

CONFIDENTIAL

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Contract Number
23-854

SAP Number

Arrowhead Regional Medical Center

Department Contract Representative
Telephone Number

William L. Gilbert, Director
(909) 580-6150

Contractor
Contractor Representative
Telephone Number
Contract Term

Alpha Care Medical Group
Chandan Basho

January 1, 2022 – December 31,
2024

Original Contract Amount
Amendment Amount
Total Contract Amount
Cost Center

Revenue Agreement

9186104200

PROVIDER SERVICES AGREEMENT

WHEREAS, Alpha Care Medical Group ("IPA") is an Independent Physician/Practice Association that is contracted with health plans to coordinate care for the health plans' Medi-Cal managed care plan members who are delegated to IPA ("Members") and is responsible for coordinating and paying for services for the Members; and

WHEREAS, San Bernardino County ("County"), by and through Arrowhead Regional Medical Center ("ARMC"), operates several healthcare facilities to ensure that the residents of San Bernardino County have access to medical services; and

WHEREAS, IPA desires to contract with the County for ARMC to provide medically necessary outpatient services to the Members; and

WHEREAS, County, by and through ARMC, desires to provide medically necessary outpatient services to the Members; and

NOW, THEREFORE, the County on behalf of ARMC and IPA enter into this Contract as a full statement of their respective responsibilities during the term of this Contract, and in consideration of the representations made above and the covenants and conditions set forth herein, the parties agree as follows:

A. RESPONSIBILITIES

A.1 ARMC shall arrange for the provision of medically necessary outpatient services ("Services"), as requested by IPA, to Members at the following locations:

- Arrowhead Regional Medical Center | 400 N. Pepper Ave., Colton, CA 92324
- Arrowhead Family Health Center – Fontana | 16888 Baseline Avenue, Fontana, CA 92336
- Arrowhead Family Health Center – McKee | 1499 E. Highland Ave., San Bernardino, CA 92404
- Arrowhead Family Health Center – Redlands | 800 East Lugonia Avenue Suite F, Redlands, CA 92374
- Arrowhead Family Health Center – Westside | 850 East Foothill Blvd., Rialto, CA 92376

Notwithstanding the foregoing, and subject to all applicable laws, ARMC reserves the right to refuse outpatient services to any individual that is dismissed as a patient from ARMC's care due to abusive, harassing, violent, or other similar conduct that endangers the safety or health of ARMC's employees, patients, or visitors, or that significantly disrupts ARMC's operations.

A.2 ARMC shall provide the Services in accordance with all applicable federal and state laws, licensing requirements, regulatory requirements, requirements of accreditation agencies, and professional standards.

A.3 All Member medical records and data related to Services to Members generated by ARMC shall remain the property of ARMC and shall be kept in compliance with all applicable privacy and confidentiality requirements imposed by state and federal laws, including, without limitation, the relevant requirements of the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, Confidentiality of Medical Information Act, Lanterman-Petris-Short Act, and other such applicable laws regarding confidentiality of medical records and regulations adopted thereunder. Notwithstanding the foregoing and subject to all applicable laws, upon IPA's reasonable request, ARMC may provide such records and data to IPA.

A.4 IPA shall be fully informed of the types of Services that ARMC and its healthcare providers are capable of providing to Members. IPA shall not refer any Members to ARMC for Services which ARMC does not have the technical capability to provide.

- A.5** Subject to all applicable laws and upon reasonable request by ARMC, IPA shall provide all medical records in its possession relating to Members referred to ARMC to enable ARMC to appropriately provide the Services.

B. GENERAL CONTRACT REQUIREMENTS

B.1 Contract Amendments

Any alterations, variations, modifications, or waivers of the provisions of the Contract, shall be valid only when reduced to writing, executed and attached to the original Contract and approved by the person(s) authorized to do so on behalf of the parties.

B.2 Contract Assignability

Neither party shall assign this Contract, or their respective obligation, duties, or benefits under this Contract without the prior written consent of the other party. This Contract, and all of its terms and conditions, shall be binding upon and shall inure to the benefit of the heirs, executors, administrators, successors, and assigns of the respective parties, provided no such assignment is in violation of the provisions of this Contract.

