# CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
# PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

**Natividad Medical Center**

**TABLE OF CONTENTS**


DEFINITIONS .......... ARTICLE I
Accreditation Organization .......... Section 1.1
Case Managed Services .......... Section 1.2
Complete Claim .......... Section 1.3
Commencement Date .......... Section 1.4
Covered Services .......... Section 1.5
Covered Services Documentation .......... Section 1.6
Covering Physicians .......... Section 1.7
DHCS .......... Section 1.8
Emergency Services .......... Section 1.9
Fiscal Year .......... Section 1.10
Law .......... Section 1.11
Linked Member .......... Section 1.12
Medi-Cal Provider Manual .......... Section 1.13
Medically Necessary .......... Section 1.14
Member .......... Section 1.15
Member Group Contract(s) .......... Section 1.16
Member Payment .......... Section 1.17
Membership Contract(s) .......... Section 1.18
Participating Provider(s) .......... Section 1.19
Primary Care Physician ("PCP") .......... Section 1.20
Primary Care Physician Services .......... Section 1.21
Program .......... Section 1.22
Program Requirements .......... Section 1.23
Provider Manual .......... Section 1.24
Provider Professional(s) .......... Section 1.25
Quality Management and Improvement ("QI") Program .......... Section 1.26
Referral Services .......... Section 1.27
Self-Referral Services .......... Section 1.28
Utilization Management ("UM") Program .......... Section 1.29

DUTIES OF PROVIDER .......... ARTICLE II
Primary Care Physician Services .......... Section 2.1
Referral Services .......... Section 2.2
Professional Standards .......... Section 2.3
Access and Availability .......... Section 2.4
Covering Physicians .......... Section 2.5
Acceptance and Transfer of Members .......... Section 2.6
Medical Records .......... Section 2.7
Insurance .......... Section 2.8
Notice of Charges .......... Section 2.9
Administrative Requirements .......... Section 2.10
Data Requirements .......... Section 2.11
Pharmaceuticals .......... Section 2.12
HIPAA Compliance .......... Section 2.13
Identification of California Children's Services Eligible Conditions .......... Section 2.14
Training .......... Section 2.15

DUTIES OF PLAN .......... ARTICLE III
Assignment of Members .......... Section 3.1
Plan Communications .......... Section 3.2
Records .......... Section 3.3
Licensure .......... Section 3.4
Limitations .......... Section 3.5

Continuation of Care .......... Section 3.6

COMPENSATION .......... ARTICLE IV
Submission of Claims .......... Section 4.1
Payment .......... Section 4.2
Adjustments to Payments .......... Section 4.3
Coordination of Benefits .......... Section 4.4
Claim Correction Requests and Disputes .......... Section 4.5
Hold Harmless .......... Section 4.6
No Surcharges .......... Section 4.7
Reporting of Surcharges and Member Payments .......... Section 4.8
No Charge for Non-Covered Services .......... Section 4.9
Payments Following Termination of this Agreement .......... Section 4.10
Incentive Programs .......... Section 4.11
No Inducement to Deny Covered Services .......... Section 4.12

TERM AND TERMINATION .......... ARTICLE V
Term .......... Section 5.1
With Cause Termination of Agreement .......... Section 5.2
Automatic Termination Upon Revocation of License or Certificate .......... Section 5.3
Termination of Member Group Contract .......... Section 5.4
Termination Without Cause .......... Section 5.5
Termination if No Agreement on Provider Manual Modifications or Material
Changes to Agreement .......... Section 5.6
Transfer of Medical Records .......... Section 5.7
Repayment Upon Termination .......... Section 5.8
Termination Not an Exclusive Remedy .......... Section 5.9
Continuing Care Obligations of Provider .......... Section 5.10
Fair Hearing .......... Section 5.11

GENERAL PROVISIONS .......... ARTICLE VI
Independent Contractor Relationship .......... Section 6.1
Indemnification .......... Section 6.2
Member Grievances .......... Section 6.3
Disputes Between Provider and Member .......... Section 6.4
Disputes Between Plan and Provider .......... Section 6.5
Notice .......... Section 6.6
Assignment .......... Section 6.7
Amendments .......... Section 6.8
Confidential and Proprietary Information. .......... Section 6.9
Solicitation of Plan Members .......... Section 6.10
No Restrictions on Discussing a Member's Health Care .......... Section 6.11
Invalidity of Sections of Agreement .......... Section 6.12
Survival .......... Section 6.13
Waiver of Breach .......... Section 6.14
Entire Agreement .......... Section 6.15
Incorporation of Exhibits and Attachments .......... Section 6.16
Authority to Bind .......... Section 6.17

GOVERNING LAW AND REGULATORY REQUIREMENTS .......... ARTICLE VII
Governing Law .......... Section 7.1
Americans with Disabilities Act of 1990 .......... Section 7.2
Civil Rights Act of 1964 .......... Section 7.3
Language Assistance .......... Section 7.4
Certification .......... Section 7.5
Antifraud Plan .......... Section 7.6

No Inducement for Referrals .......... Section 7.7
Compliance with Law .......... Section 7.8

Schedule Of Programs .......... Exhibit A
Medi-Cal Program Attachment .......... Exhibit B
Healthy Families Program Attachment .......... Exhibit C
Alliance Care IHSS Health Program Attachment .......... Exhibit D
Healthy Kids Program Attachment .......... Exhibit E
Alliance Care Access For Infants And Mothers
Program Attachment .......... Exhibit F
Alliance Care Individual Conversion Program Attachment .......... Exhibit G
Compensation Schedule .......... Exhibit H
Primary Care Physician Utilization Management
Incentive Program .......... Addendum 1
Primary Care Physician Quality Based Incentive Program .......... Addendum 2
Primary Care Physician Care Based Incentive Program .......... Addendum 3
CBI Table .......... Attachment 1

**Central California Alliance for Health**
**Primary Care Physician Services Agreement**

## RECITALS

This Primary Care Physician Services Agreement ("Agreement") is made and entered into as of the Commencement Date specified herein, by and between Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as Central California Alliance for Health ("Plan"), and the County of Monterey, a political subdivision of the State of California, doing business as Natividad Medical Center, on behalf of its Natividad Medical Center Specialty Clinic ("Provider"), with reference to the following facts:

WHEREAS, Plan has entered into or will enter into a contract or contracts with the State of California Department of Health Care Services ("DHCS") or other entities under which the Plan has agreed to arrange for the provision of health care services and benefits to eligible Santa Cruz, Monterey, and Merced County Medi-Cal beneficiaries or other covered individuals under the programs identified in Exhibit A hereto.

WHEREAS, Provider desires to participate in Plan's network of contracting providers by providing Covered Services, including Primary Care Physician Services, to Members.

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the parties hereto agree as follows:

## ARTICLE I.
## DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article I. Terms used in this Agreement which are defined by Law shall be interpreted consistent with such Laws.

1.1. Accreditation Organization. Accreditation Organization means any organization engaged in accrediting or certifying Plan or Providers.

1.2. Case Managed Services. Case Managed Services shall mean providing or arranging for all Covered Services including health assessments, identification of risks, treatment planning, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; coordination of Medically Necessary Covered Services; provision of preventive services in accordance with established standards and periodicity schedules; maintenance of a medical record with documentation of referral services, and follow-up as medically indicated, including but not limited to post-Emergency follow-up; ordering of therapy, admission to hospitals, coordinated hospital discharge planning that includes necessary post-discharge care, and referral to services. Case Managed Services includes the responsibility for organizing and monitoring a pattern of supportive medical resources and continuity of care, so that Members may be appropriately served by medical advice and supervision seven (7) days each week and twenty-four (24) hours per day. Case Managed Services, also known as Primary Care Physician Services subject to Case Management, are described in the Provider Manual.

1.3. Complete Claim. Complete Claim shall have the meaning set forth in Title 28 of the California Code of Regulations, Section 1300.71 (a)(2).

1.4. Commencement Date. Commencement Date is the date this Agreement becomes effective, as specified in Section 5.1.

1.5. Covered Services. Covered Services are those Medically Necessary health care services, supplies and benefits which are required by a Member pursuant to the coverage provisions of a Program, as further

specified in the Program Requirements and in the applicable Member Group Contracts and Membership Contracts.

1.6. Covered Services Documentation. Covered Services Documentation means documentation developed by Primary Care Physicians to support the Covered Services, including Primary Care Physician Services, provided hereunder, including, without limitation, claims for payment, encounter data, discharge summaries, medical records, emergency visit records and diagnostic reports.

1.7. Covering Physicians. Covering Physicians are Primary Care Physicians who have entered into contracts with Provider to provide Primary Care Physician Services under the terms of this Agreement when Provider is not available and who are Participating Providers or have been approved by the Plan.

1.8. DHCS. DHCS is the State of California Department of Health Care Services, the agency responsible for administering the Medi-Cal program in California.

1.9. Emergency Services. Emergency Services are health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), 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 Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

1.10. Fiscal Year. Fiscal Year of Plan shall mean each twelve (12) month period beginning January 1st and ending December 31st.

1.11. Law. Law means any and all laws and regulations of the State of California or of the United States and all orders, instructions and other requirements of any government agency which are applicable to this Agreement.

1.12. Linked Member. Linked Member shall mean a Member that has been assigned to Provider as their Primary Care Physician, pursuant to Plan's policies for such assignment as set forth in the Provider Manual, for the provision of Case Managed Services and Primary Care Physician Services.

1.13. Medi-Cal Provider Manual. Medi-Cal Provider Manual means the DHCS provider manual, issued by DHCS' fiscal intermediary.

1.14. Medically Necessary. Medically Necessary means, unless otherwise defined in a Membership Contract, Program Requirements or by Law, those 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. No service or supply is a Covered Service unless it is Medically Necessary.

1.15. Member. Member is an individual who is enrolled in a Program and who is determined to be eligible for membership in the applicable Program as of the date of service.

1.16. Member Group Contract(s). Member Group Contract(s) refers to the contracts between the Plan and various government agencies, including the State Medi-Cal Contract, as amended from time to time, under which the Plan has agreed to arrange for the provision of Covered Services to Members.

1.17. Member Payment. Member Payment means an amount (whether expressed as either a percentage of cost or as a specific dollar amount) that a Member is obligated to pay directly to a Participating Provider for a specific service in accordance with the Program under which he or she is covered and in accordance with any applicable Membership Contract. Member Payments shall include, but not be limited to, those payments commonly referred to as "coinsurance," "copayments," and/or "deductibles."

1.18. Membership Contract(s). Membership Contract(s) refers to the evidences of coverage or member handbooks, as amended from time to time, that the Plan issues to its Members and that include complete descriptions of the terms, conditions and benefits available to Members under applicable Programs.

1.19. Participating Provider(s). Participating Provider(s) are physicians, medical groups, IPAs, health care professionals, hospitals, facilities and other providers of health care services or supplies that have entered into written contracts directly or indirectly with Plan to provide Covered Services to Members pursuant to a Program.

1.20. Primary Care Physician ("PCP"). PCP is a Participating Provider who provides Primary Care Physician Services to Members. PCP must meet Plan's criteria for participation as a PCP. Primary Care Physicians must be physicians practicing in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology, or another specialty approved by Plan and DHCS.

1.21. Primary Care Physician Services. Primary Care Physician Services are those Case Managed Services and other Covered Services provided by Provider to Members as further described in this Agreement and in the Provider Manual.

1.22. Program. Program means any health care plan for the provision of Covered Services as more fully described in the Exhibits hereto, the Provider Manual, and any applicable Membership Contract(s), as each may be amended from time to time. The specific Program(s) under which Provider renders Covered Services are set forth on the Schedule of Programs attached as Exhibit A hereto, as may be amended from time to time.

1.23. Program Requirements. Program Requirements are those requirements as established under Law and through any Member Group Contracts and Membership Contracts applicable to specific Programs as summarized in the Exhibits hereto.

1.24. Provider Manual. Provider Manual means that document or series of documents created, maintained, updated and distributed from time to time by Plan that describes the Plan's policies and procedures and provides administrative and Program Requirements for Provider. The Provider Manual is incorporated into this Agreement and made a part hereof.

1.25. Provider Professional(s). Provider Professional(s) are Participating Providers who are physicians and other professionals who are shareholders or partners of, employed by or contract with Provider to deliver Covered Services hereunder. Provider Professionals must meet Plan's criteria for participation as a Participating Provider. References to Provider hereunder shall include Provider and its Provider Professionals.

1.26. Quality Management and Improvement ("QI") Program. Quality Management and Improvement ("QI") Program are those standards, protocols, policies and procedures adopted by Plan to monitor and improve the quality of clinical care and quality of services provided to Members. A summary of the QI Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.27. Referral Services. Referral Services shall mean any Covered Services provided by physicians which are not Primary Care Physician Services, and which are provided by physicians on referral from a Primary Care Physician.

