upon request. The disclosure requirement includes, but is not limited to, the provision of information upon request by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS. PROVIDER shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by PROVIDER related to this Agreement.

6.4 Patient Confidentiality.

a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 42 CFR, Section 431.300 et. Seq. and Section 14100.2, Welfare and Institutions Code and regulations adopted thereunder.

b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and

pertaining to Beneficiaries will be protected by the PARTNERHIP and his/her staff from unauthorized disclosure. Acknowledges that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received from the Program identifying or otherwise relating to the patients in the Program, it is fully bound by the provisions of the federal regulation governing the Confidentiality of Alcohol and Drug Abuse Patients Records, 42 C.F.R. (Code of Federal Regulations), Part 2 and may not use or disclose the information except as permitted or required by this Agreement or by law.

c. PROVIDER may release Medical Records in accordance with applicable law pertaining to the release of this type of information.

d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the PROVIDER, the PROVIDER (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the PARTNERSHIP all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than PARTNERSHIP, the federal government including the Department of Health and Human Services and Comptroller General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities the COHS program and contracts, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. Seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the PARTNERSHIP or maintain such information according to written procedures sent the PARTNERSHIP by the Department of Health Care Services for this purpose.

6.4.1 All subcontracts between PROVIDER and PROVIDER's Subcontractors will be in writing, and will be entered into in accordance with the requirements of the Medi-Cal Agreement, Health and Safety Code Section 1340 et seq.; Title 10, CCR, Section 1300 et seq.; W & I Code Section 14200 et seq.; Title 22, CCR, Section 53000 et seq.; and applicable federal and State laws and regulations.

6.4.2 All subcontracts and their amendments will become effective only upon written approval by PARTNERSHIP and DHCS and will fully disclose the method and amount of compensation or other consideration to be received by the Subcontractor from the PROVIDER. PROVIDER will notify DHCS and PARTNERSHIP when any subcontract is amended or terminates. PROVIDER will make available to PARTNERSHIP and Governmental Agencies, upon request, copies of all agreements between PROVIDER and Subcontractor(s) for the purpose of providing Covered Services.

6.4.3 All agreements between PROVIDER and any Subcontractor will be in writing and will require Subcontractor to comply with the following:

a. Records and Records Inspection – Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least seven (7) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to PROVIDER and PARTNERSHIP all reports required by PROVIDER, PARTNERSHIP or DHCS and timely gather, preserve and provide to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recover for Litigation.

b. Surcharges – PROVIDER will not make a Surcharge for Covered Services for a Case Managed Member or other person acting on their behalf. If a Surcharge erroneously occurs, PROVIDER will refund the amount of such Surcharge to the Case Managed Member within fifteen (15) days of the occurrence and will notify PARTNERSHIP of the action taken. Upon notice of any Surcharge, PARTNERSHIP will take appropriate action consistent with the terms of this Agreement to eliminate such Surcharge, including, without limitation, repaying the Case Managed Member and deducting the amount of the Surcharge and the expense incurred by PARTNERSHIP in correcting the payment from the next payment due to PROVIDER.

c. Notification – Notify DHCS and PARTNERSHIP in the event the agreement with PROVIDER is amended or terminated. Notice will be given in the manner specified in Section 10.4 Notices.

d. Assignment – Agree that assignment or delegation of the subcontract will be void unless prior written approval is obtained from DHCS and PARTNERSHIP.

e. Additional Requirements – Be bound by the provisions of Section 9.7, Obligations After Termination, and Section 7.4, 7.5 Indemnification.

Other Insurance Coverage. Medi-Cal is the payor of last resort recognizing Other Health coverage as primary. PROVIDER must bill Other Health Coverage (primary) carrier before billing PARTNERSHIP for reimbursement of covered services and, with the exception of authorized Medi-Cal share of cost payments, will at no time seek compensation from Medi-Cal Members or the DHCS. The Specialist may look to the Member for non-covered services.