B.3 Choice of Law; Venue

This Contract shall be governed by and construed under the laws of the State of California. Any action under this Contract shall be venued exclusively in the Superior Courts of the State of California, San Bernardino County, San Bernardino District.

B.4 Confidentiality

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, regulations have been promulgated governing the privacy of individually identifiable health information. The parties acknowledge they are covered entities who are subject to HIPAA and HITECH. The parties agree to fully comply with the applicable provisions of HIPAA and HITECH, and all other applicable federal and state laws pertaining to the protection of health information.

B.5 County Representative

The ARMC Hospital Director shall represent the County in all matters pertaining to the services to be rendered under this Contract, including termination and assignment of this Contract.

B.6 Debarment and Suspension

The parties represent and warrant that they are not and at no time have been convicted of any criminal offense related to health care nor has been debarred, excluded, or otherwise ineligible for participation in any federal or state government health care program, including Medicare and Medicaid. Further, the parties represent and warrant that no proceedings or investigations are currently pending or to the party's knowledge threatened by any federal or state agency seeking to exclude the party from such programs or to sanction the party for any violation of any rule or regulation of such programs. In the event that either party receives notice of, or otherwise becomes aware of, any debarment, proposed debarment or such other exclusion, suspension, restriction or sanction of itself, or any person

providing services in connection with the performance of this Contract, the party shall notify the other party of this immediately, and the other party shall have the right to immediately terminate this Contract upon written notice.

B.7 Legality and Severability

The parties' actions under the Contract shall comply with all applicable laws, rules, regulations, court orders and governmental agency orders. The provisions of this Contract are specifically made severable. If a provision of the Contract is held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall remain in full effect.

B.8 Licenses, Permits and/or Certifications

The parties shall ensure that they have all necessary licenses, permits and/or certifications required by the laws of Federal, State, County, and municipal laws, ordinances, rules and regulations. The parties shall maintain these licenses, permits and/or certifications in effect for the duration of this Contract. Each party will notify the other immediately of loss or suspension of any such licenses, permits and/or certifications. Failure to maintain a required license, permit and/or certification may result in immediate termination of this Contract.

B.9 Nondisclosure

Each party shall hold as confidential this Contract, and shall not disclose this Contract to any third-party, except where disclosure is required by law.

B.10 Access to Records

Each party shall maintain all records and books pertaining to the delivery of services under this Contract and demonstrate accountability for contract performance. All records shall be complete and current and comply with all Contract requirements. During the term of this Contract, plus four (4) years after the term, both parties will comply with all applicable requirements of 42 CFR Section 420.302, including without limitation: (i) retaining required documents, and (ii) giving the US Comptroller General, HHS, and their duly authorized representatives access to its contract, books, documents, and records related to this Contract and those of any organizations related to the parties.

B.11 Relationship of the Parties

The relationship between the parties is an independent contractor relationship. Neither parties' employees and/or agents are or shall be considered an employee and/or agents of the other party. Nothing contained in this Contract shall be construed as creating a joint venture, partnership, or employment arrangement between the Parties hereto, nor shall either Party have the right, power or authority to create an obligation or duty, expressed or implied, on behalf of the other Party.

B.12 Mutual Covenants

The parties to this Contract mutually covenant to perform all of their obligations hereunder, to exercise all discretion and rights granted hereunder, and to give all consents in a reasonable manner consistent with the standards of "good faith" and "fair dealing".

C. TERM AND TERMINATION

This Contract is retroactively effective as of January 1, 2022 and will continue in effect for a period of three (3) years, but may be terminated earlier in accordance with the provisions of this Contract.

Each party reserves the right to terminate the Contract, for any reason without cause, with a One Hundred Eighty (180) days written notice. Upon termination and in accordance with the Fiscal Provisions in this Contract, payment will be made by the IPA to County for all Services rendered to Members prior to the date of termination. Upon termination, the parties shall cooperate with each other to ensure continuity of care for the Members, and IPA shall comply with all applicable laws and contractual requirements with the health plan relating to continuity of care for such Members.