1.28. Self-Referral Services. Self-Referral Services are those Covered Services, including Emergency Services, that Members may access without a referral as set forth for each Program in the Membership Contracts and Provider Manual. Self-Referral Services are subject to the Plan's UM Program.

1.29. Utilization Management ("UM") Program. Utilization Management ("UM") Program are those standards, protocols, policies and procedures adopted by Plan regarding the management, review and approval of the

provision of Covered Services to Members. The UM Program is included in the Provider Manual, which may be updated from time to time by Plan.

## ARTICLE II.
## DUTIES OF PROVIDER

2.1. Primary Care Physician Services. Provider shall provide Covered Services, including Primary Care Physician Services, in accordance with the terms and conditions set forth in this Agreement, the Provider Manual, the Plan's QI and UM Programs, the applicable Program Requirements, applicable Accreditation Organization standards and the Law. Provider shall be the sole source of primary medical contact and advice for its Linked Members and shall be responsible for Case Managed Services for Linked Members except for Emergency Services, Self-Referral Services and non-Covered Services. Provider shall verify a Member's eligibility with Plan prior to rendering non-Emergency Services. Provider shall comply with prospective, concurrent and post-service review requirements as specified in the UM Program. Provider shall ensure that Covered Services provided under this Agreement are readily available, accessible, appropriate, and provided in a prompt and efficient manner as required by applicable Law.

2.2. Referral Services. Provider shall arrange any necessary Referral Services to be provided by specialists or other providers in accordance with the Plan's UM Program by referring Members to the Plan's selection of Participating Providers, except for Emergency Services, Self-Referral Services, and in other cases where the Plan authorizes such a referral. Provider shall obtain a referral from the Member's Primary Care Provider and an authorization request approved by Plan, if required by Plan, prior to providing Referral Services to Members who are not Linked Members, except for Emergency Services and Self-Referral Services.

2.3. Professional Standards. The primary concern of Provider shall be the quality of Covered Services provided to Members. All Covered Services provided by Provider shall be provided by duly licensed, certified or otherwise authorized professional personnel in accordance with (i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) Plan's QI and UM Programs, (iii) applicable rules and regulations of California state medical boards, (iv) Law, and (v) the standards of Accreditation Organizations.

2.3.1. Licensure of Provider. Provider shall maintain in good standing at all times and ensure that any and all professionals that provide or assist Provider in the provision of Covered Services hereunder maintain in good standing at all times, any and all licenses, certificates, and/or approvals required under Law and by the Plan.

2.3.2. Hospital Privileges. Provider shall maintain in good standing at all times medical staff membership and clinical privileges, or have executed a formal agreement with another physician to admit and follow patients, at one or more of the Plan's contracted network hospital(s) as necessary to provide Covered Services to Members.

2.3.3. No Conflicts. Provider is not subject to any agreements or obligations that would interfere with Provider's ability to enter into or perform its obligations under this Agreement in accordance with its terms.

2.3.4. Credentialing. Provider and its Provider Professionals shall meet Plan's credentialing standards as specified in the Provider Manual and must be approved by the Plan before providing Covered Services to Members. Provider shall respond to requests from Plan for credentialing information. Failure to timely respond to such requests shall be grounds for termination pursuant to Section 5.2 hereto.

2.3.5. Right to Withdraw. Plan reserves the right to immediately withdraw from Provider any or all Members in the event that the health or safety of Members is endangered by the actions of

Provider or if Provider ceases to maintain required licenses, hospital privileges, or ceases to meet Plan's credentialing criteria.

2.3.6. Change in Status or Information. Provider shall immediately notify Plan in writing of any change in licensure or hospital privilege status, any change in information provided to Plan through the credentialing process, and any change in address or practice status.

2.4. Access and Availability. Provider shall comply with the access and availability requirements and conditions for each applicable Program as required by Law and as further delineated in the Provider Manual, including but not limited to prompt scheduling of appointments and availability of Primary Care Physician Services.

2.5. Covering Physicians. If Provider and its Provider Professionals are unable to provide Covered Services from time to time, Provider shall secure the services of qualified Covering Physicians who are Participating Providers or who otherwise meet the Plan's credentialing criteria and who are approved by the Plan to provide Primary Care Physician Services to Members. Provider shall enter into written agreements with Provider Professionals and Covering Physicians consistent with the terms and conditions of this Agreement and the requirements of Law. Provider shall provide the Plan with a complete list of its Provider Professionals and Covering Physicians, together with the information required by the Plan for credentialing and plan administration, which this Agreement is signed and thereafter whenever requested by the Plan. Upon request, Provider shall make such written agreements available to Plan or any applicable government agency, for review and approval.

2.6. Acceptance and Transfer of Members. Provider agrees to provide Primary Care Physician Services to at least one hundred (100) Linked Members, unless excepted by Plan. The Plan process for linking Members to Provider is described in the Provider Manual. Provider may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients. Provider shall not request or demand the transfer, discharge, or removal of any Member for reasons of the Member's need for, or utilization of, Primary Care Physician Services, except in accordance with the procedures established by Plan for such action. Provider shall not request or demand the transfer, discharge or removal of any Member while the Member is hospitalized or is in the middle of a course of treatment and a determination has been made that interruption of care would be detrimental to the health of the Member. Provider shall not refuse or fail to provide or arrange Primary Care Physician Services to any Linked Member. Provider shall be responsible for a Linked Member's Case Managed Services until the time such Linked Member's Primary Care Physician is changed in accordance with Plan's policies.

2.7. Medical Records. Provider shall maintain all patient medical records relating to Covered Services provided to Members, in such form and containing such information as required by the Provider Manual, QI and UM Programs, Accreditation Organizations and Law. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review by Provider and Plan pursuant to the QI Program. Medical records shall be maintained in a form and physical location which is accessible to Provider, Plan, government agencies and Accreditation Organizations. Upon request and within the timeframe requested, Provider shall provide to Plan, at Provider's expense, copies of Member medical records for purposes of conducting quality assurance, case management and utilization review, credentialing and peer review, claims processing, verification and payment, resolving Member grievances and appeals and other activities reasonably necessary for the proper administration of the applicable Program consistent with Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by Law.

2.8. Insurance. Provider shall maintain professional and general liability insurance in the minimum amounts required by Law but not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate, to apply separately for each physician and health care practitioner who is insured under the policy (or policies) and for a period of seven (7) years following termination. In the event Provider procures a "claims made" policy as distinguished from an occurrence policy, Provider shall procure and maintain prior to termination of such insurance, continuing tail or extended reporting coverage for a period of not less than seven (7) years following such termination.

Provider, at its sole cost and expense, shall also maintain throughout the term of this Agreement, workers' compensation insurance as required by the State of California and general liability insurance, including but not limited to premises, personal injury and contractual liability insurance, in a minimum amount of one million dollars ($1,000,000) per occurrence, combined single limit, bodily injury and property damage, to insure Provider and its employees, agents, and representatives against claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the performance of any Covered Services provided under this Agreement, (ii) the use of any property and facilities of the Provider, and (iii) activities performed in connection with this Agreement.

All insurance required of Provider under this Agreement shall be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best financial strength rating of A- or better and are classified by A.M. Best as being of financial size category VIII or greater. Provider may substitute comparable self-insurance coverage for the insurance coverage required by this Section only upon the prior written approval of Plan.

A certificate of insurance shall be issued to Plan prior to the Commencement Date and upon each renewal of the insurance coverage specified in this Section. The certificate shall provide that Plan shall receive thirty (30) days prior written notice of cancellation or material reduction in the insurance coverage specified in this Section. Notwithstanding anything to the contrary, if Provider has a claims-made based policy and such policy (or policies) is cancelled or not renewed, Provider agrees to exercise any option contained in the policy (or policies) to extend the reporting period to the maximum period permitted; provided, however, that Provider need not exercise such option if the superseding insurer will accept all prior claims. Notwithstanding any other provision of this Agreement, Provider's failure to provide the certificate of insurance shall be grounds for immediate termination of this Agreement.

2.9. Notice of Charges. Provider shall notify Plan immediately of the issuance of any formal charges against Provider or any professional delivering Covered Services on behalf of Provider by any governmental authority or licensing or Accreditation Organization which would, if sustained, impact the Provider's ability to comply with its duties and obligations pursuant to this Agreement. Provider shall further notify the Plan immediately of the initiation of any formal inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, hospital committee, or other committee, organization or body which reviews quality of medical care which complaint, inquiry, investigation, or review directly or indirectly, evaluates or focuses on the quality of care provided by Provider either in any specific instance or in general. Provider does not waive its rights to confidentiality protections provided under State or federal law, including California Evidence Code Section 1157.

2.10. Administrative Requirements. Provider agrees to perform its duties under this Agreement in accordance with Plan's administrative guidelines, policies and procedures as set forth in this Agreement, the Provider Manual, the Medi-Cal Provider Manual and Law. In the event of a conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. In the event of a conflict between the Medi-Cal Provider Manual and either this Agreement or the Provider Manual, this Agreement or the Provider Manual, as applicable, will govern.

2.11. Data Requirements.

2.11.1. General Data and Information. Provider shall maintain and provide at no cost to Plan, upon written request, any and all information as reasonably required by Plan, Law, government agencies or Accreditation Organizations. Provider shall submit such information and data to Plan in the format and within the time periods specified by Plan. Upon reasonable request, Provider shall allow Plan personnel reasonable on-site access to Provider records in connection with Plan's QI Program, UM Program or for other valid purposes. Provider shall accurately and completely maintain all information and data required by this Agreement, including medical records, necessary to characterize the scope and purpose of Covered Services provided to Members for the time period required by Law.

2.11.2. Covered Services Documentation. Upon reasonable request and as required by the Provider Manual, Provider shall provide Plan with Covered Services Documentation at no cost to Plan. Provider will utilize and cooperate with Plan reporting tools for Covered Services Documentation as set forth in the Provider Manual. All Covered Services Documentation shall be provided on a timely basis and shall be supported by information recorded in the applicable Member's medical chart. By signing this Agreement, Provider hereby attests to the accuracy, completeness and truthfulness of all Covered Services Documentation provided pursuant to this Agreement. Provider shall provide additional attestations as requested by the Plan to support the accuracy, completeness and truthfulness of the Covered Services Documentation.

2.11.2.1. Without limiting Section 2.11.2 above, Provider shall provide encounter data in the format of a claim to Plan within thirty (30) days of the provision of Case Managed Services to Provider's Linked Members, if Provider is paid capitation for such Members. Such encounter data shall contain the elements and shall be on the form and in the format as set forth in the Provider Manual.

2.12. Pharmaceuticals. If Provider is licensed to prescribe drugs and medications, Provider shall prescribe drugs and medications in accordance with all applicable Law and the Plan's drug formulary. Plan's drug formulary is the Medi-Cal drug contract list as specifically modified by Plan. Provider may access the Plan's formulary online at http://www.ccah-alliance.org/formulary.html to find out if a particular medication is listed.

2.13. HIPAA Compliance. Provider represents and warrants that it is presently and shall remain at all relevant times compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Provider represents and warrants with respect to all Protected Health Information ("PHI"), (as defined under 45 C.F.R. § 164.501), that it is a Covered Entity under 45 C.F.R. Section 164.501 (and not a business associate of Plan), and that it shall use all appropriate safeguards to prevent the use or disclosure of PHI other than as allowed by Law.

2.14. Identification of California Children's Services Eligible Conditions. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification and referral of Members with suspected California Children's Services ("CCS") eligible conditions to the local CCS Program Office. If a CCS eligible Member is identified, Provider shall continue to provide all Primary Care Physician Services other than those services necessary to treat the CCS eligible condition. Provider agrees to coordinate services for such CCS eligible Members with CCS specialty providers and the CCS Program.

2.15. Training. Provider and its practitioners and staff will participate in applicable training programs available through the Plan as required by any applicable Member Group Contract or as required by the Plan to address any Plan policies and procedures. The Plan will notify Provider of any training program that must be completed pursuant to a Member Group Contract and the timeframe for completing such required training.

## ARTICLE III.
## DUTIES OF PLAN

3.1. Assignment of Members. Plan shall allow Members whose Program and status requires assignment of a Primary Care Physician to select and then be assigned to a Primary Care Physician and shall assign Members who do not make such a selection in accordance with Plan policies. A Member that selects and is assigned or does not select and is assigned to a Primary Care Physician is considered to be a Linked Member as to the Primary Care Physician for the provision of all Primary Care Physician Services.

3.2. Plan Communications. Plan shall establish a system of Member identification, communicate the requirements of the Provider Manual to Participating Providers, and identify Participating Providers to Members. Plan shall be responsible for providing applicable notification to Members upon notification of termination of Provider.

3.3. Records. Plan shall maintain and furnish such records and documents as may be required by applicable Law, and shall create, maintain and transmit such records and documents in accordance with generally accepted industry standards and the requirements of applicable Laws.