6.5.1 Coordination of Benefits. PROVIDER has the right to collect all sums as a result of Coordination of Benefits efforts for Covered Services provided to Medi-Cal Member with Other Health Coverage.

a. The determination of liability will be in accordance with the usual procedures employed by the appropriate Governmental Agencies and applicable law, the Medi-Cal Provider Manual, and the PARTNERSHIP Operations Manual.

b. The authority and responsibility for Coordination of Benefits will be carried out in accordance Title 22, CCR, Section 51005, and the DHCS Agreement with PARTNERSHIP.

c. PROVIDER shall report to PARTNERSHIP the discovery of third party insurance coverage for a Medi-Cal Member within 10 days of discovery.

d. Specialist will recover directly from Medicare for reimbursement of medical services rendered. Medicare recoveries are retained by the PROVIDER, but will be reported to the PARTNERSHIP on the encounter form or encounter tape.

6.6 Third Party Liability Tort. In the event that PROVIDER provides services to Medi-Cal Members for injuries or other conditions resulting from the acts of third parties, the State of California will have the right to recover from any settlement, award or recovery from any responsible third party the value of all Covered Services which have been rendered by PROVIDER pursuant to the terms of this Agreement.

a. Primary Care Physician will cooperate with the DHCS and PARTNERSHIP in their efforts to obtain information and collect sums due to the State of California as result of third party liability tort, including Workers' Compensation claims for Covered Services.
b. PROVIDER shall report to PARTNERSHIP the discovery of third party insurance coverage for a Medi-Cal Member within 10 days of discovery.

SECTION 7
INSURANCE AND INDEMNIFICATION

7.1 Insurance – Throughout the term of this Agreement and any extension thereto, PROVIDER will maintain appropriate insurance programs or policies as follows:

7.1.1 PROVIDER will carry, at its sole expense, liability insurance or other risk protection programs, in the amounts of at least Five Hundred Thousand Dollars ($500,000) per person per occurrence in aggregate, including "tail coverage" in the same amounts whenever claims made malpractice is involved. Notification of PARTNERSHIP by PROVIDER of cancellation or material modification of the insurance coverage or the risk protection program will be made to PARTNERSHIP at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to PARTNERSHIP upon execution of this Agreement.

7.2 Other Insurance Coverage. In addition to Section 7.1.1 above, PROVIDER will also maintain, at its sole expense, a policy or program of general liability insurance (or other risk protection) with minimum coverage including and no less than One Hundred Thousand Dollars ($100,000) per person for the protection of the interest and property of

PROVIDER's property together with a Combined Single Limit Body Injury Liability and Property Damage Insurance of not less than One Hundred Thousand Dollars ($100,000) for its members and employees, PARTNERSHIP Members, PARTNERSHIP and third parties, namely, personal injury on or about the premises of the PROVIDER, and general liability.

7.3 Workers' Compensation. PROVIDER's employees will be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code. Documents evidencing such coverage will be provided to PARTNERSHIP upon request.

7.3 PARTNERSHIP Insurance PARTNERSHIP, at its sole cost and expense, will procure and maintain a professional liability policy to insure PARTNERSHIP and its agents and employees, acting within the scope of their duties, in connection with the performance of PARTNERSHIP's responsibilities under this Agreement.

7.4 PROVIDER Indemnification The PROVIDER will indemnify, defend, and hold harmless Medi-Cal Members. The State of California, the PARTNERSHIP and their respective officers, agents, and employees from the following:

a. PROVIDER claims. Any and all claims and losses accruing or resulting to PROVIDER or any of its Subcontractors or any person, firm, corporation or other entity furnishing or supplying work, services, materials or supplies in connection with the performance of this Agreement.
b. Third Party Claims. Any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by PROVIDER, its agents, employees and Subcontractors, in the performance of this Agreement.

PARTNERSHIP Indemnification – PARTNERSHIP will indemnify, defend, and hold harmless PROVIDER, and its agents, and employees from any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by PARTNERSHIP, its officers, agents or employees, in the performance of this Agreement.