A party may terminate this Contract for material breach of this Contract by the other party upon thirty (30) calendar days' written notice specifying the nature of the breach, if such breach has not been cured to the reasonable satisfaction of the non-breaching party within such thirty (30) day period..

D. FISCAL PROVISIONS

D.1 Compensation: IPA shall pay to County 100% of the prevailing Medi-Cal rate on the date of service for the Services rendered by ARMC to the Members. Notwithstanding the foregoing, payment shall not exceed ARMC's total billed charges. IPA shall make such payments within forty-five (45) working days (as defined in 28 CCR Section 1300.71(a)(13)) from receipt of a Clean Claim. The term "Clean Claim" is defined as claim forms submitted that include all reasonably relevant information necessary to process the claim, per Medi-Cal guidelines. County and IPA agree that for any Services provided to Members during the period between January 1, 2022, through the date this Agreement is fully executed, and- for which County has been reimbursed according to rates established by DHCS or by other existing agreements which County and IPA are a party, such rates shall be honored and not contested by either party. Nothing herein, however, waives County's right to appeal a denial of a claim under such rates established by DHCS or other agreements.

D.2 Billing: ARMC shall submit Clean Claims to IPA within ninety (90) days but no later than one-hundred and eighty (180) calendar days from the date of service. The claim shall be submitted on the Universal Billing Form (UB04), or its successor claim form.

D.3 ARMC shall send all claims to IPA at the following address, Electronic Data Interchange (EDI) # or fax number:

*Alpha Care Medical Group, Inc.
c/o: Network Medical Management
Claims Department
1600 Corporate Center Dr., Suite 103
Monterey Park, CA 91754*

E. INDEMNIFICATION AND INSURANCE REQUIREMENTS

E.1 Indemnification

- IPA shall defend, indemnify and hold County, its officers, employees and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages that is proximately caused by the negligent or intentional acts or omissions of IPA, its officers, employees, and agents.
- County shall indemnify and hold IPA, its officers, employees, and agents harmless from and against any and all liability, loss, expense (including reasonable attorneys' fees), or claims for injury or damages that is proximately caused by the negligent acts or omissions of County, its officers, employees and agents.
- In the event that IPA or County is found to be comparatively at fault for any claim, action, loss or damage which results from their respective actions or omissions, the IPA and/or County shall indemnify the other to the extent of its comparative fault.
- The parties' indemnification obligations set forth above are conditioned on the following: (a) the indemnified party must provide the indemnifying party with: (i) prompt written notice of such claim (but in any event notice in sufficient time for the indemnifying party to respond without prejudice); (ii) the exclusive right to control and direct the investigation, defense and settlement (if applicable) of such claim; except that the indemnified party may participate in such defense at its own cost; and (iii) all reasonable necessary cooperation at the indemnifying party's expense in defending the claim; and (b) the indemnifying party will not settle any indemnifiable claim without the indemnified party's prior written consent to the extent such settlement requires the indemnified party to admit any liability or pay any amount not reimbursed by the indemnifying party. The parties' indemnification obligations provided herein survive expiration or termination of this Contract.

E.2 Insurance

Each party agrees to maintain insurance policies or a self-insurance program with the minimum policy limits set forth below for the term of this Contract:

- Workers' Compensation/Employer's Liability – A program of Workers' Compensation insurance or a state-approved, self-insurance program in an amount and form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability.
- Commercial/General Liability Insurance – General Liability Insurance covering all operations performed by or on behalf of the party providing coverage for bodily injury and property damage with a combined single limit of not less than one million dollars (\$1,000,000), per occurrence. The policy coverage shall include personal injury, contractual liability, and a minimum \$3,000,000 general aggregate limit.
- Professional Liability – Professional Liability Insurance with limits of not less than one million (\$1,000,000) per claim and three million (\$3,000,000) aggregate.

F. REGULATORY COMPLIANCE

Both parties agree to the terms and provisions set forth in the following Exhibits, each of which are attached hereto and incorporated herein by reference, which shall control over any inconsistent provisions in this Contract.