3.4. Licensure. Plan shall maintain such licenses as are necessary for the performance of its obligations hereunder.

3.5. Limitations. Plan makes no representations or guarantees concerning the number of Members it can or will assign to Provider under this Agreement. Plan shall not be obligated to include Provider in all Participating Provider directories or in all Programs or to utilize or market Provider for all services available from Provider.

3.6. Continuation of Care. In the event this Agreement is terminated due to Plan's insolvency, Plan shall provide for continuation of Covered Services to Members for the duration of the period for which payment has been made by DHCS to Plan, as well as for inpatient admissions until discharge. Plan shall comply with its legal obligations to ensure continuity of care for its Members pursuant to California Law.

## ARTICLE IV.
## COMPENSATION

4.1. Submission of Claims. Provider agrees to submit to Plan all fee-for-service Complete Claims for Covered Services rendered to eligible Members. Complete Claims shall be submitted to the location described in the Provider Manual within one (1) year of the provision of Covered Services and in the format specified in the Provider Manual. Complete Claims will be paid within the timeframe required by Law as applicable to each Program. If Plan is the secondary payor, coordination of benefits claims may be submitted within ninety (90) days after the primary payor's date of payment or date of contest, denial or notice, if such period is longer than one (1) year. Plan may deny payment for claims not submitted by Provider within the timeframe set forth above and in accordance with the billing procedures set forth in the Provider Manual. Provider agrees that Plan will be materially damaged by late claim submittals and agrees to waive any right to assert that it is entitled to payment for claims asserted beyond the time periods specified above, unless Provider submits a dispute pursuant to Section 6.5 and shows good cause for delay.

4.2. Payment. Plan shall pay Provider for Covered Services rendered to eligible Members in accordance with the provisions of this Agreement, including Exhibit H hereto, and the Provider Manual. Provider agrees to accept such amounts paid by Plan, and any applicable Member Payment, as payment in full.

4.3. Adjustments to Payments. Only those charges for Covered Services billed in accordance with the Plan's claims coding standards will be payable. If Plan determines that services rendered are inappropriate or not Medically Necessary, coding practices do not comply with Plan standards, payment is not in accordance with the terms of this Agreement or services were provided to a patient who was not an eligible Member as of the date of service, Plan may deny, reduce, or otherwise adjust payment to Provider. The Plan may also adjust payment rates as specified in Exhibit H for the following reasons:

4.3.1. Adjustments to Fee Schedules. In the event a government program (including, without limitation, the Medi-Cal Program, as defined in Exhibit B) revises a payment rate or a procedure or revenue code under a Program fee schedule pursuant to which payments are determined under this Agreement, Plan shall, in order to ensure payment according to the current fee schedule, adopt such adjustments in the same manner and on the same effective date as adopted by the government program.

4.3.2. Audit and Recovery. Plan, or the Plan's third party designee, shall have the right to conduct periodic audits of all records maintained by the Provider with respect to all payments received by Provider from Plan for Covered Services rendered to Members during the term of this Agreement. If an audit shows that the Plan has overpaid any claim or if Plan identifies an overpayment through any other process, Plan will send a written request for the reimbursement of the overpayment

within one year (365 days) of the date of the claim overpayment as required by applicable Law, unless the overpayment was caused in whole or in part by Provider's fraud or misrepresentation, in which case Plan shall not be limited to 365 days. If Provider does not contest the Plan's request for reimbursement of the overpayment within thirty (30) days in writing or reimburse the Plan, the Plan may offset or recoup the amounts overpaid against amounts due and owing from Plan to Provider. If Provider contests a request for reimbursement, then Provider shall send a written notice to Plan stating the basis for which the claim was not overpaid and the matter shall be resolved in accordance with the Plan's provider dispute resolution process in Section 6.5 of this Agreement and the Provider Manual. This provision shall survive the termination of this Agreement.

4.4. Coordination of Benefits. Provider agrees to comply with the Plan's coordination of benefits ("COB") policies and procedures as specified in this Agreement, the Provider Manual, the Membership Contracts, and any applicable Law.

4.4.1. Member Screening. Provider agrees to screen each Member receiving Covered Services to determine if the Member has Medicare coverage or other health coverage, and agrees to provide such information to Plan upon request.

4.4.2. Plan is Primary. When Plan is primary under the Plan's coordination of benefits rules, Plan shall pay Provider, as set forth in this Agreement, the amount due for Covered Services rendered to Members.

4.4.3. Plan is Secondary. When Plan is secondary under the Plan's coordination of benefits rules, Plan shall pay for Covered Services according to the Plan's policies and procedures as set forth in the Provider Manual. Plan will deny claims from Provider if it fails to first make recoveries from other health care coverage sources.

4.4.4. Refund. If following payment by Plan for Covered Services Provider discovers that it is entitled to payment or receives payment from another payor that is primary to Plan, Provider shall notify Plan and refund any amount overpaid by Plan within thirty (30) days.

4.5. Claim Correction Requests and Disputes. If Provider believes Provider is entitled to any payment for a Covered Service from Plan, or for payment in excess of the amount the Plan has paid or indicated it will pay, then Provider shall not directly or indirectly bill for or seek to collect from Plan any such payment or additional payment for Covered Services beyond the amount that Plan has paid or indicated it will pay for such Covered Services except pursuant to either a request for a claim correction submitted to the Claims Department as specified in the Provider Manual, or pursuant to a dispute filed with Plan as specified in Section 6.5 of this Agreement and the Provider Manual.

4.6. Hold Harmless. Provider agrees that, in no event, including but not limited to nonpayment by Plan, insolvency of Plan, breach of this agreement, or denial of claims by Plan due to Provider's failure to properly submit claims, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or any person acting on behalf of a Member to whom Covered Services have been provided in accordance with the terms of this Agreement or any Program, or the State of California for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting Member Payments as specifically provided under any applicable Member Group Contract or Membership Contract or from pursuing claims against the applicable primary payor. Failure to comply with this Section shall be deemed a material breach of this Agreement and Provider may be terminated for cause pursuant to Section 5.2.2 of this Agreement as the result of such failure. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including insolvency of Plan.

4.7. No Surcharges. Provider understands that surcharges against Members are prohibited and that Plan will take appropriate action if surcharges are imposed. A "surcharge" is an additional fee which is charged to a

Member for a Covered Service but which is not a Member Payment as provided for under the applicable Member Group Contract and Membership Contract.

4.8. Reporting of Surcharges and Member Payments. Provider will report to Plan all surcharge and Member Payment monies paid by Member directly to Provider and shall refund all surcharges.

4.9. No Charge for Non-Covered Services. Provider shall not charge a Member for a service which is not a Covered Service unless, in advance of the provision of such service, the Member has been notified by Provider that the particular service will not be covered and Provider obtains a written statement in a form acceptable to the Plan, signed by the Member or the person responsible for paying for services rendered that he or she shall be responsible for payment of charges for such service.

4.10. Payments Following Termination of this Agreement. Following termination of this Agreement and during the continuing care period described in Section 5.10 hereto, Plan shall compensate Provider at the applicable Program payment rates set forth in Exhibit H to this Agreement for providing and arranging Primary Care Physician Services to Members until such Members are assigned to other Plan Participating Providers.

4.11. Incentive Programs. Provider shall participate in Plan's Utilization Management Incentive Program, as described in Addendum 1 hereto, and Quality Based Incentive Program, as described in Addendum 2 hereto, for the respective terms of such programs, and may elect to participate in the Care Based Incentive Program, as described in Addendum 3 and Attachment 1 hereto. Provider must separately execute Addendum 3 in order to participate in the Care Based Incentive Program.

4.12. No Inducement to Deny Covered Services. Provider acknowledges and agrees that this Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary health care services.

## ARTICLE V.
## TERM AND TERMINATION

5.1. Term. The term of this Agreement shall commence on January 1, 2011 (the "Commencement Date"), and shall expire on December 31 of the same year of the Commencement Date. Thereafter, the term of this Agreement shall be automatically extended for a one (1) year term on each succeeding January 1 (the "Renewal Date"), unless terminated by either party as provided herein.

5.2. With Cause Termination of Agreement. Either Plan or Provider may terminate this Agreement for cause as set forth below, subject to the notice requirement and cure period set forth below.

5.2.1. Cause for Termination of Agreement by Provider. The following shall constitute cause for termination of this Agreement by Provider:

5.2.1.1. Non-Payment. Material failure by Plan to make any payments due Provider hereunder within forty-five (45) days of any such payment's due date and Plan's failure to cure such failure to make such payments due to Provider within the cure period provided at Section 5.2.3, below.

5.2.1.2. Breach of Material Term and Failure to Cure. Plan's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2. Cause for Termination of Agreement by Plan. The following shall constitute cause for termination of this Agreement by Plan:

5.2.2.1. Breach of Material Term and Failure to Cure. Provider's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2.2. Insolvency. Provider becomes insolvent, as reasonably determined by Plan.

5.2.2.3. Failure to Comply with Standards. Provider fails to provide Covered Services in accordance with the standards set forth in this Agreement and Plan's QI Program and UM Program. Plan reserves the right to immediately transfer from Provider any Linked Members and cease referrals of any or all Members in the event the health or safety of Members is endangered by the actions of Provider, or as a result of continuation of this Agreement.

5.2.3. Notice of Termination, Cure Period and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "terminating party") shall provide written notice of termination to the other party specifying the breach or deficiency with sufficient information to allow the receiving party to identify the actions necessary to cure such breach. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the terminating party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the terminating party within the Cure Period or if the breach or deficiency is not curable, the terminating party shall have the right to provide written notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period. The Agreement shall terminate thirty (30) calendar days following receipt of the written notice of failure to cure or at such later date as may be specified in such notice. During the Cure Period and the period following the Cure Period, Plan may begin transferring Members to other Participating Providers. Notwithstanding the above, in the event Plan provides notice of termination as the result of a breach by Provider and the Plan reasonably determines the health and safety of Members is endangered by the actions of Provider, Plan shall have the right to terminate the Agreement immediately.

5.3. Automatic Termination Upon Revocation of License or Certificate. This Agreement shall automatically terminate upon the revocation, suspension or restriction of any license, certificate or other authority required to be maintained by Provider or Plan in order to perform the services required under this Agreement or upon the Provider's or Plan's failure to obtain such license, certificate or authority. In addition, this Agreement shall automatically be terminated if: (i) Provider is excluded from participation in the Medicare program or is subjected to sanctions imposed by the Medicare program or the Medicaid program; (ii) Provider's professional liability insurance or any other Provider insurance required under this Agreement is cancelled, non-renewed, or is no longer in effect; (iii) Provider fails to comply with Section 2.3 of this Agreement; or (iv) Provider dies or becomes incapacitated (as reasonably determined by Plan).

5.4. Termination of Member Group Contract. If any Member Group Contract terminates, this Agreement shall automatically terminate with respect to Members covered under the Member Group Contract on the date the Member Group Contract and any continuing care obligations under the Member Group Contract terminate.

5.5. Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving the other party at least one hundred twenty (120) days prior written notice.

5.6. Termination if No Agreement on Provider Manual Modifications or Material Changes to Agreement. This Agreement may be terminated pursuant to the terms specified in Sections 6.8.2 and 6.8.3.

5.7. Transfer of Medical Records. Following termination of this Agreement, at Plan's request, Provider shall copy all requested Member medical records in the possession of Provider and forward such records to another provider of Covered Services designated by Plan, provided such copying and forwarding is not

otherwise objected to by such Members. The cost of copying the Members' medical records shall be borne by Provider. Provider shall maintain the confidentiality of such Member medical records at all times.

5.8. Repayment Upon Termination. Within one hundred eighty (180) calendar days of the effective date of termination of this Agreement, an accounting shall be made by Plan of the monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) calendar days of such accounting.

5.9. Termination Not an Exclusive Remedy. Any termination by either party pursuant to this Article V is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement. Notwithstanding the foregoing, the parties agree to waive any and all rights they may have to assert claims for or recover exemplary or punitive damages against the other party.

5.10. Continuing Care Obligations of Provider. If this Agreement is terminated for any reason, Provider shall continue to provide Covered Services, including Primary Care Physician Services, to Members, including any Members who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the first to occur of (i) a period of one hundred and twenty (120) days following termination of this Agreement or such longer period required for any Member as required by Law, or (ii) the date Plan provides written notice to Provider that it has made arrangements for all Members to receive services from another Participating Provider of Primary Care Physician Services. In addition, Provider will continue to provide Covered Services, including Primary Care Physician Services, to any Members who cannot be transferred within the time period specified above for Members who are hospitalized upon the expiration of the continuing care period, for Members who are entitled to continuing care as the result of their condition pursuant to Law, and otherwise in accordance with Plan's legal and contractual obligations to ensure continuity of care for its Members.