SECTION 8
TERM, TERMINATION, AND AMENDMENT

8.1 Initial Term and Renewal – This Agreement will be effective on the date indicated and will automatically renew at the end of one year and annually thereafter unless terminated sooner as set forth below.

8.2 Termination Without Cause – Either party upon sixty (60) days prior written notice to the other party may terminate this Agreement without cause.

8.3 Immediate Termination for Cause by PARTNERSHIP – The PARTNERSHIP may terminate this Agreement immediately by written notice to PROVIDER upon the occurrence of any of the following events:

The suspension or revocation of PROVIDER's license to practice

medicine in the State of California; the suspension or termination of PROVIDER's membership on the active medical staff of any hospital; or the suspension, revocation or reduction in PROVIDER's clinical privileges at any hospital; or suspension from the State Medi-Cal Program; or loss of malpractice insurance; or failure to meet PARTNERSHIP's recredentialing criteria.

8.3.2 PROVIDER's death or disability. As used in this Subsection, the term "disability" means any condition which renders PROVIDER unable to carry out his/her responsibilities under this Agreement for more than forty-five (45) working days (whether or not consecutive) within any 12-month period.

8.3.3 If PARTNERSHIP determines, pursuant to procedures and standards adopted in its Utilization Management or Quality Improvement Programs, that PROVIDER has provided or arranged for the provision of services to Medi-Cal Members which are not Medically Necessary or provided or failed to provide Covered Services in a manner which violates the provisions of this Agreement or the requirements of the PARTNERSHIP Operations Manual.

8.3.4 If PARTNERSHIP determines that the continuation hereof constitutes a threat to the health, safety or welfare of any Medi-Cal Member.

8.3.5 If PARTNERSHIP determines that PROVIDER has filed a petition for bankruptcy or reorganization, insolvency, as defined by law or PARTNERSHIP determines that PROVIDER is unable to meet financial obligations as described in this Agreement.

8.3.6 If PROVIDER breaches Article 9.10, Marketing Activity and Patient Solicitation. An immediate termination for cause made by PARTNERSHIP pursuant to this will not be subject to the cure provisions specified in Section 8.4 Termination for Cause with Cure Period.

8.4 Termination for Cause With Cure Period – In the event of a material breach by either party other than those material breaches set forth in Section 8.3, Immediate Termination for Cause by PARTNERSHIP above of this Agreement, the non-breaching party may terminate this Agreement upon twenty (20) days written notice to the breaching party setting forth the reasons for such termination; provided, however, that if the breaching party cures such breach during the twenty (20) day period, then this Agreement will not be terminated because of such breach unless the breach is not subject to cure.

8.5 Continuation of Services Following Termination – Should this Agreement be terminated, PROVIDER will, at PARTNERSHIP's option, continue to provide Covered Services to Medi-Cal Members who are under the care of PROVIDER at the time of termination until the services being rendered to the Medi-Cal Members by PROVIDER are completed, unless PARTNERSHIP has made appropriate provision for the assumption of such services by another physician and/or provider. PROVIDER will ensure an orderly

transition of care for Medi-Cal Members, including but not limited to the transfer of Medi-Cal Member medical records. Payment by PARTNERSHIP for the continuation of services by PROVIDER after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to the physician of photocopying such records will be reimbursed by the PARTNERSHIP at a cost not to exceed $.10 per page.

8.6 Medi-Cal Member Notification Upon Termination – Notwithstanding Section 8.3, Immediate Termination for Cause by PARTNERSHIP, upon the receipt of notice of termination by either PARTNERSHIP or PROVIDER, and in order to ensure the continuity and appropriateness of medical care to Medi-Cal Members, PARTNERSHIP at its option, may immediately inform Medi-Cal Members of such termination notice. Such Medi-Cal Members will be required to select another PROVIDER prior to the effective date of termination of this Agreement.