- Exhibit A- Claims Settlement Practices & Dispute Resolution Mechanism
- Exhibit B - Medi-Cal Program Requirements
- Exhibit C- Utilization Management Program

G. NOTICES

All written notices provided for in this Contract or which either party desires to give to the other shall be deemed fully given, when made in writing and either served personally, or deposited in the United States mail, postage prepaid, and addressed to the other party as follows:

Arrowhead Regional Medical Center
400 N. Pepper Avenue
Colton, CA 92324
Attn: Hospital Director

Alpha Care Medical Group, Inc.
c/o: Network Medical Management
1668 S. Garfield Ave. 2nd Floor
Alhambra, CA 91801
Attn: CEO

Notice shall be deemed communicated two (2) County working days from the time of mailing if mailed as provided in this paragraph.

H. ENTIRE AGREEMENT

This Contract represents the final, complete agreement between the parties hereto. Any prior agreement, promises, negotiations or representations relating to the subject matter of this Contract not expressly set forth herein are of no force or effect. This Contract is executed without reliance upon any promise, warranty or representation by any party or any representative of any party other than those expressly contained herein. Each party has carefully read this Contract and signs it of its own free will.

I. ELECTRONIC SIGNATURES

This Contract may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Contract. The parties shall be entitled to sign and transmit an electronic signature of this Contract (whether by facsimile, PDF or other mail transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Contract upon request.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, San Bernardino County on behalf of Arrowhead Regional Medical Center and IPA have each caused this Contract to be subscribed by its respective duly authorized officers, on its behalf.

SAN BERNARDINO COUNTY on behalf of Arrowhead Regional Medical Center

► Dawn Rowe

Dawn Rowe, Chair, Board of Supervisors

Dated: AUG 08 2023

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD

By Lynna Monell
Clerk of the Board of Supervisors
San Bernardino County

By [Signature]
Deputy



Type text here

Alpha Care Medical Group

(Print or type name of corporation, company, contractor, etc.)

By ► [Signature]
(Authorized signature - sign in blue ink)

Name CHANDAN BASHO
(Print or type name of person signing contract)

Title Chief Strategy & Financial Officer
(Print or Type)

Dated: 6/20/2023

Address AlphaCare Medical Group Inc.
c/o Network Medical Management

1668 S. Garfield Ave. 2nd floor
Alhambra, CA 91801

FOR COUNTY USE ONLY

Approved as to Legal Form

► [Signature]
Charles Phan, Deputy County Counsel

Date 7/12/2023

Reviewed for Contract Compliance

► _____
Date _____

Reviewed/Approved by Department

► [Signature]
William L. Gilbert, Hospital Director

Date 7/12/23

EXHIBIT A
CLAIMS SETTLEMENT PRACTICES & DISPUTE RESOLUTION MECHANISM

As required by Assembly Bill 1455, the Department of Managed Health Care has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the Department of Managed Health Care. This information notice is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and claim disputes for commercial HMO, POS, Medicare HMO, Medi-Cal HMO and, where applicable, PPO products where Network Medical Management is delegated to perform claims payment and provider dispute resolution processes. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

I. Claim submission instructions

- A. Sending Claims to Alpha Care Medical Group, Inc. Claims for services provided to members assigned to Alpha Care Medical Group, Inc. must be sent to the following:

Via Mail: *Alpha Care Medical Group, Inc.
c/o: Network Medical Management
Claims Department
1600 Corporate Center Dr., Suite 103
Monterey Park, CA 91754*

Via Physical Delivery: *[Same as above]*

- B. Calling Alpha Care Medical Group, Inc. Regarding Claims. For claim filing requirements or status inquiries, you may contact *Network Medical Management Customer Service* by calling: (626) 943-6180
- C. Claim Submission Requirements. The following is a list of claim timeliness requirements, claims supplemental information and claims documentation required by *Alpha Care Medical Group, Inc.*:

If claim is being presented for the first time (1st submission), the following apply:

- *contracted providers: 90 days from DOS*
- *non-contracted providers: 180 days from DOS*
- *COB claims, when IPA is not the primary payor: 90 days from the date of primary carrier's EOB.*
 *** (If provider submitted claims previously and IPA does not have records of claims received or received on time, IPA has 45 days to return the claims to the provider requesting provider to resubmit appeal with proof of timely filing).*