5.11. Fair Hearing. Notwithstanding the time periods for termination set forth in Sections 5.2 through 5.5 of this Agreement, in all cases in which Plan terminates this Agreement and Provider is entitled to a fair hearing under Plan's applicable notification and hearing procedures set forth in the Provider Manual, the termination will be final thirty (30) days from notice of the right to request a hearing, unless Provider requests a hearing within such thirty (30) day period. If such a hearing is requested, this Agreement will continue in effect until a decision is rendered; provided, however, upon the request of Plan, Provider shall not thereafter provide Covered Services to Members until a decision is rendered and Plan reserves the right to transfer Linked Members to other Participating Providers in its reasonable discretion.

## ARTICLE VI.
## GENERAL PROVISIONS

6.1. Independent Contractor Relationship. The relationship between Plan and Provider is an independent contractor relationship. Neither Provider nor its employees or agents are employees or agents of Plan. Neither Plan nor its employees or agents are partners, employees or agents of Provider.

6.2. Indemnification. Provider shall indemnify and hold harmless Plan and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability (including reasonable costs of defense) arising out of or related to the performance or nonperformance by Provider, its employees or agents of any Covered Services or other services to be performed or arranged by Provider under this Agreement; provided, however, that Provider shall not be responsible for indemnifying Plan for Plan's own acts or omissions.

6.3. Member Grievances. Plan shall be responsible for resolving Member claims for benefits under the Programs and all other claims against Plan. Provider will immediately refer Members to contact Plan or deliver any written complaint to Plan for handling pursuant to Plan's Member Grievance Procedures. Provider shall comply with all final determinations made by Plan through the Member Grievance Procedures.

6.4. Disputes Between Provider and Member. Any controversies or claims between Provider and a Member arising out of the performance of this Agreement by Provider, other than claims for benefits under the Program, are not governed by this Agreement. Provider and the Member may seek any appropriate legal action to resolve such controversy or claim deemed necessary. Provider will provide written notice to Plan of any dispute between Provider and Member.

6.5. Disputes Between Plan and Provider. Any claim, dispute, or other matter arising out of, relating to, or in any way connected with this Agreement, shall be addressed through the Plan's provider dispute resolution procedure as set forth in the Provider Manual. Provider will be informed of any changes to the provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. If the procedure set forth in this Section has been exhausted and such matter is not resolved to the satisfaction of the parties, either party may pursue any available legal remedy. Venue shall be in Santa Cruz, Monterey or Merced County. Plan retains all immunities applicable to public entities to which it is entitled by law.

6.6. Notice. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission. The addresses or facsimile number specified on the signature page shall be the addresses for delivery or mailing of notice. The parties may change the names, addresses, and facsimile numbers noted above through written notice in compliance with this Section. Notices shall be effective upon receipt.

6.7. Assignment. Neither this Agreement nor any portion of this Agreement shall be assigned, transferred or pledged in any way by Provider and shall not be subject to execution, attachment or similar process without the prior written consent of Plan. A change of ownership through the sale of Provider's stock or assets shall be deemed an assignment requiring consent pursuant to this Section.

6.8. Amendments. Except as provided herein, no amendments or modifications to this Agreement shall be valid unless made in writing and signed by both Provider and Plan, and unless any required regulatory approvals are obtained.

6.8.1. Legally Required Modifications. The Plan may amend this Agreement at any time in order to comply with Law or any requirements of a private sector Accreditation Organization, as reasonably interpreted by the Plan. Plan shall notify Provider of such legally required modification. Such amendment shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.2. Provider Manual Modifications. If Plan materially amends a manual, policy or procedure document referenced in the Agreement ("Provider Manual Modification"), Plan will provide at least forty five (45) business days' notice to Provider, and Provider will have the right to negotiate and agree to the change. If the parties cannot agree to the Provider Manual Modification, Provider will have the right to terminate the Agreement prior to the implementation of the Provider Manual Modification.

6.8.3. Material Changes to Agreement. For Providers compensated on a fee-for-service basis, Plan may amend a material term to the Agreement by providing a minimum of ninety (90) business days' notice of its intent to change a material term of the Agreement ("Material Change Notice"). Provider shall have the right to negotiate and agree to the change within thirty (30) business days of Provider's receipt of the Material Change Notice ("Right to Negotiate") by providing written notice of such intent within the thirty (30) business day period. Provider shall have the right to terminate the Agreement effective ninety (90) business days following the receipt of the Material Change Notice if Provider does not exercise Provider's Right to Negotiate or no agreement is reached during the ninety (90) business day period and if Provider provides notice of its intent to terminate prior to the expiration of the ninety (90) business day period. The material change shall become effective ninety (90) business days following the Material Change Notice if Provider does not exercise its Right to Negotiate or does not provide timely notice of its intent to terminate as

described above. The parties may agree to the material change at any time during the ninety (90) business day period by mutual written agreement.

6.8.4. Non-Material Amendments to Agreement. The Plan may notify Provider of amendments to non-material terms of this Agreement. Such amendments shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.5. Program Benefit Changes. Program benefit changes shall be effective upon implementation, following receipt of any required regulatory approvals.

6.9. Confidential and Proprietary Information.

6.9.1. Information Confidential and Proprietary to Plan. Provider shall maintain confidential all information designated in this Section. The information which Provider shall maintain confidential (the "Confidential Information") consists of: (i) any information containing the names, addresses and telephone numbers of Members which has been compiled by Plan; (ii) the financial arrangements between Plan and any of Plan's Participating Providers, including Provider; and (iii) any other information compiled or created by Plan which is proprietary to Plan and which Plan identifies in writing to Provider.

6.9.2. Non-Disclosure of Confidential Information. Neither party shall disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. The parties may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of the other party. Upon the effective date of termination of this Agreement, Provider shall provide and return to Plan the Confidential Information in their possession in the manner specified by Plan.

6.9.3. Plan Names, Logos and Service Marks. Each party shall obtain the written consent of the other party prior to using the party's name, product names, logos and service marks in any promotional, marketing or advertising materials or for any other reason.

6.10. Solicitation of Plan Members. Provider shall not engage in solicitation of Members without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee or contractor of Provider or their respective assignees or successors during the term of this Agreement, and during the twelve (12) months immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members to disenroll from the Program or discontinue their relationship with Plan. Provider agrees that Plan shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Provider to enforce its rights under this Section in a manner consistent with and to the extent permitted by California law.

6.11. No Restrictions on Discussing a Member's Health Care. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider or its Provider Professionals from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

6.12. Invalidity of Sections of Agreement. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

6.13. Survival. The following provisions of this Agreement shall survive the termination of this Agreement: Sections 2.7, 2.8, 2.11, 2.13, 3.6, Article IV, Sections 5.6, 5.7, 5.8, 5.9, 5.10, 6.2, 6.4, 6.5, 6.10, 6.11 and any other section where survival of termination is required by Law.

6.14. Waiver of Breach. The waiver by either party to this Agreement of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

6.15. Entire Agreement. This Agreement, including all exhibits, attachments, addenda, and amendments hereto and the Provider Manual contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

6.16. Incorporation of Exhibits and Attachments. The schedules, exhibits, addenda, and attachments to this Agreement and the Provider Manual are integral parts of this Agreement and are incorporated in full herein by this reference.

6.17. Authority to Bind. Each signatory of this Agreement represents and warrants individually on behalf of himself or herself, and the party on whose behalf he or she executes this Agreement, that he or she is duly authorized to execute this Agreement.

## ARTICLE VII.
## GOVERNING LAW AND REGULATORY REQUIREMENTS

7.1. Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California, except where preempted by federal law, and the laws of the United States of America.

7.2. Americans with Disabilities Act of 1990. Provider's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

7.3. Civil Rights Act of 1964. Provider will comply with Title VI of the Civil Rights Act of 1964 and any implementing regulations that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

7.4. Language Assistance. Provider agrees to comply with the Plan's Language Assistance Program as detailed in the Plan's Policies and Procedures and Provider Manual.

7.5. Certification. As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, Provider certifies to the best of Provider's knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are $100,000 or more, Provider shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Provider shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities", in accordance with its instructions. Provider shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Provider. Provider shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.

7.6. Antifraud Plan. Provider agrees to comply with Plan's antifraud plan, as detailed in the Provider Manual. Provider will immediately notify Plan of (i) investigations of Provider or Provider's employees in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred.

7.7. No Inducement for Referrals. The parties acknowledge and agree that: (1) they intend to comply with the safe harbor requirements set forth in 42 C.F.R. §1001.952(t); (2) in establishing the terms of the Agreement, including the exhibits, addenda and attachments hereto, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by the Agreement) for which payment may be made in whole or in part by a federal health care program on a fee-for-service or cost basis; and (3) neither party will shift the financial burden of the Agreement to the extent that increased payments are claimed from a federal health care program. Plan represents and agrees that it is an eligible managed care organization, as defined in 42 C.F.R. §1001.952(t). Provider represents and agrees that (a) Provider is a first tier contractor under the Agreement, defined as an individual or entity that has a direct contract with Plan, as the managed care organization, to provide or arrange for items or services; and (b) Provider cannot and will not claim payment in any form, directly or indirectly, from a federal health care program for items or services covered under the Agreement for Members enrolled in the Plan, except as provided in 42 C.F.R. §1001.952(t).

7.8. Compliance with Law. Provider and any subcontractor to Provider shall comply with the Program Requirements set forth in the exhibits hereto. Any provisions required to be included in the Agreement by applicable Law, including the Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code Section 1340 et seq.) and the regulations promulgated thereunder, shall be binding upon and enforceable against the parties to the Agreement and shall be deemed incorporated herein whether or not expressly set forth in the Agreement, including the exhibits hereto.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the Commencement Date.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

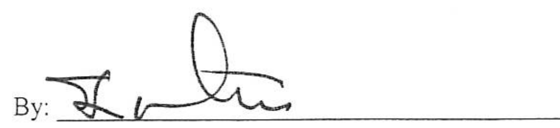
By:

Print: Jane Parker

Title: Chair, CCAH

Date: July 29, 2011

PROVIDER

By: 

Print: HARRY WEIS

Title: CEO

Date: 06/13/11

Provider Address and Facsimile Number for Notices:

Street: 1441 CONSTITUTION BLVD.

City, State ZIP: SALINAS, CA 93908

Facsimile Number: (831) 755-6254

## EXHIBIT A

## SCHEDULE OF PROGRAMS

Provider has been approved to provide Covered Services, including Primary Care Physician Services, under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

**Medi-Cal Program:** is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Merced, Monterey, and Santa Cruz Counties.

**Healthy Families Program:** is a state- and federally-funded Program pursuant to a contract between the Plan and the California Managed Risk Medical Insurance Board ("MRMIB") for coverage of Members who meet Healthy Families Program eligibility requirements, as determined by MRMIB. The Healthy Families Program is, as of the Commencement Date, offered in Monterey and Santa Cruz Counties.

**Alliance Care IHSS Health Program:** is a state- and federally-funded Program pursuant to a contract between the Plan and the County of Monterey for coverage of Members who meet Alliance Care IHSS Health Program eligibility requirements, as determined by the County of Monterey. As of the Commencement Date, the Alliance Care IHSS Health Program is offered in Monterey County.

**Healthy Kids Program:** Provider is not participating in this Program with Plan.

**Alliance Care Access for Infants and Mothers (AIM) Program:** is a state-funded Program pursuant to a contract between the Plan and the California Managed Risk Medical Insurance Board ("MRMIB") for coverage of Members who meet AIM Program eligibility requirements as determined by MRMIB. As of the Commencement Date, the AIM Program is offered in Monterey County.

**Alliance Care Individual Conversion Program:** is a Program offered by the Plan to the Plan's Alliance Care IHSS Members when IHSS Members are no longer eligible to continue participation in the Plan's Alliance Care IHSS Program through COBRA or Cal-COBRA. As of the Commencement Date, the Alliance Care Individual Conversion Program is offered in Monterey County.

**EXHIBIT B**
**MEDI-CAL PROGRAM ATTACHMENT**

This Exhibit B sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, 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 Member Group Contract and Medi-Cal Member Handbook. Covered Services, including Primary Care Physician 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 Primary Care Physician Services, excluded services, and certain health screening and preventive services for Medi-Cal Members is set forth in the Provider Manual.

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.

3. Provider agrees to make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, 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 Provider'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 Agreement 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.

4. Member Payments are not permitted under the Medi-Cal Program. Provider shall not seek reimbursement of any such payments from Medi-Cal Members for any Covered Services provided under this Agreement.

5. Provider agrees to submit reports as required by Plan.

6. Plan shall conduct site reviews on all Primary Care Physician Services sites according to Medi-Cal Managed Care Division Policy Letter 02-02.

7. If this Agreement terminates for any reason, Provider will assist the Plan in the transfer of care. Additionally, Provider will assist in the orderly transfer of necessary data and records to the Plan, a successor Plan, or DHCS. Provider will assist in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Provider 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.