Survival of Obligations After Termination – Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of PROVIDER will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 8.5, Continuation of Services Following Termination; 2) Section 6.2, Records and Records Inspection; and, 3) Section 7.3, Hold Harmless. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between PROVIDER and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. PROVIDER will assist PARTNERSHIP in the orderly transfer of Medi-Cal Members to the provider they choose or to whom they are referred. Furthermore, PROVIDER shall assist PARTNERSHIP in the transfer of care as set forth in the Provider Manual, in accordance with the Phaseout Requirements set forth in the Medi-Cal Contract.

8.8 Access to Medical Records Upon Termination – Upon termination of this Agreement and request by PARTNERSHIP, PROVIDER will allow the copying and transfer of medical records of each Medi-Cal Member to the physician and/or provider assuming the Medi-Cal Member's care at termination. Such copying of records will be at PARTNERSHIP's expense if termination was not for cause. PARTNERSHIP will continue to have access to records in accordance with the terms hereof.

8.9 Termination or Expiration of PARTNERSHIP's Medi-Cal Agreement – In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, PROVIDER will allow DHCS and PARTNERSHIP to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, PROVIDER will assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the PROVIDER's Subcontractors, necessary for

efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. Under no circumstances will a Medi-Cal Member be billed for this service. Termination will require sixty (60) days advance written notice of intent to terminate, transmitted by PROVIDER to PARTNERSHIP by Certified U S Mail, Return Receipt Requested, addressed to the office of PARTNERSHIP, as provided in Section 9.4. of this Agreement

SECTION 9
GENERAL PROVISIONS

9.1 Assignment – This Agreement and the rights, interests and benefits hereunder will not be assigned, transferred, pledged, or hypothecated in any way by PROVIDER and will not be subject to execution, attachment or similar process, nor will the duties imposed on PROVIDER be set, contracted or delegated without the prior written approval of PARTNERSHIP and DHCS. Subcontractor's agreements must state that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS. PARTNERSHIP will not assign this Agreement without the approval of PROVIDER.

Amendment – This Agreement may be amended at any time upon written agreement of both parties subject to review and approval by the DHCS and shall become effective only as set forth in subparagraph C Department Approval – Non Federally Qualified HMOS of the Medi-Cal Agreement. This Agreement may be amended by the PARTNERSHIP upon thirty (30) days written notice to the PROVIDER.

9.2.1 If PROVIDER does not give written notice of termination within sixty (60) days, as authorized by Section 8, PROVIDER agrees that any such amendment by PARTNERSHIP will be a part of the Agreement.

9.2.2 Unless PROVIDER or DHCS notifies PARTNERSHIP that it does not accept such amendment, the amendment will become effective sixty (60) days after the date of PARTNERSHIP's notice of proposed amendment.

9.2.3 Proposed amendments to the compensation, services or term provisions of this Agreement, will become effective sixty (60) days after the date DHCS has acknowledged receipt of the notice.

9.2.4 In the event a change in law, regulation or the Medi-Cal Agreement requires an amendment to this Agreement, PROVIDER's refusal to accept such amendment will constitute reasonable cause for PARTNERSHIP to terminate this Agreement pursuant to the termination provisions hereof.

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

Notices – Any notice required or permitted to be given pursuant to this Agreement will be in writing addressed to each party at its respective last known address. Either party will have the right to change the place to which notice is to be sent by giving forty eight (48) hours written notice to the other of any change of address.

9.4.1 PROVIDER will notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. A copy of the written notice will also be mailed as first-class registered mail to:

California State Department of Health Care Services,
Medi-Cal Managed Care Division
1501 Capitol Avenue, Suite 71.4001
MS 4407, P.O. Box 997413
Sacramento, CA 95899-7413

9.4.2 PROVIDER will notify PARTNERSHIP in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. A copy of the written notice will also be mailed as first-class registered mail to:

Partnership HealthPlan of California
360 Campus Lane, Ste 100
Fairfield, CA 94534

9.4.3 PARTNERSHIP will notify PROVIDER in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first class registered mail, postage attached. A copy of the written notice will also be mailed as first-class registered mail to the address indicated on the signature page of this Agreement.