- D. Claim Receipt Verification. For verification of claim receipt by *Alpha Care Medical Group, Inc.*, please call *Customer Service* at (626) 943-6180

For appealed claims submitted on time:

- *IPA issues an acknowledgement for receipt within 15 days.*
- *2 days if electronically submitted.*

II. Dispute Resolution Process for Contracted Providers

- A. Definition of Contracted Provider Dispute. A contracted provider dispute is a provider's written notice to *Alpha Care Medical Group, Inc.* and/or the member's applicable health plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an

overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

- (i) If the contracted provider dispute concerns a claim or a request for reimbursement of an underpayment of a claim from *Alpha Care Medical Group, Inc.* to a contracted provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
- (ii) If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
- (iii) If the contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. **Sending a Contracted Provider Dispute to Alpha Care Medical Group, Inc.** Contracted provider disputes submitted to *Alpha Care Medical Group, Inc.* must include the information listed in Section II.A., above, for each contracted provider dispute. All contracted provider disputes must be sent to the attention of *Provider Dispute Unit* at the following:

Via Mail: [Same as above]

Via Physical Delivery: [Same as above]

C. **Time Period for Submission of Provider Disputes.**

- (i) Contracted provider disputes must be received by *Alpha Care Medical Group, Inc.* within 365 days from *Alpha Care Medical Group, Inc.*'s action that led to the dispute (or the most recent action if there are multiple actions) that led to the dispute, or
- (ii) In the case of *Alpha Care Medical Group, Inc.*'s inaction, contracted provider disputes must be received by *Alpha Care Medical Group, Inc.* within 365 days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
- (iii) Contracted provider disputes that do not include all required information as set forth above in Section II.A. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to *Alpha Care Medical Group, Inc.* within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. **Acknowledgement of Contracted Provider Disputes.** *Alpha Care Medical Group, Inc.* will acknowledge receipt of all contracted provider disputes as follows:

- (i) Electronic contracted provider disputes will be acknowledged by *Alpha Care Medical Group, Inc.* within two (2) Working Days of the Date of Receipt by *Alpha Care Medical Group, Inc.*
- (ii) Paper contracted provider disputes will be acknowledged by *Alpha Care Medical Group, Inc.* within fifteen (15) Working Days of the Date of Receipt by *Alpha Care Medical Group, Inc.*

E. **Contact Alpha Care Medical Group, Inc. Regarding Contracted Provider Disputes.** All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to *Alpha Care Medical Group, Inc.* at: *Customer Service: (626) 943-6180*

F. **Instructions for Filing Substantially Similar Contracted Provider Disputes.** Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

- (i) Sort provider disputes by similar issue
- (ii) Provide cover sheet for each batch
- (iii) Number each cover sheet

- (iv) *Provide a cover letter for the entire submission describing each provider dispute with references to the numbered coversheets*

- G. Time Period for Resolution and Written Determination of Contracted Provider Dispute. *Alpha Care Medical Group, Inc.* will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) Working Days after the Date of Receipt of the contracted provider dispute or the amended contracted provider dispute.
- H. Past Due Payments. If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, *Alpha Care Medical Group, Inc.* will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) Working Days of the issuance of the written determination.

III. Dispute Resolution Process for Non-Contracted Providers

- A. Definition of Non-Contracted Provider Dispute. A non-contracted provider dispute is a non-contracted provider's written notice to *Alpha Care Medical Group, Inc.* challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must contain, at a minimum, the following information: the provider's name, the provider's identification number, contact information, and:
 - (i) If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from *Alpha Care Medical Group, Inc.* to provider the following must be provided: a clear identification of the disputed item, the Date of Service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect;
 - (ii) If the non-contracted provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including the Date of Service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.
- B. Dispute Resolution Process. The dispute resolution process for non-contracted Providers is the same as the process for contracted Providers as set forth in sections II.B., II.C., II.D., II.E., II.F., II.G., and II.H. above.