8. Provider shall notify DHCS in the event the Agreement 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.

9. Provider agrees that the assignment or delegation of any part of this Agreement shall be void unless prior written approval is obtained from DHCS in those instances where prior approval is required.

10. Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

11. Prior to commencing services under the Agreement, Provider 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.

12. If Provider 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).

13. Provider 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.

14. Provider 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).

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.

16. When Provider provides Emergency Services to a Medi-Cal Member and such Member's treatment requires the use of drugs, Provider 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.

17. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, 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. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

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

19. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

20. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 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.

21. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 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.

22. In the event of the Provider's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Provider may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 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.

23. By signing this Agreement, Provider agrees that if any performance under this Agreement 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.

24. Provider 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.

25. Provider 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. Provider shall make no 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. Provider shall identify and notify Plan of cases in which such an action could result in recovery by the Member. Provider 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 and following.

**EXHIBIT C**

**HEALTHY FAMILIES PROGRAM ATTACHMENT**

This Exhibit C sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Healthy Families Program.

1. With respect to the Healthy Families Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Healthy Families Member Group Contract. Covered Services, including Primary Care Physician Services, for Healthy Families Members are set forth in Sections 2699.6700 through 2699.6707 of Title 10 of the California Code of Regulations, and are also described in the Healthy Families Evidence of Coverage and the Plan's Provider Manual.

2. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification and referral of Members that have a serious emotional disturbance or serious mental disorder to the County Mental Health Department Programs.

3. Provider will provide extended payment plans for Members utilizing a significant number of health services for which Member Payments are required. When feasible, Provider shall offer an extended payment plan when a Member's Payment exceeds twenty-five dollars ($25) in one month.

4. Provider agrees that the awarding department ("the State"), the Department of Managed Health Care and the Bureau of State Audits, or their designated representatives, shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated or required by Law. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Provider agrees to include the same right of the State to audit records and interview staff in any subcontract related to performance of this Agreement.

5. During the performance of this Agreement, Provider, its employees and agents, shall not unlawfully discriminate, deny benefits to, harass, or allow harassment against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical disability including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS-Related Complex (ARC), mental disability, medical condition (including health impairments related to or associated with cancer for which a person has been rehabilitated or cured), marital status, political affiliation, age (over 40), sex, gender, sexual preference, sexual orientation, pregnancy, childbirth, or related medical conditions, or the use of family and medical care leave and pregnancy disability leave pursuant to state and federal law. Provider, its employees and agents, shall insure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and harassment. Provider, its employees and agents, shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 (a-f), and following) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285.0, and following). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider shall give written notice of its obligations under this clause to labor organizations with which it has a collective bargaining or other agreement.

6. 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 Commencement Date, on an annual basis, upon any change in information, and upon request, if required by law or by Plan's Member Group Contracts.

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 Plan's Member Group Contracts. Such Debarment Certification and its instructions are set forth in the Provider Manual.

**EXHIBIT D**

**ALLIANCE CARE IHSS HEALTH PROGRAM ATTACHMENT**

This Exhibit D sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care IHSS Health Program.

1. With respect to the Alliance Care IHSS Health Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the IHSS Member Group Contract. Covered Services, including Primary Care Physician Services for IHSS Members are set forth in Sections 2699.6700 through 2699.6707 of Title 10 of the California Code of Regulations, and are also described in the Alliance Care IHSS Health Program Evidence of Coverage and the Plan's Provider Manual.

2. The County of Monterey and the Department of Managed Health Care may examine, monitor, and audit all records, documents, conditions, and activities of Provider related to the provision of Alliance Care IHSS Health Program Covered Services. Provider agrees to submit to an examination and audit of the State Auditor pertaining to matters connected with the performance of the IHSS Member Group Contract or provision of Alliance Care IHSS Health Program Covered Services for a period of three years after the final payment under the IHSS Member Group Contract.

3. Discrimination: The term "discrimination" as used in this Exhibit D, means the illegal denial of equal employment opportunity, harassment (including sexual harassment and violent harassment), disparate treatment, favoritism, subjection to unfair or unequal working conditions, and/or other discriminatory practice by any Monterey County official, employee or agent, due to an individual's race, color, ethnic group, national origin, ancestry, religious creed, sex, sexual orientation, age, veteran's status, cancer-related medical condition, physical handicap (including AIDS) or disability. The term also includes any act of retaliation.

4. Plan shall establish and follow its own written procedures for the prompt and fair resolution of discrimination complaints made against Plan by Provider.

5. During the performance of this Agreement, Plan and Provider shall comply with all Laws which prohibit discrimination, including but not limited to the following:

    i. California Fair Employment and Housing Act;

    ii. California Government Code Sections 11135-11139.5 and 22 CCR Sections 98000-98413;

    iii. Federal Civil Rights Acts of 1964 and 1991;

    iv. The Rehabilitation Act of 1973, and all guidelines and interpretations issued pursuant thereto;

    v. 7 Code of Federal Regulations (CFR) Part 15 and 28 CFR Part 42;

    vi. Title II of the Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. Sections 12101 et seq. and 47 U.S.C. Sections 225 and 611, and any federal regulations issued pursuant thereto (see 24 CFR Chapter I; 28 CFR Parts 35 and 36; 29 CFR Parts 1602, 1627, and 1630; and 36 CFR Part 1191);

    vii. Unruh Civil Rights Act, California Civil Code Section 51 et seq., as amended;

    viii. Chapter 2.80 of the Monterey County Code;

ix. Age Discrimination in Employment Act 1975, as amended (ADEA), 29 U.S.C. Sections 621 et seq.;

x. Equal Pay Act of 1963, 29 U.S.C. Section 206(d);

xi. California Equal Pay Act, Labor Code Section 1197.5;

xii. California Government Code Section 4450;

xiii. The Dymally-Alatorre Bilingual Services Act; California Government Code Section 7290 et seq.;

xiv. The Food Stamp Act of 1977, as amended and in particular Section 272.6.;

xv. California Code of Regulations, Title 24, Section 3105A (e); and

xvi. Removal of Barriers to Inter-Ethnic Adoption Act of 1996, Section 1808

6. Upon request by the County of Monterey, Provider will give any written assurances of compliance with the Civil Rights Act of 1964 and 1991, the Rehabilitation Act of 1973 and/or the Americans with Disabilities Act of 1990, as may be required by the federal government in connection with the IHSS Member Group Contract as may be required by Law.

7. Provider agrees to comply with the Elder Abuse and Dependent Adult Civil Protection Act, and will comply with its provisions which define a mandated reporter, and requires that reports of abuse or neglect be made by a mandated reporter when, in his or her professional capacity, or within the scope of his or her employment, he/she observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect. Provider will require any Participating Provider, employee, consultant, and agent performing services under the Agreement and this Exhibit D, who are mandated reporters under the Elder Abuse and Dependent Adult Civil Protection Act, to sign statements indicating that they know of and will comply with the reporting requirements of the Act.

## EXHIBIT E

## HEALTHY KIDS PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

## EXHIBIT F

## ALLIANCE CARE ACCESS FOR INFANTS AND MOTHERS PROGRAM ATTACHMENT

This Exhibit F sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care Access for Infants and Mothers (AIM) Program.

1. With respect to the Alliance Care AIM Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the AIM Member Group Contract and are included in Section 2699.300 of Title 10 of the California Code of Regulations. Any services listed in Section 2699.301 of Title 10 of the California Code of regulations shall not be considered Covered Services. Covered Services for AIM Members, including Primary Care Physician Services, are set forth in the Alliance Care AIM Program Evidence of Coverage, and are also described in the Plan's Provider Manual.

2. With respect to the Alliance Care AIM Program, the term "Emergency Services" shall mean health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), which is manifested by acute symptoms of sufficient severity, active labor or 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 Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

3. Provider agrees that the Managed Risk Medical Insurance Board, the Department of Managed Health Care and the Bureau of State Audits, or their designated representatives, shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated or required by Law. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records.

4. During the performance of this Agreement, Provider as well as its agents and employees, shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (over 40), marital status, and use of family and medical care leave pursuant to state or federal law. Provider, as well as its agents and employees, shall ensure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, as well as its agents and employees, will comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2, California Code of Regulations, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Provider will give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

5. Provider shall keep accurate books and records connected with the performance of this Agreement during and for three (3) years after the term of this Agreement, or until the final payment under this Agreement, whichever is later. If an audit, review, examination or evaluation is commenced during the time specified herein for the maintenance of books and records, Provider shall continue to maintain all relevant books and records until the audit, review, examination or evaluation is completed.

6. 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 Commencement Date, on an annual basis, upon any change in information, and upon request, if required by law or by Plan's Member Group Contracts. 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 Plan's Member Group Contracts. Such Debarment Certification and its instructions are set forth in the Provider Manual.

## EXHIBIT G

## ALLIANCE CARE INDIVIDUAL CONVERSION PROGRAM ATTACHMENT

This Exhibit G sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Alliance Care Individual Conversion Program.

1. With respect to the Alliance Care Individual Conversion Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under California Health and Safety Code Sections 1345(b), 1366.35, and 1373.6 and the Alliance Care Individual Conversion Program Evidence of Coverage and the Plan's Provider Manual.

## EXHIBIT H

## COMPENSATION SCHEDULE

1. Payment in Full. Provider agrees to accept payment rendered pursuant to this Exhibit H, and any applicable Member Payment, as payment in full for any Covered Services provided by Provider to a Member, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 4.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 4.4 of this Agreement.

2. Definitions. The following definitions are applicable to this Exhibit H:

   a. "Capitation Payment" shall mean the PMPM amount, as set forth in this Exhibit H, paid to Provider for the provision of Primary Care Physician Services subject to Case Management as described in the Provider Manual.

   b. "Medi-Cal Linked Members" are Medi-Cal Members, as defined in Exhibit B, Section 2, who are also Linked Members.

   c. "Medi-Cal Rate" shall mean the current applicable Medi-Cal rate, as published by the California Department of Health Care Services in effect at the time Covered Services are rendered.

   d. "Monterey Medicare Rate" shall mean the schedule of Medicare maximum fee-for-service allowances and rates of payment for health care services in effect for the federal Medicare Program in Monterey County at the time when the Covered Services are rendered.

   e. "Outpatient Clinical Laboratory Services" shall mean clinical laboratory testing for Members not provided or ordered as part of an inpatient hospitalization that provides information for the diagnosis, prevention, or treatment of disease, or the assessment of medical condition and includes, but is not limited to, microbiological, serological, chemical, hematological, cytological, immunohematology, and pathological examinations performed on materials derived from the human body. Outpatient Clinical Laboratory Services also include consulting services for all tests performed or arranged by Provider, all necessary and required supplies, requisition forms, and the collection, preparation, and storage of specimens.

   f. "PMPM" means per Medi-Cal Linked Member per month.

   g. "Santa Clara Medicare Rate" shall mean the schedule of Medicare maximum fee-for-service allowances and rates of payment for health care services in effect for the federal Medicare Program in Santa Clara County at the time when the Covered Services are rendered.

3. Payment for Covered Services Provided to Medi-Cal Members.

   a. List of Members. Plan will provide Provider with a list of Provider's Medi-Cal Linked Members by the first (1st) day of each month (the "Medi-Cal Linked Members List").

   b. Case Managed Primary Care Physician Services. Plan will pay Provider for Case Managed Services provided to Medi-Cal Members on Provider's Medi-Cal Linked Members List as set forth below in subsections i., ii., and iii.

      i. Capitation Payments. Plan will pay Provider for Case Managed Services provided to Medi-Cal Members on Provider's Medi-Cal Linked Members List by the fifteen (15th) day of each month. The Capitation Payments by Medi-Cal Member type and by age/sex/eligibility categories effective January 1, 2011 is as follows:

RATES
REDACTED

RATES
REDACTED

ii. Fee-For-Service Payment. If Provider's submittal of encounter data for Provider's Medi-Cal Linked Members during any full twelve (12) month period is less than an average of 1.47 visits per Medi-Cal Linked Member per twelve (12) month period ("Data Benchmark"), Plan shall provide written notice to Provider that Provider shall be subject to a corrective action plan. If during the 180 day notice period Provider is able to take steps to achieve the Data Benchmark, Plan will continue to compensate Provider at the Capitation payment rate specified in Section 3.b. above during and following the expiration of the 180-day corrective action period. If Provider does not achieve the Data Benchmark within one hundred eighty (180) days, Plan will compensate Provider on a fee-for-service basis as specified in this Section 3.c. following the completion of the 180-day corrective action period as described below.

(1)

RATES

(2) REDACTED

iii. Reversion to Capitation Payment. If Provider's submittal of encounter data for Provider's Medi-Cal Linked Members during any full twelve (12) month period following the change to fee-for-service payment becomes equal to or greater than an average of 1.47 visits per Medi-Cal Linked Member per twelve (12) month period, Plan will provide Provider with sixty (60) days prior written notice that Plan will compensate Provider at the Capitation Payment rates specified in Section 3.b. above. Payment shall revert to the Capitation Payments as of the date specified in the Plan's notice to Provider.

c. Other Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., and v.

i.

ii.