9.5 Entire Agreement – This Agreement, together with the Exhibits and the PARTNERSHIP Operations Manual and policies and procedures, contains the entire agreement between PARTNERSHIP and PROVIDER relating to the rights granted and the obligations assumed by this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

9.6 Headings – The headings of articles and paragraphs contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

9.7 Governing Law – The validity, construction, interpretation and enforcement of this Agreement will be governed by the laws of the State of California, the United States of America, and the contractual obligations of PARTNERSHIP. Further, this Agreement is subject to the requirements of the Act and the regulations promulgated thereunder. Any provision required tobe in this Agreement by law, regulation, or the Medi-Cal Agreement will bind PARTNERSHIP and PROVIDER whether or not provided in this Agreement.

9.8 Affirmative Statement, Treatment Alternatives. Practitioners may freely communicate with patients regarding appropriate treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

9.9 Reporting Fraud and Abuse – PROVIDER is responsible for reporting all cases of suspected fraud and abuse, as defined in 42 CFR Section 455.2 where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by PARTNERSHIP contracted physicians or providers, within 10 days to PARTNERSHIP for investigation.

9.10 Marketing Activity and Patient Solicitation – PROVIDER will not engage in any activities involving the direct marketing of Eligible Beneficiaries without the prior approval of PARTNERSHIP and DHCS.

9.10.1 PROVIDER will not engage in direct solicitation of Eligible Beneficiaries for enrollment, including but not limited to door-to-door marketing activities, mailers and telephone contacts.

9.10.2 During the period of this Agreement and for a one year period after termination of this Agreement, PROVIDER and PROVIDER's employees, agents or Subcontractors will not solicit or attempt to persuade any Medi-Cal Member not to participate in the Medi-Cal Managed Care Program or any other benefit program for which PROVIDERS render contracted services to PARTNERSHIP Members.

9.10.3 In the event of breach of this Section 9.10, in addition to any other legal rights to which it may be entitled, PARTNERSHIP may at its sole discretion, immediately terminate this Agreement. This termination will not be subject to Section 8.4, Termination for Cause with Cure Period.

9.11 Nondisclosure and Confidentiality – PROVIDER will not disclose the payment provisions of this Agreement except as may be required by law.

9.12 Proprietary Information – With respect to any identifiable information concerning a Medi-Cal Member that is obtained by PROVIDER and its Subcontractors will not use any such information for any purpose other than carrying out the express terms of this Agreement; will promptly transmit to PARTNERSHIP all requests for disclosure of such information, except requests for medical records in accordance with applicable law; will not disclose any such information to any party other than DHCS without PARTNERSHIP's prior written authorization, except as specifically permitted by this Agreement or the PARTNERSHIP Medi-Cal Agreement with DHCS, specifying that the information is releasable by law as set forth in the Medi-Cal Agreement; and, will, at expiration or termination of this Agreement, return all such information to PARTNERSHIP or maintain such information according to written procedures provided by PARTNERSHIP for this purpose.

9.13 Non-Exclusive Agreement – To the extent compatible with the provision of Covered Services to Medi-Cal Members for which PROVIDER accepts responsibility hereunder, PROVIDER reserves the right to provide professional services to persons who are not

Medi-Cal Members including Eligible Beneficiaries. Nothing contained herein will prevent PROVIDER from participating in any other prepaid health care program.

9.14 Counterparts – This Agreement may be executed in two (2) or more counterparts, each one (1) of, which will be deemed an original, but all of which will constitute one (1) and the same instrument.

9.15 HIPAA. Health Insurance Portability Accountability Act. Section 1171 (5)(e). The PARTNERSHIP is required to comply with HIPAA standards. PROVIDER is required to be in compliance with HIPAA standards.