IV. Claim Overpayments

- A. Notice of Overpayment of a Claim. If *Alpha Care Medical Group, Inc.* determines that it has overpaid a claim, *Alpha Care Medical Group, Inc.* will notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the Date of Service(s) and a clear explanation of the basis upon which *Alpha Care Medical Group, Inc.* believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.
- B. Contested Notice. If the provider contests *Alpha Care Medical Group, Inc.*'s notice of overpayment of a claim, the provider, within 30 Working Days of the receipt of the notice of overpayment of a claim, must send written notice to *Alpha Care Medical Group, Inc.* stating the basis upon which the provider believes that the claim was not overpaid. *Alpha Care Medical Group, Inc.* will process the contested notice in accordance with *Alpha Care Medical Group, Inc.*'s contracted provider dispute resolution process described in Section II above.
- C. No Contest. If the provider does not contest *Alpha Care Medical Group, Inc.*'s notice of overpayment of a claim, the provider must reimburse *Alpha Care Medical Group, Inc.* within thirty (30) Working Days of the provider's receipt of the notice of overpayment of a claim.

- D. Offsets to payments. *Alpha Care Medical Group, Inc.* may only offset an uncontested notice of overpayment of a claim against provider's current claim submission when; (i) the provider fails to reimburse *Alpha Care Medical Group, Inc.* within the timeframe set forth in Section IV.C., above, and (ii) *Alpha Care Medical Group, Inc.*'s contract with the provider specifically authorizes *Alpha Care Medical Group, Inc.* to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims pursuant to this section, *Alpha Care Medical Group, Inc.* will provide the provider with a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

EXHIBIT B
MEDI-CAL PROGRAM REQUIREMENTS

This Exhibit B sets forth requirements, in addition to those requirements set forth elsewhere in the Contract, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Medi-Cal Program.

1. With respect to the Medi-Cal Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Medi-Cal Services Agreement and Medi-Cal Member Handbook. Covered Services, including Medical Group Services, for Medi-Cal Members are set forth in Title 22 of the California Code of Regulations Section 51301 et seq., and Title 17 of the California Code of Regulations Section 6840 et seq. Information regarding Medical Group Services, excluded services, and certain health screening and preventive services for Medi-Cal Members is set forth in the Provider Manual. **[[22 CCR § 53250(c)(1)]]**
2. With respect to the Medi-Cal Program, the term "Medi-Cal Member" shall mean an individual who is enrolled in Medi-Cal and who is determined to be eligible for membership in the Medi-Cal Program. A newborn of a Medi-Cal Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment. **[[DHCS Contract, Exhibit A, Attachment 16, No. 3]]**
3. County agrees to make all of its books and records, pertaining to the goods and services furnished under the terms of this Contract, available for inspection, examination or copying: (A) By the California Department of Health Care Services ("DHCS"), the United States Department of Health and Human Services, the California Department of Corporations, the United States Department of Justice, and the California Department of Managed Health Care; (B) At all reasonable times at the County's place of business, or at such other mutually agreeable location in California; (C) In a form maintained in accordance with the general standards applicable to such book or record keeping; (D) For a term of at least five years from the close of the Fiscal Year in which this Contract was in effect; five years from the close of the current Fiscal Year in which the date of service occurred; five years from the date that the record or data was created or applied, and for which the financial record was created, or such longer period as required by Law; and (E) including all Covered Services Documentation for a period of at least 5 years, or such longer period as required by Law. **[[22 CCR 53250(e)(1)]]**
4. Member Cost-Sharing Payments are not permitted under the Medi-Cal Program. County shall not seek reimbursement of any such payments from Medi-Cal Members for any Covered Services provided under this Contract. **[[Medi-Cal Contract Exhibit A, Attachment 8, No. 5, W & I § 14452.6]]**
5. County agrees to submit reports as required by Plan. **[[Exhibit A, Attachment 6, No. 12-B-6; 22 CCR § 53250(c)(5)]]**
6. Plan shall conduct site reviews on all Medical Group Services sites according to Medi-Cal Managed Care Division Policy Letter 02-02. **[[Exhibit A, Attachment 4, No. 10-A]]**
7. If this Contract terminates for any reason, County will assist the Plan in the transfer of care. **[[DHCS Contract Exhibit A, Attachment 6, No. 12-B-11]]** Additionally, County will assist in the orderly transfer of necessary data and records to the Plan, a successor Plan, or DHCS. County will assist in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, County will make available to Plan or DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director of DHCS. In no circumstances will a Medi-Cal Member be billed for this activity. **[[DHCS Contract Exhibit A, Attachment 6, No. 12-B-10]]**
8. County shall notify DHCS in the event the Contract is terminated. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Notice should be mailed to the Department of Health Care Services, Medi-Cal Managed Care Division, County Organized Health Systems MS 4408, P.O. Box 997413, Sacramento, CA 95899. **[[DHCS Contract Exhibit A, Attachment 6, No. 12-B-12]]**
9. County agrees that the assignment or delegation of any part of this Contract shall be void unless prior written approval is obtained from DHCS in those instances where prior approval is required. **[[DHCS Contract Exhibit A, Attachment 6, No. 12-B-13]]**
10. County agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. **[[H&S § 1261; DHCS Contract Exhibit A, Attachment 6, No. 12-B-21]]**