RATES REDACTED

iii.

iv.

v.

Laboratory Services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

4. Payment for Covered Services Provided to Healthy Families Members.

a. List of Members. Plan will provide Provider with a list of Provider's Linked Members enrolled in and determined to be eligible for the Healthy Families Program ("Healthy Families Members") by the first (1st) day of each month.

b. r

der

RATES
REDACTED

c.

d.

ii.

RATES REDACTED

5. Payment for Covered Services Provided to IHSS Members.

a. List of Members. Plan will provide Provider with a list of Provider's Linked Members enrolled in and determined to be eligible for the IHSS Program ("IHSS Members") by the first (1st) day of each month.

b.

c.

RATES REDACTED

d.

6. Payment for Covered Services Provided to AIM Members.

a. List of Members. Plan will provide Provider with a list of Provider's Linked Members enrolled in and determined to be eligible for the AIM Program ("AIM Members") by the first (1st) day of each month.

b.

ıd

;

r

c.

RATES REDACTED

;

d.

e. C

I

i

i

7. Payment for Covered Services Provided to Conversion Members.

a. List of Members. Plan will provide Provider with a list of Provider's Linked Members enrolled in and determined to be eligible for the Alliance Care Individual Conversion Program ("Conversion Member") by the first (1st) day of each month.

b.

c.

RATES REDACTED

d.

it

i

## ADDENDUM 1

## PRIMARY CARE PHYSICIAN UTILIZATION MANAGEMENT INCENTIVE PROGRAM

A. Introduction

1. Applicable Programs.

Provider agrees to participate in the utilization management incentive program described in this Addendum 1 for the Medi-Cal Program only [__] or for both Medi-Cal and Healthy Families [_XX__]. For Providers who participate in the utilization management incentive program for Medi-Cal only, the references below to Health Families will not be applicable.

2. Definitions. For the purposes of this Addendum, the following definitions are applicable. Additional terms are defined in other sections to the Addendum and in Article I to the Agreement.

**"Administrative Members"** are Members who are not Linked Members and who are enrolled in Medi-Cal and determined to be eligible for membership in the Medi-Cal Program.

**"Inpatient Hospital Services"** are Covered Services provided to a Member who is admitted as a registered bed patient in a hospital, excluding physician services, unless such services are listed as inclusions in the hospital's agreement with Plan.

**"Other Services"** are Covered Services that are not Primary Care Physician Services, Referral Services or Inpatient Hospital Services.

**"Primary Hospital"** is any hospital under contract with Plan with which Primary Care Physicians are affiliated by virtue of their agreement with Plan, and which is designated as a Primary Hospital by Plan.

**"Risk Group"** is the group of PCPs to which Provider is compared to determine its percentile ranking within the group and for which Provider participates in a risk sharing pool.

B. Case Managed Services Risk Sharing

1. Risk Group Reserve

Medi-Cal Capitation and Fee-For-Service Reserve. Ten percent (10%) of the Capitation Payment as described in Exhibit H Section 3.b.i. for each Member on Provider's Medi-Cal Linked Members List will be held in reserve to absorb possible deficits in the Provider's Risk Group Medi-Cal risk sharing pools, as described herein. In the event Provider is paid fee-for-service pursuant to Exhibit H Section 3.b.ii. or Exhibit H Sections 3.c i. and ii., Plan will hold ten percent (10%) of the Medi-Cal Rate payment in reserve to absorb possible deficits in Provider's Risk Group Medi-Cal risk sharing pools.

Healthy Families Reserve. Ten percent (10%) of the fee-for-service payment as described in Exhibit H Section 4 for each Healthy Families Member will be held in reserve to absorb possible cost overruns in Provider's Risk Group Healthy Families sharing pools.

2. Budgeting.

Plan will set up "Primary Care Physician Accounts" for each Primary Care Physician contract with Plan. A Primary Care Physician contract may include one or more Primary Care Physicians. Primary Care Physician Accounts will be maintained separately for Primary Care Physicians' Linked Santa Cruz Medi-Cal Members, Linked Santa Cruz Healthy Families Members, Linked Monterey Medi-Cal Members, Linked Monterey Healthy Families Members and Linked Merced Medi-Cal Members. Each Primary Care Physician Account Total will be allocated an amount called the "Full Budget Amount" for Linked Members. The Full Budget Amount will consist of budgeted health care costs

for three service categories: a) Primary Care Physician Services, b) Referral Physician and Other Services, and c) Inpatient Hospital Services. The Primary Care Physician's Account Totals will consist of the sum of the balances in such Primary Care Physician's Accounts for these three service categories.

Actual health care costs incurred by each Primary Care Physician's Linked Medi-Cal Members and Linked Healthy Families Members will be allocated against the Full Budget Amount. Health care costs incurred for Covered Services include, but are not limited to, fee-for-service claims; the incurred cost of acute care hospital inpatient services, including any amounts paid and held in reserve; Primary Care Physician payment, including any amounts paid and held in reserve; capitation payments; and estimated costs for services incurred but not yet reported (IBNR).

3. Referral Physician and Other Services Expense Limit.

Referral Services and Other Services expenses allocated to a Primary Care Physician's Referral Physician and Other Services Account will be limited to seven thousand five hundred dollars ($7,500) per Member annually ("Referral Physician and Other Services Expense Limit"). Actual paid expenses above seven thousand five hundred dollars ($7,500) per Linked Medi-Cal Member or per Linked Healthy Families Member per year shall be shared on a pro rata basis based on that county's Medi-Cal Member allocations or Healthy Families allocations among all Risk Groups of that county.

4. Hospital Inpatient Expense Limit.

Hospital inpatient expenses allocated to a Primary Care Physician's Hospital Inpatient Account will be limited to seventy five thousand dollars ($75,000) per Member annually ("Hospital Inpatient Expense Limit"). Actual paid expenses above seventy five thousand dollars ($75,000) (excluding amounts held in reserve) per Linked Medi-Cal Member per year or per Linked Healthy Families Member per year shall be shared on a pro rata basis based on that county's Medi-Cal Member allocations and Healthy Families Member allocations among all Risk Groups of that county.

5. Risk Sharing Pool.

Each Primary Care Physician will be affiliated with a Risk Group. Primary Care Physician Accounts will be maintained for each Primary Care Physician contract. Primary Care Physician Accounts will be maintained separately for Primary Care Physicians' Linked Santa Cruz Medi-Cal Members, Linked Santa Cruz Healthy Families Members, Linked Monterey Medi-Cal Members, Linked Monterey County Healthy Families Members and Linked Merced Medi-Cal Members. Risk sharing pools will be maintained at the Risk Group level. Risk Group risk sharing pools are the sum of the Primary Care Physician Accounts affiliated with that Group. All Administrative Members will be assigned to risk pools, which are maintained separately for Administrative Members that are Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members and Merced Medi-Cal Members. The Medi-Cal Administrative Member risk pool for each county also includes the long term care facility benefit costs for that county's Medi-Cal Members. There are no Administrative Members for the Healthy Families Program.

6. Account Sharing of Surplus and Deficits.

An accounting of the transactions and operations of Primary Care Physician Accounts and all Risk Group risk sharing pools shall be rendered by Plan annually four (4) months after the conclusion of each Fiscal Year and shall be certified by its Finance Director. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Primary Care Physicians following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

All balances will be determined as follows: Each Risk Group risk sharing pool balance will be determined by summing the individual balances of affiliated Primary Care Physician Accounts. Risk Group risk sharing pools will be allocated a pro-rata share of the Administrative Member risk pools. Finally, costs in excess of the Referral Physician and Other Expense Limit and Hospital Inpatient Expense Limit will be allocated on a pro-rata basis to the appropriate risk sharing pools of each Risk Group. Santa Cruz Medi-Cal allocations shall be made to Santa Cruz

Medi-Cal risk sharing pools, Santa Cruz Healthy Families allocations shall be made to Santa Cruz Healthy Families risk sharing pools, Monterey Medi-Cal allocations shall be made to Monterey Medi-Cal risk sharing pools, Monterey Healthy Families allocations shall be made to Monterey Healthy Families risk sharing pools and Merced Medi-Cal allocations shall be made to Merced Medi-Cal risk sharing pools.

Policy regarding actual and proposed budget and cost allocations to the Primary Care Physician Accounts and Risk Group risk sharing pools is subject to the approval of Plan. Plan shall have the sole discretion to establish binding policies regarding determination of account and pool balances.

7. Deficit Funding.

Any deficit in the Risk Group's Referral Physician and Other Services pools shall be funded by a surplus in such Risk Group's Inpatient Hospital Services pools, and any deficit in the Risk Group's Inpatient Hospital Services pools shall be funded by a surplus in such Risk Group's Referral Physician and Other Services pools. Deficit accounting and funding shall occur separately for a Risk Group's Santa Cruz Medi-Cal risk sharing pools, Santa Cruz Healthy Families risk sharing pools, Monterey Medi-Cal risk sharing pools, Monterey Healthy Families risk sharing pools and Merced Medi-Cal risk sharing pools.

The Risk Group Primary Care Physician payment held in reserve shall be used to fund remaining deficits in the following Risk Group risk sharing pools at the following rates:

a. Referral Physician and Other Services pool - Primary Care Physician payment held in reserve shall be used to fund one hundred percent (100%) of any deficit, not to exceed the total amount held in reserve.

b. Inpatient Hospital Services pool - Primary Care Physician payment held in reserve shall be used to fund one hundred percent (100%) of any deficit not to exceed the total amount held in reserve.

Deficits shall also be funded by amounts held in reserve from the Primary Hospital affiliated with the Risk Group, to the extent there are Primary Hospital amounts held in reserve remaining for that Risk Group. Accounting for and funding of amounts held in reserve shall occur separately for (i) amounts held in reserve from Santa Cruz Medi-Cal Capitation and other payments, (ii) amounts held in reserve from Santa Cruz Healthy Families fee-for-service payments, (iii) amounts held in reserve from Monterey Medi-Cal Capitation and other payments, (iv) amounts held in reserve from Monterey Healthy Families fee-for-service payments, and (v amounts held in reserve from Merced Medi-Cal Capitation and other payments.

8. Distribution of Amounts Held in Reserve.

If the Risk Group risk sharing pool total is in surplus, all Primary Care Physicians in that Risk Group will receive in full their amounts held in reserve relating to that Risk Group risk sharing pool. If the Risk Group risk sharing pool total is in deficit, but the deficit is less than the aggregate amount held in reserve from all Primary Care Physicians in that Risk Group, the aggregate remaining Primary Care Physician account amounts held in reserve will be paid to individual Primary Care Physicians directly in proportion to the amount originally held in reserve from each Primary Care Physician relating to that Risk Group risk sharing pool. Distribution of amounts held in reserve shall occur separately for (i) amounts held in reserve from Santa Cruz Medi-Cal Capitation and other payments, (ii) amounts held in reserve from Santa Cruz Healthy Families fee-for-service payments, (iii) amounts held in reserve from Monterey Medi-Cal Capitation and other payments, (iv) amounts held in reserve from Monterey Healthy Families fee-for-service payments, and (v) amounts held in reserve from Merced Medi-Cal Capitation and other payments.

9. Surplus Distribution.

If a Risk Group risk sharing pool total is in surplus after all amounts held in reserve relating to that Risk Group risk sharing pool have been distributed, then each Primary Care Physician Account total balance will be determined by summing each service account balance for that Primary Care Physician. The amount available for surplus distribution to Primary Care Physicians is (i) fifty percent (50%) of the surplus in the Referral Physician and Other

pool balances, and (ii) thirty three and 1/3 percent (33 1/3%) of the surplus in the Hospital Inpatient pool balances. Surplus accounting and funding shall occur separately for a Risk Group's Santa Cruz Medi-Cal risk sharing pools, Santa Cruz Healthy Families risk sharing pools, Monterey Medi-Cal risk sharing pools, Monterey Healthy Families risk sharing pools, and Merced Medi-Cal risk sharing pools.

Primary Care Physician Account totals in deficit will not be paid a portion of the surplus distribution. If the Risk Group Pool is in surplus, Primary Care Physician Account totals in surplus will receive a portion of the Risk Group Pool surplus equal to the following formula:

$$\frac{\text{Total Account surplus for Primary Care Physician in Risk Group}}{\text{Total pool surplus in the Risk Group as determined by Plan}} = \text{“Distribution Percentage”}$$

Subject to the limitation set forth below, Primary Care Physician shall receive the following:

(1) fifty percent (50%) of said surplus in the Referral Physician and Other pool balances times the Distribution Percentage; and

(2) thirty three and 1/3 percent (33 1/3%) of said surplus in the Hospital Inpatient pool balances times the Distribution Percentage.