Provisions for Protected Health Information – The agreement between the PROVIDER and PHC includes the use of protected health information (PHI). PHI may be used for purposes of payment, treatment, and operations. The PROVIDER must protect PHI internally and within any organization with which the PROVIDER contracts for clinical or administrative services. Upon request, the PROVIDER must provide individuals with access to their PHI. If the PROVIDER identifies any inappropriate uses of or breach of PHI, the PROVIDER must notify PHC's Privacy Officer immediately. If the PROVIDER agreement ends or is terminated, the PROVIDER agrees to continue to protect PHI.

SECTION 10
GRIEVANCES AND APPEALS

10.1 Appeals and Grievances.

10.1.1 PROVIDER complaints, concerns, or differences, which may arise as a health care provider under contract with PARTNERSHIP will be resolved as outlined in the following paragraphs and as set forth in the PARTNERSHIP Operations Manual. PROVIDER and PARTNERSHIP agree to and will be bound by the decisions of PARTNERSHIP's grievance and appeal mechanisms.

10.1.2 PROVIDER will cooperate with PARTNERSHIP in identifying, processing and resolving all Medi-Cal Member complaints and grievances in accordance with the Medi-Cal Member grievance procedure set forth in the PARTNERSHIP Operations Manual.

10.2 Responsibility – It is the responsibility of the PARTNERSHIP's Executive Director for maintenance, review, formulation of policy changes, and procedural improvements of the grievance system. The Executive Director will be assisted in this process by the Directors of Provider Relations and Health Services.

10.3 Arbitration – If the parties cannot settle grievances or disputes between them in an informal and expeditious fashion, the dispute will be submitted, upon the motion of either party, to arbitration under the appropriate rules of the American Arbitration Association (AAA). All such arbitration proceedings will be administered by the AAA; however, the arbitrator will be bound by applicable state and federal law, and will issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that all arbitration proceeding will take place in Fairfield, California, that the appointed arbitrator will be encouraged to initiate hearing proceedings within thirty (30) days of the date of

his/her appointment, and that the decision of the arbitrator will be final and binding as to each of them. The party against whom the award is rendered will pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award, or take an appeal pursuant to the provisions of the California Civil Code.

10.3.1 Administration and Arbitration Fees. In all cases submitted to AAA, the parties agree to share equally the AAA administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees will be advanced by the initiating party subject to final apportionment by the arbitrator in the award.

10.3.2 Enforcement of Award. The parties agree that the arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce said award. Costs of filing may be recovered by the party, which initiates such action to have an award enforced.

10.3.3 Impartial Dispute Settlement. Should the parties, prior to submitting a dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, joint request for such services may be made to the AAA, or the parties may initiate such other procedures as they may mutually agree upon at such time.

10.3.4 Initiation of Procedure. Nothing contained herein is intended to create, nor will it be construed to create, any right of any Medi-Cal Member to independently initiate the arbitration procedure established in this Article. Further, nothing contained herein is intended to require arbitration of disputes regarding professional negligence between the Case Managed Member and the PROVIDER.

Administrative Disputes. Notwithstanding anything to the contrary in this Agreement, any and all administrative disputes which are directly or indirectly related to an allegation of Primary Care Physician malpractice may be excluded from the requirements of this Article.

10.4 Peer Review and Fair Hearing Process – Providers determined hereto to constitute a threat to the health, safety or welfare of Medi-Cal Members will be referred to the PARTNERSHIP Peer Review Committee. The Provider will be afforded an opportunity to address the Committee. The Provider will be notified in writing of the Peer Review Committee's recommendation and of their rights to the Fair Hearing process. The Peer Review Committee can recommend to suspend, restrict, or terminate the provider affiliation, to institute a monitoring procedure, or to implement continuing educational requirements.