11. Prior to commencing services under the Contract, County shall provide Plan with any necessary disclosure statements, including the statement set forth in Title 22 of the California Code of Regulations, Section 51000.35. **[[H&S § 1261; DHCS Contract Exhibit A, Attachment 6, No. 12-B-22]]**
12. If County provides Covered Services through nurse practitioners, physician assistants, or nurse midwives ("Non-Physician Medical Practitioners"), the ratio of one physician to Non-Physician Medical Practitioners may not exceed the following: (i) four (4) nurse practitioners; (ii) three (3) nurse midwives; (iii) four (4) physician assistants; or (iv) four (4) of the above individuals in any combination which does not exceed three (3) nurse midwives or two (2) physician assistants. Each individual Non-Physician Medical Practitioner shall maintain a full-time equivalent provider to patient caseload of no more than one thousand (1,000). **[[DHCS Contract Exhibit A, Attachment 6, No. 3]]**
13. County shall ensure that Members are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Members for sterilization consistent with requirements of applicable Law. **[[22 CCR §§ 51305.1, 51305.3; DHCS Contract Exhibit A, Attachment 9, No. 8-A]]**
14. County will comply with the Medi-Cal Minor Consent Services program. Minors do not need parental consent in order to access services related to sexual assault, including rape, drug or alcohol abuse (for children 12 years of age or older), pregnancy, family planning, and STDs and HIV/AIDS (in children 12 years of age or older). **[[DHCS Contract Exhibit A, Attachment 9, No. 8-D]]**
15. For Medi-Cal Members under the age of 21, the term "Medically-Necessary" includes those standards set forth in Title 22 of the California Code of Regulations Sections 51340 and 51340.1. **[[Exhibit A, Attachment 10, No. 2; 22 CCR 51340 and 51340.1]]**
16. When County provides Emergency Services to a Medi-Cal Member and such Member's treatment requires the use of drugs, County shall provide to the Member at least a 72-hour supply of Medically Necessary drugs, which may include an initial dose and a prescription for additional drugs. **[[DHCS Contract Exhibit A, Attachment 10, No. 7-F-1-a]]**
17. County will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. County will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of payment and other forms of compensation; and career development opportunities and selection for training, including apprenticeship. County agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Provider's and Represented Providers' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. **[[DHCS Contract Exhibit D(F), No. 1-A]]**
18. County will, in all solicitations or advancements for employees placed by or on behalf of County or its Represented Providers, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. **[[DHCS Contract Exhibit D(F), No. 1-B]]**
19. County will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the County's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment. **[[DHCS Contract Exhibit D(F), No. 1-C]]**
20. County will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor. **[[DHCS Contract Exhibit D(F), No. 1-D]]**