Such surplus distributions shall be limited per physician to 1.8 multiplied by the average Primary Care Physician Per Member Per Month (PMPM) surplus distribution through the Risk based program for the prior Fiscal Year. If Primary Care Physician has exceeded the limitation, such amount in excess shall be returned for further distribution to other Primary Care Physicians through the Risk based program formula.

C. Referral Services Risk Sharing.

PCPs who provide Referral Services may earn points under the Referral Services and Other Services pool and the Inpatient Hospital Services Pool, in addition to their participation as described in Section B above. The Referral Services and Other Services Pool and Inpatient Hospital Services Pool will be administered as described in Section B above.

1. Surplus Balance

a. If a Referral Physician and Other Services Account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

$$\frac{\text{Acceptances for a Member course of treatment (regardless of the number of visits) by Provider}}{\text{Total acceptances for a Member course of treatment by all Referral Physicians}} \times \text{ten percent (10\%) of the total surplus balance in the Referral Physician and Other Services Account}$$

and

b. If an Inpatient Hospital Services Account is in surplus after all applicable amounts held in reserve have been distributed to Providers, Provider will receive a portion of the surplus according to the following formula:

| | | |
|---|---|---|
| Acceptances for a Member course of treatment (regardless of the number of visits) by Provider / Total acceptances for a Member course of treatment by all Referral Physicians | X | six and two thirds percent (6 2/3%) of the total surplus balance in the Inpatient Hospital Services Account |

Plan shall determine what constitutes an acceptance for a Member course of treatment, which shall be determined separately for Santa Cruz Medi-Cal Members, Santa Cruz Healthy Families Members, Monterey Medi-Cal Members, Monterey Healthy Families Members and Merced Medi-Cal Members. Surplus accounting and sharing shall occur separately for Santa Cruz Medi-Cal risk sharing accounts, Santa Cruz Healthy Families risk sharing accounts, Monterey Medi-Cal risk sharing accounts, Monterey Healthy Families risk sharing accounts and Merced Medi-Cal risk sharing accounts.

D. Distribution of Amounts Held in Reserve and Surplus Sharing in Event of Termination.

If this Agreement is terminated before the end of Plan's Fiscal Year by Provider or by Plan, Provider will be eligible for distribution of amounts held in reserve at the next annual accounting, but not for surplus sharing described in this Addendum 1 Section C.

E. Term of Primary Care Medi-Cal Utilization Management Incentive Program.

The term of this Primary Care Physician Medi-Cal Utilization Management Incentive Program, as described in this Addendum 1, shall begin on January 1, 2011 and end on December 31, 2011 (the "UMIP Term").

F. UMIP Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement utilization management incentive programs for periods after completion of the UMIP Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the UMIP Term, no such program shall be binding upon Plan.

## ADDENDUM 2

## PRIMARY CARE PHYSICIAN QUALITY BASED INCENTIVE PROGRAM

The Quality Based Incentive Program ("**QBI**") is a pay for performance program that uses positive incentives to promote quality clinical practices such as appropriate preventive services and chronic disease management. In addition to the payment set forth elsewhere in this Agreement, Plan shall budget an amount annually for the QBI for each Fiscal Year and may update such amount during the Fiscal Year, which is reviewed and approved by its governing board and which shall be allocated to the QBI (the "**Total Quality Pool**"). An accounting of the transactions and operations of the QBI shall be rendered by Plan annually four (4) months after the conclusion of each Fiscal Year and shall be certified by its Finance Director. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Primary Care Physicians following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Amounts distributed through the QBI program are based on 1) the quality points earned for clinical performance and access to care and 2) the implementation of pain management contracts and pediatric asthma plans by each Primary Care Physician Practice Site during the Fiscal Year.

A "**Practice Site**" is defined as the Primary Care Physician individual or group to whom Linked Members are assigned. Practice Sites are divided into three (3) categories: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the family practice/general practice category.

Certain measurements are based on the number of Medi-Cal Members without other health coverage, such as Medicare coverage. References to "**Medi-Cal Prime Members**" in this QBI Program Addendum means Medi-Cal Members without other health coverage.

A. Quality Pools for Clinical Performance and Access to Care. The Total Quality Pool is divided into three (3) pools (each a "Quality Pool"): 1) the FP/GP Quality Pool, 2) the PED Quality Pool and 3) the IM Quality Pool. Amounts are allocated to each pool depending on the number of Medi-Cal Prime Members linked to each category of Practice Site as of the end of the Fiscal Year. All Medi-Cal Member calculations for the QBI program are made together for Monterey County Medi-Cal Members, Santa Cruz County Medi-Cal Members, and Merced County Medi-Cal Members. There are no separate Quality Pools for each county.

Quality points are assigned to each Practice Site based on clinical performance and access to care measures. The maximum number of quality points that a Practice Site may earn each Fiscal Year is one hundred (100). There is a possible total of eighty (80) points for the clinical performance measures and a possible total of twenty (20) points for the access to care measures.

1. Clinical Performance Measures. The clinical performance measures are HEDIS defined measures. The measurements follow the applicable HEDIS methodology. The clinical performance measures are based on claims and encounter data and not on chart review. In order for a Practice Site to receive points for a clinical performance measure, there must be a minimum of five (5) Medi-Cal Prime Members that qualify for the measure based on HEDIS specifications. Each qualifying Practice Site is then compared to the performance of the same category of qualifying Practice Sites for each clinical performance measure and assigned points based on the Practice Site's rank. For example, a qualifying IM Practice Site is ranked in comparison to all other qualifying IM Practice Sites for each clinical performance measure. A Practice Site, however, may earn the maximum points available for a clinical performance measure by meeting the Plan Goal percentage for such measure, even if the Practice Site is not ranked in the top quartile. The "**Plan Goal**" is established by the Plan for each performance criteria and is calculated for each Practice Site based on the HEDIS algorithm.

    a. IM Practice Site Clinical Performance. For IM Practice Sites, there are five (5) clinical performance measures, as follows: (1) breast cancer screening, (2) cervical cancer screening, (3) diabetes LDL-C screening, (4) diabetes HbA1c screening, and (5) monitoring of persistent angiotensin converting enzyme inhibitors/angiotensin receptor blockers (ACE/ARBs). For each

IM Practice Site clinical performance measure, sixteen (16) points are assigned for a rank of more than seventy-five percent (75%) when compared to other IM Practice Sites, eight (8) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if an IM Practice Site meets or exceeds the Plan Goal for a clinical performance measure the Practice Site shall be assigned sixteen (16) points for such clinical performance measure, even if the Practice Site is not in the top quartile. The Plan Goal is ninety percent (90%) for each IM Practice Site clinical performance measure.

b. PED Practice Site Clinical Performance. For PED Practice Sites, there are three (3) clinical performance measures, as follows: (1) well child visit 3 – 6 years, (2) well adolescent visit 12 – 21 years, and (3) asthma controller medication. For the well child visit 3 – 6 years clinical performance measure, thirty (30) points are assigned for a rank of more than seventy-five percent (75%) when compared to other PED Practice Sights, fifteen (15) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if a PED Practice Site meets or exceeds the Plan Goal for the well child visit 3 – 6 years clinical performance measure the Practice Site shall be assigned thirty (30) points for such clinical performance measure, even if the Practice Site is not in the top quartile. For the adolescent child visit 12 - 21 years clinical performance measure, thirty (30) points are assigned for a rank of more than seventy-five percent (75%), fifteen (15) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if a PED Practice Site meets or exceeds the Plan Goal for the well adolescent visit 12 - 21 years clinical performance measure the Practice Site shall be assigned thirty (30) points for such clinical performance measure, even if the Practice Site is not in the top quartile. For the asthma controller medication clinical performance measure, twenty (20) points are assigned for a rank of more than seventy-five percent (75%), ten (10) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%). provided, however, if a PED Practice Site meets or exceeds the "Plan Goal" for the asthma controller medication clinical performance measure the Practice Site shall be assigned twenty (20) points for such clinical performance measure, even if the Practice Site is not in the top quartile. The Plan Goal is ninety percent (92.5%) for asthma controller medication, and ninety percent (90%) for the other clinical performance measures.

c. FP/GP Practice Site Clinical Performance. For FP/GP Practice Sites, there are eight (8) clinical performance measures, as follows: (1) well child visit 3 – 6 years, (2) well adolescent visit 12 – 21 years, (3) asthma controller medication (4) breast cancer screening, (5) cervical cancer screening, (6) monitoring of persistent angiotensin converting enzyme inhibitors/angiotensin receptor blockers (ACE/ARBs), (7) diabetes LDL-C screening, and (8) diabetes HbA1c screening. For each FP/GP Practice Site clinical performance measure, ten (10) points are assigned for a rank of more than seventy-five percent (75%) when compared to other FP/GP Practice Sites, five (5) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if a FP/GP Practice Site meets or exceeds the Plan Goal for a clinical performance measure the Practice Site shall be assigned ten (10) points for such clinical performance measure, even if the Practice Site is not in the top quartile. The Plan Goal is ninety percent (92.5%) for asthma controller medication, and ninety percent (90%) for the other clinical performance measures.

2. Access to Care Measures. For all Practice Sites, there are two access to care measures as follows: (1) level of Medi-Cal Prime Member linkage, and (2) appropriate emergency department use.

a. IM, PED and FP/GP Level of Medi-Cal Prime Member Linkage Access Measure. The level of Medi-Cal Prime Member linkage access to care measure is based on administrative linkage data. If a Practice Site is open to auto assignment of Medi-Cal Prime Members for ten (10) or more months in the Fiscal Year, then the Practice Site is assigned ten (10) points. Practice Sites not

open to auto assignment for ten (10) or more months are assigned points based on the average number of Medi-Cal Prime Members linked to the Practice Site during the Fiscal Year, as follows:

| | |
|---|---|
| 0-49 | 0 points |
| 50-99 | 1 point |
| 100-199 | 2 points |
| 200-299 | 3 points |
| 300-399 | 4 points |
| 400-499 | 5 points |
| 500-599 | 6 points |
| 600-699 | 7 points |
| 700-799 | 8 points |
| 800-899 | 9 points |
| 900 or more | 10 points |

b. IM, PED and FP/GP Appropriate Emergency Department Use. The appropriate emergency department use access measure is based on claims data. In order for a Practice Site to receive points for the appropriate emergency department use measure, the Practice Site must have a minimum of one thousand two hundred (1,200) Medi-Cal Prime Member months in the Fiscal Year. The number of non-emergent Medi-Cal Prime Member emergency department visits (CPT codes 99281 – 99283) are calculated for each Practice Site and the rate of utilization is determined for one thousand (1,000) Medi-Cal Prime Member months for such Site. Each Practice Site is then compared to the performance of the same category of Practice Sites for the access measure and assigned points based on the number of standard deviations away from the average. Ten (10) points are assigned if the Practice Site has a rate which is less then one (1) standard deviation below the average, five (5) points are assigned for a rate of one (1) standard deviation below the average through one (1) standard deviation above the average, and zero (0) points are assigned for a rate of more than one standard deviation above the average.

3. Clinical Performance and Access to Care Distribution. After the assignment of points for the clinical performance measures and access to care measures, the total quality points are determined for each Practice Site. The total quality points are multiplied by the number of Linked Medi-Cal Prime Member months for the Practice Site during the Fiscal Year to determine the Practice Site's "Weighted Points". Percentages are then determined for each Practice Site by comparison to the totals for Practice Sites of the same category, as follows: Total Weighted Points For Practice Site divided by Total Weighted Points for all Practice Site of the same category (IM, PED or FP/GP) equals the PCP's "QBI Distribution Percentage"

Practice Sites will receive a portion of the applicable Quality Pool (e.g. IM Quality Pool, PED Quality Pool or FP/GP Quality Pool) by multiplying the Site's QBI Distribution Percentage by the total amount of funds in such Quality Pool.

B. Best Practice Implementation. The implementation of medication agreements and pediatric asthma action

RATES REDACTED

1. PED Practice Sites are eligible to submit pediatric asthma action plans.

2. IM Practice Sites are eligible to submit medication agreements.

3. FP/GP Practice Sites are eligible to submit both pediatric asthma action plans and medication agreements.

C. Term of QBI.

The term of this QBI shall begin on January 1, 2011 and end on December 31, 2011 (the QBI Term").

D. QBI Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement quality incentive programs for periods after completion of the QBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the QBI Term, no such program shall be binding upon Plan.

## ADDENDUM 3

## PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

This Addendum sets forth the terms of care based incentives offered to PCPs by Plan. The program is designed to compensate PCPs for efforts undertaken to improve the care provided to Eligible Members as reflected by data measured by Plan, all as described herein (the "Care-Based Incentive" or the "CBI").

The CBI consists of two components: (1) the CBI Incentive Program and (2) the CBI Fee-for-Service Incentive. The CBI continues for a limited term, as described in Section 7 of this Addendum 3, unless it is specifically extended by mutual written agreement of the parties hereto. The budget for the CBI Incentive Program is separate for the Medi-Cal and Healthy Families Programs. The budget and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Families, Healthy Kids, Alliance Care IHSS, Alliance Care AIM and Alliance Care Individual Conversion Programs.