10.5 Credentialing – The PHC Credentialing Committee will review all provider files to determine whether a provider meets the PARTNERSHIP credentialing or recredentialing requirements or, as applicable, provider licensure and compliance with the State Medi-Cal Program Standards of Participation. If the committee deems otherwise, the Provider will be afforded an opportunity to address this committee. The Provider will be advised in writing of the Credentialing Committee's recommendation and notified of their rights

to the Fair Hearing process. The Credentialing Committee can recommend denial of a provider's initial application or can deny the recredentialing of a current provider.

SECTION 11
RELATIONSHIP OF PARTIES

11.1 Overview – None of the provisions of this Agreement are intended, nor will they be construed to create, any relationship between the parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture or employment between the parties. Unless mutually agreed, nothing contained herein will prevent PROVIDER from independently participating as a provider of services in any other health maintenance organization or system of prepaid health care delivery. In such event, PROVIDER will provide written assurance to PARTNERSHIP that any contract providing commitments to any other prepaid program will not prevent PROVIDER from fulfilling its obligations to Medi-Cal Members under this Agreement, including the timely provision of services required hereunder and the maximum capacity allowed under the Medi-Cal Agreement.

Oversight Functions – Nothing contained in this Agreement will limit the right of PARTNERSHIP to perform its oversight and monitoring responsibilities as required by applicable state and federal law, as amended.

PROVIDER-Patient Relationship – This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her PROVIDER. PROVIDERS will be responsible for maintaining the professional relationship with Medi-Cal Members and are solely responsible to such Medi-Cal Members for all medical services provided. PARTNERSHIP will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of PROVIDER.

ATTACHMENT A
NONDISCRIMINATION CLAUSE
(OPC – 1)

1. During the performance of this Agreement, Provider and its subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, age (over 40), or sex. Providers and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) And the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0, et seq.). The Applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations and incorporated into this Agreement by reference and made part hereof as set fourth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have collective bargaining or other agreement.

2. This Provider shall include the nondiscrimination and compliance provisions of this clause in all Subcontractors to perform work under this Agreement.

ATTACHMENT B
INFORMATION REGARDING OFFICERS, OWNERS, AND STOCKHOLDERS

List the names of the officers, owners, stockholders owning more than 5% of the stock issued by the physician, and major creditors holding more than 5% of the debt of the organization identified on the execution page of this Agreement. (This is a requirement of Title 22, CCR, Section 53250).

None

ATTACHMENT C
FACILITY LOCATIONS

List under each applicable county name, the physician name, location(s) and hours of operation, mid-level practitioners supervised and languages spoken that shall apply to this Agreement.

Mendocino County Health and Human Services Agency
Alcohol and Other Drug Programs
1120 South Dora Street
Ukiah, CA 95482

Monday through Thursday – 8:00 a.m. to 5:00 p.m. by appointment.
Languages spoken: English and Spanish

Mendocino County Health and Human Services Agency
Alcohol and Other Drug Programs
120 West Fir Street
Fort Bragg, CA 95437

Monday through Thursday – 8:00 a.m. to 5:00 p.m. by appointment.
Languages spoken: English, Spanish, French

Mendocino County Health and Human Services Agency
Communicable Disease and Immunization Programs
Craig McMillan, Interim Public Health Officer
Charles Evans, M.D.
1120 South Dora Street
Ukiah, CA 95482

Monday through Thursday – 8:00 a.m. to 5:00 p.m. by appointment
Languages spoken: English and Spanish

Mendocino County Health and Human Services Agency
Communmicable Disease and Immunization Programs
Craig McMillan, Interim Public Health Officer
Charles Evans, M.D.
120 West Fir Street
Fort Bragg, CA 95437

Monday through Thursday – 8:00 a.m. to 5:00 p.m. by appointment
Languages spoken: English and Spanish

Mendocino County Health and Human Services Agency
Communicable Disease and Immunization Programs
Craig McMillan, Interim Public Health Officer
Charles Evans. M.D.
221 South Lenore - Suite B
Willits, CA 95490