21. County will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. **[[DHCS Contract Exhibit D(F), No. 1-E]]**
22. In the event of the County's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part and the County may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. **[[DHCS Contract Exhibit D(F), No. 1-F]]**
23. By signing this Contract, County agrees that if any performance under this Contract or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto. **[[DHCS Contract Exhibit D(F), No. 17]]**
24. County shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC Section 794) Nondiscrimination under Federal grants and programs; Title 45 CFR Part 84 Nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance; Title 28 CFR Part 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality. **[[DHCS Contract Exhibit E, Attachment 2, No. 25]]**
25. County shall comply with Plan's policies and procedures as described in the Provider Manual relating to the identification of Members that may be eligible for other Programs.
26. County shall not make any claim for recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving the tort or Workers Compensation liability of a third party, casualty liability coverage, or any other third-party liability which could result in recovery by the Medi-Cal Member of funds for which DHCS has lien rights under Welfare and Institutions Code Section 14124.70. County shall identify and notify Plan of cases in which such an action could result in recovery by the Member. County shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. DHCS retains the right to such third-party tort and Workers Compensation liability, and casualty liability recoveries with respect to Medi-Cal Members as set forth in Welfare and Institutions Code Section 14124.70 et seq.

EXHIBIT C
UTILIZATION MANAGEMENT PROGRAM

I. Authorization Procedure

References to "IPA" in this Exhibit "C" shall mean IPA, IPA Affiliates and Payors, as applicable based upon the responsible party. If payment is based on capitation compensation, prior Authorization must be obtained for non-urgent and non-Emergency Services rendered from IPA's Medical Director or his/her designee. If payment is other than capitation compensation, claims for non-urgent and non-Emergency Hospital Services rendered to Members will not be paid unless there was prior Authorization for those specific services by IPA's Medical Director or his/her designee. Evidence of this prior Authorization will be the Authorization form, which will be provided to County within two Business Days after the Hospital Service has been Authorized. Verbal communication of Authorization by a IPA physician may precede the written confirmation but must be documented in County's records. If a Member needs non-urgent/non-Emergency Services as an inpatient or outpatient in a hospital, County should obtain prior Authorization before admitting any Member or before performing any procedures and/or diagnostic services not previously Authorized. Failure to obtain prior Authorization may lead to a denial of payment for such unauthorized services determined to be not Medically Necessary during retrospective utilization review.

Please note that additional prior Authorization must be obtained for continued services, follow-up visits or treatment after an initial Authorized consultation/length of stay unless such services are approved pursuant to an approved IPA of treatment. Also, any outpatient diagnostic work (x-ray, laboratory, etc.) is to be referred back to IPA when possible, as IPA usually has the ability to provide such services. The charge for any diagnostic or therapeutic work not specifically Authorized will not be reimbursed if it is later determined that such services were not Medically Necessary. Dates of service must be accurate to ensure timely payment.

Additionally, Members should not be referred by County to another provider without prior Authorization. Unauthorized services will not be paid by IPA and cannot be billed to Member. Individual managed care Health Plans will not pay claims for services which are not accompanied by a prior Authorization from IPA.

The prior Authorization number should be noted on the bill when it is submitted to the Claims Department.

II. Utilization Review Instructions

It is the responsibility of Hospital to (i) obtain Authorization for all Services, (ii) keep IPA informed of Member's progress/status and, (iii) request an extension of the Authorization if continued services or follow-up visits or treatment are determined to be Medically Necessary. Requests for Authorization, including Authorization for continued services and follow-up visits or treatment, may be submitted online if access has been granted to Hospital, or directed in writing or by phone to IPA or his/her designee. Authorization may also be obtained after-hours and on weekends by calling the IPA, which is available 24 hours a day, 7 days a week; however, notification and request for Authorization for services performed during non-working hours will be accepted the next Business Day.

Requests for extension of an Authorization must include the following information at a minimum:

1. Estimated length of further services (e.g., number of visits);
2. Member's status/progress;
3. Current treatment plan; and

4. Treatment goals.

Additional information may be requested by IPA in order to make a determination of Medical Necessity.

In the event County has provided services requiring Authorization to a Member prior to receiving Authorization, County may submit claims with copies of the relevant portion of Member's medical record to IPA's claim processing department and IPA will review such record in accordance with IPA's utilization review procedures for retrospective review. If such claim is not approved for payment upon retrospective review, Member cannot be held liable for the cost of such services.