2. Definitions.

In addition to other terms defined in this Addendum 3 or in the Agreement, the following terms shall have the meanings set forth below:

2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.

2.2 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.

2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP Site's performance under the CBI Incentive Program.

2.4 CBI Incentive Program is a program whereby PCP Sites are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance.

2.5 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.

2.6 Comparison Group is the group of PCP Sites to which Provider is compared to determine Provider's percentile ranking within the group. PCP Sites are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.

2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

2.8 Eligible Members

2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.

2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz County Healthy Kids Members; the Monterey County IHSS Members, Monterey County AIM Members, and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.

2.9 Measurement Component shall mean the measures as described in the CBI Table.

2.10 Measurement Period is the period for which Plan shall measure data in order to calculate the applicable CBI Incentive Payment.

2.11 Methodology is the internally developed methodology, or the source of data utilized by Plan, to measure Provider's performance for each Measurement Component under the CBI.

2.12 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.

2.13 Performance Target Measures are those Measurement Components for which the PCP Site receives points based upon meeting a specified Performance Target.

2.14 PCP Site is the individual or group of PCPs to whom Linked Members are assigned.

2.15 Plan Goal is the percentage of Eligible Members for whom the PCP Site provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for all Quality of Care Measures is ninety percent (90%).

2.16 Relative Ranking Measures are those Measurement Components for which a PCP Site receives points based on its ranking relative to performance other PCP Sites within the PCP Site's Comparison Group

3. CBI Incentive Program.

PCP Sites are eligible to receive an incentive payment from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each category correlate to each PCP Site's rank within its Comparison Group for each measure or for the PCP Site meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.2 through 3.8 below. Section 3.1 below establishes an eligibility requirement for participation in the CBI Pool.

3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than one standard deviation, the Provider is not eligible to participate in the CBI Incentive Program. The Member Reassignment Threshold eligibility requirement is not applied to PCP Sites with less than one hundred (100) Linked Members.

3.2 Rate of Preventable Inpatient (IP) Admissions. This Measurement Component measures the rate of preventable inpatient admissions for PCP Site's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable admissions per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP Site must have a minimum of one hundred (100) Linked Members as of December 31, 2011.

3.3 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP Site's Linked Members among all prescriptions filled for PCP Site's Linked Members as determined by a review of claims data.

3.4 Rate of use of Controller Medications for Asthma Cases. This Measurement Component measures the percent of controller medications filled for PCP Site's Linked Members among all controller and rescue medications filled for PCP Site's Linked Members, as determined by a review of claims data.

3.5 Quality of Care Measures. The Quality of Care Measures Component are HEDIS defined clinical performance measures that follow the applicable HEDIS methodology and are based on claims and encounter data, not on chart review. In order for a PCP Site to receive points for a Quality of Care Measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications.

3.5.1 Internal Medicine (IM) Quality of Care. For IM PCP Sites, there are five (5) clinical performance measures, as follows: (1) breast cancer screening, (2) cervical cancer screening, (3) diabetes LDL-C screening, (4) diabetes HbA1c screening, and (5) diabetes care – monitoring for diabetic nephropathy.

3.5.2 Pediatrics (PED) Quality of Care. For PED PCP Sites, there are three (3) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, and (3) Body Mass Index (BMI) percentile calculated.

3.5.3 FP/GP Quality of Care. For FP/GP PCP Sites, there are eight (8) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) breast cancer screening, (4) cervical cancer screening, (5) diabetes LDL-C screening, (6) diabetes HbA1c screening (7) comprehensive diabetes care – monitoring for diabetic nephropathy, and (8) Body Mass Index (BMI) percentile calculated.

3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP Site's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP Site must have a minimum of one hundred (100) Linked Members as of December 31, 2011.

3.7 Rate of Primary Care Visits. This Measurement Component measures the rate of primary care visits provided to PCP Site's Linked Members on an annual basis. The target for this measure is more than three (3) PCP visits per Linked Member, per Fiscal Year. Partial points may be earned by Provider for visits per Linked Member per Fiscal Year between two and one-quarter (2.25) and three (3) visits per Member per Fiscal Year.

3.8 Electronic Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP Site's eligible claims and encounter data submitted to the Plan electronically. Eligible claims include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. Distributions are made to PCP Sites following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

4.1 Relative Ranking Measures. Except as stated below in 4.1.1, PCP Sites shall be awarded the maximum number of points for each measure in which the PCP Site is ranked at or above the 76th percentile. PCP Site shall be awarded one-half the maximum number of points for each measure in which the PCP Site is ranked between the 51st and 75th percentile. PCP Site shall receive zero (0) points for any measure in which the PCP Site is ranked at the 50th percentile or below.

4.1.1 Quality of Care Measures. For the Quality of Care Measures, if the PCP Site meets or exceeds the Plan Goal, the PCP Site shall be awarded the maximum number of points for the measure even if the PCP Site is not in the top quartile for the measure.

4.2 Performance Target Measures. PCP Site shall be awarded the full amount of points if the PCP Site meets the Performance Target for the Electronic Claims/Encounter Data Submittal Measure. If the PCP Site falls below the Performance Target for this measure, the PCP Site earns zero (0) points. PCP Site shall be awarded the full amount of points if the PCP Site meets or exceeds the Performance Target for the Rate of Primary Care Visits Measure. PCP Sites shall be awarded partial points if they provide between two and one-quarter (2.25) and three (3) visits per Linked Member per Fiscal Year. If the PCP Site falls below two (2) visits per Linked Member per Fiscal Year, it will earn zero (0) points.

4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP Site. The total points are multiplied by the number of Eligible Member months for the PCP Site during the Fiscal Year to determine the PCP Site's "Weighted Points". Percentages are then determined by comparison to the totals for PCP Sites of the same Comparison Group, as follows: Total Weighted Points for PCP Site divided by Total Weighted Points for all PCP Sites of the same Comparison Group equals the PCP Site's "CBI Distribution Percentage".

4.4 PCP Sites will receive a portion of the applicable CBI Pool (e.g. IM CBI Pool, PED CBI Pool or FP/GP CBI Pool) by multiplying the Site's CBI Distribution Percentage by the total amount of funds in such CBI Pool.

5. Fee-for-Service Incentives

5.1 Increased preventive and disease management actions. Plan shall pay a fee-for-service incentive for performance of the following:

5.1.1

5.1.2

RATES REDACTED

5.1.3

5.1.4 Medication Management Agreements. Plan shall pay Provider fifty-dollars ($50) for Plan's receipt of the first submitted Medication Management Agreement per Linked Member per Fiscal Year.

5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of capitation or the fee-for-service equivalent for non-capitated Programs for holding office hours for at least eight (8) hours beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCP Sites under Provider's contract located within a 5 mile radius of the site with extended hours availability if Linked Members may access care during the extended hours at the extended hours site.

5.3 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. Distributions are made to PCP Sites following Plan approval of such accounting and are made no later than ninety (90) calendar days after the conclusion of each quarter.

6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.

7. Term of CBI. The term of this CBI shall begin on January 1, 2011 and end on December 31, 2011 (the "CBI Term").

8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.

9. Effect of Termination of Agreement. In the event of the termination of the Agreement for any reason prior to the expiration of the CBI Term, no CBI Incentive Payments shall be earned or made hereunder.

| CENTRAL CALIFORNIA ALLIANCE FOR HEALTH | PROVIDER |
| --- | --- |
| | **Provider Name** |
| By: Jane Parker | By: [signature] |
| Title: Jane Parker | Title: CEO |
| Date: Chair, CCAH | Date: 06/13/11 |
| July 29, 2011 | |

## ATTACHMENT 1 – CBI Table

| CBI Program<br>Measurement Components | Available Points | Member Requirement | Performance Target/Relative Ranking | Measurement Period | Measurement Data Source | Methodology |
|---|---|---|---|---|---|---|
| ***Health and Cost Management:*** | ***45 total*** | | | | | |
| Rate of <u>Preventable IP admissions</u><br>Number of preventable IP admissions per 1,000 Linked Members per Fiscal Year. | 30 | ≥ 100 Linked Members as of 12/31. | Relative Ranking[4] | FY 2011 | Claims | AHRQ[1] |
| Rate of <u>Generic Prescriptions</u><br>Percent of Generic prescriptions among all prescriptions, regardless of prescriber. | 10 | None. | Relative Ranking[4] | FY 2011 | Claims | IHA P4P[2] |
| Rate of <u>Controller Medications</u> for Asthma<br>Percent of Controller Medications among Controller and Rescue Medications. | 5 | None. | Relative Ranking[4] | FY 2011 | Claims | IHA P4P[3] |
| ***Quality of Care (HEDIS):*** | | | | | | |
| **<u>Internal Medicine HEDIS</u>** | **25 total** | | | | | |
| Breast Cancer Screening | 5 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Cervical Cancer Screening | 5 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Diabetes LDL-C Screening | 5 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Diabetes HbA1c Screening | 5 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Diabetes Care – Monitoring for Diabetic Nephropathy | 5 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| **<u>Pediatrics HEDIS</u>** | **25 total** | | | | | |
| Well Child Visit 3-6 Years | 8 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Well Adolescent Visit 12-21 Years | 8 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Body Mass Index (BMI) percentile calculated. | 9 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |

## ATTACHMENT 1 – CBI Table

| **FP/GP HEDIS** | **25 total** | | | | | |
|---|---|---|---|---|---|---|
| Well Child Visit 3-6 Years | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Well Adolescent Visit 12-21 Years | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Breast Cancer Screening | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Cervical Cancer Screening | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Diabetes LDL-C Screening | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Diabetes HbA1c Screening | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy | 3 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| BMI Percentile Calculated | 4 | ≥ 5 continuously Linked Members[5] | Relative Ranking[4] | FY 2011 | Claims | HEDIS |
| ***Appropriate Access to Care*** | ***25 total*** | | | | | |
| Rate of Preventable Emergency Department Visits<br>Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. | 20 | ≥ 100 Linked Members as of 12/31 | Relative Ranking[4] | FY 2011 | Claims | Medi-Cal ER Collaborative definition based on NYU study |
| Rate of Primary Care Visits<br>Greater than three (3) Primary Care visits provided by Provider to Linked Members per Fiscal Year. Partial points will be awarded for 2.25 to 3 visits PMPY. | 5 | None | >3.0 PMPY Performance Target | FY 2011 | Claims | Plan developed |
| ***Information Technology*** | ***5 total*** | | | | | |
| Electronic Claims/Encounter Data Submittal<br>95% of eligible claims/encounter data submitted electronically to the Alliance. | 5 | None | 95% Performance Target | FY 2011 | Claims | # eligible electronic claims / All eligible claims |

## ATTACHMENT 1 – CBI Table

| CBI FFS Incentive Measurement Component | Amount (All paid quarterly.) | Member Requirement | Measurement Period | Measurement Data Source |
|---|---|---|---|---|
| Extended Office Hours<br>Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per Primary Care Site covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours site. | 5% of Cap. or Case Management Fee-for-Service | None | FY 2011 | Administrative Data |
| Diabetes Services<br>Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, Retinal exam, Nephropathy screen during the Fiscal Year. The Member must be linked to the Provider at the date of service of each of the above elements for Provider to receive payment. | RATES REDACTED | embers ages and older, ked to ovider at date ervice for ı service. | FY 2011 | Claims |
| Childhood Obesity Notification<br>Provider to notify Plan by Plan's notification form of child 3 – 18 y/o with BMI at or above the 90th percentile. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about Plan's support program. | | mbers aged ı 18 | FY 2011 | Notification Form |
| Pediatric Asthma Action Plans (PAAP)<br>Provider to submit PAAP to Plan for Members with Asthma. Incentive paid to the PCP who first submits the PAAP in the Fiscal Year and is paid only once per Fiscal Year. | | mbers ages o to 18 | FY 2011 | Plans Submitted by Providers |
| Medication Management Agreements (MMA)<br>Provider to submit MMA for members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Fiscal Year. | | one | FY 2011 | Plans Submitted by Providers |

[1] http://www.ahrq.gov/data/safetynet/billappb.htm
[2] http://www.iha.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf
[3] http://www.iha.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf
[4] For relative ranking measures, PCP Sites ranked at 100th to 76th percentile amongst peers earns maximum available points, ranked at 75th to 51st percentile earns one-half available points, ranked below 50th percentile earns no points for the measure.
[5] For HEDIS Measures, the continuously Linked Members must be qualified per HEDIS specifications.

Note: If a Provider has 100 or more Linked Members, and the Provider's rate of member reassignment per 1,000 Linked Members exceeds the Plan mean of member reassignment rate per 1,000 Linked Members by one standard deviation, the Provider is not eligible to participate in the CBI Incentive Program.