Monday through Thursday – 8:00 a.m. to 5:00 p.m. by appointment

Languages spoken: English and Spanish

ATTACHMENT D
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUPPLEMENTAL SUBSTANCE ABUSE BENEFIT
BENEFIT DESCRIPTION

Level of Care	Benefit	Full Services	Partial Services
Pre-Treatment Readiness and Prevention Program H0001 $40/session/ person	up to 6 sessions, per person per episode* (1 - 1.5 hours to be provided per person, per session)	Assessment Counseling (Individual or Group)* Education	Prevention (6 sessions)
Perinatal Residential H0018 $71/diem	up to 30 days maximum per person, per episode.*	Intake Assessment Admission Physical Exam Laboratory Tests Diagnosis Medical Direction Individual Counseling Group Counseling* Urine Drug Screens Medication Management Collateral Services Crisis Intervention Education *(These services are available for females on day 61 postpartum if she did not access her Drug Medi-Cal benefit during the first 60 days postpartum.)*	Individual Counseling Group Counseling Urine Drug Screens Medication Management Collateral Services Crisis Intervention Education *(These services are available for females on day 61 postpartum if Drug Medi-Cal dollars have been exhausted.)*
Day Treatment H0015 + modifier TH (Perinatal) $81/session H0015 (Non-Perinatal) $66/session	1 session per day, per person allowed (minimum 3 hours per session). 7 days per week, per person allowed (up to 14 sessions max per episode)*	Intake (Assessment, Evaluatio Diagnosis) Admission Physical Exam Treatment Planning Individual Counseling Group Counseling* Urine Drug Screens Medication Management Collateral Services Crisis Intervention Education *(These services are available to females who are at least 61 days postpartum and males/females who are not between the ages of 13-21 as they do not have access to Drug Medi-Cal benefits.)*	Individual Counseling Group Counseling* Urine Drug Screens Medication Management Collateral Services Crisis Intervention Education *(These services are available if Drug Medi-Cal dollars have been exhausted for females 60 days postpartum and teens 13-21 years old).*

ATTACHMENT D – PAGE 2
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUPPLEMENTAL SUBSTANCE ABUSE BENEFIT
BENEFIT DESCRIPTION

Outpatient Drug Free T1008 $50/session/ person T1008 + modifier HQ $35/person for group sessions	Individual: 1 session per day, per person allowed (minimum of 50 minutes per session, per person to be provided). Up to 20 sessions per rolling*** year per person allowed. Group: 1 session per day, per person allowed (minimum of 90 minutes per session). Up to 48 sessions pe rolling*** year per person allowed.	Individual Counseling* Collateral Services** Group Counseling	
Continuous Recovery/ Treatment T1011 $ 33/session/ person	up to 3 sessions per week per person allowed (1-1.5 hours per session to be provided) up to 20 sessions max per episode.*	Regular process group Individual Counseling Education Support Groups Conjoint Therapy	
Family and Codependency Program T1006 $ 40/session/ family unit	1 session per week up to 4 sessions max per episode per Family Unit or Significant Other* 1-2 hours per session, then referral to al/nar anon. *(Only the Family Unit will participate, not the member. Any authorization would be created under the members name).*	Education	

Notes:

1. An intake must be created on any PHC member who accesses the PHC Substance Abuse Benefit.
2. This matrix assumes that 7 days = 1 week, 4 weeks = 28 days, and 3 months = 84 days.
3. ** Indicates services to which individual counseling is limited.
4. * Episode is based on medical necessity.
5. * Group => 1 person, no limit on number of participants.
6. *** Rolling Year = 365 days from entry into first O.D.F. treatment. (revised 7/19/02)
7. Local codes were replaced with HCPCS 2003 codes to be HIPAA compliant, effective 6/1/03.

Revised: 7/26/00, 7/19/02, 6/1/03, (June 1, 2005 to increase pre-treatment readiness to 6 sessions, from 3)