

# PROFESSIONAL SERVICES AGREEMENT

## BETWEEN

**EMPLOYEE HEALTH SYSTEMS MEDICAL GROUP, INC.**

## AND

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IN WITNESS WHEREOF, the parties have hereunto executed this Agreement, including Schedules A, B, C and D on the day and year written below.

For: **Provider**

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Primary Care Specialty(ies): \_\_\_\_\_

For: **Employee Health Systems Medical Group, Inc.**

Signature: \_\_\_\_\_

Print Name: James Mason

Title: Attorney in Fact

Date: \_\_\_\_\_

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THIS PRIMARY CARE PROFESSIONAL SERVICES AGREEMENT (“**Agreement**”), effective on the date executed by both Parties, is made and entered by and between **Employee Health Systems Medical Group, Inc.**, a California professional corporation doing business as an IPA provider network in the greater Los Angeles area and operating as EHS Medical Group (hereinafter “**EHS**”), and \_\_\_\_\_ (hereinafter “**PROVIDER**”).

WHEREAS, EHS has executed a number of managed care and other contracts with Plans (as defined herein) to arrange for the provision of certain services to Members on a prepaid (capitation) or fee-for-service (“FFS”) basis; and

WHEREAS, the Parties desire to enter into this Agreement in order to facilitate the provision of quality, cost effective, covered health care services to Members; and

WHEREAS, both Parties recognize that this Agreement represents the foundation of responsibilities to successfully provide Covered Services to Members on a continuing basis; that mutual cooperation, respect and communication are essential to the fulfillment of these responsibilities; and that the timely, accurate and good faith fulfillment of each Party’s responsibilities is necessary in order for the other to satisfy its responsibilities; and

WHEREAS, the Parties resolve that by executing this Agreement, any prior agreements between the parties shall be superseded by this Agreement, and that Provider agrees to participate in EHS-negotiated Payor agreements, and to honor and fulfill all terms, conditions and obligations as a contracted provider.

NOW, THEREFORE, in consideration of the premises set forth above and the terms, covenants and conditions set forth below, the Parties mutually agree as follows:

**SECTION I**  
**DEFINITIONS**

- 1.1. **Capitation**, if applicable, shall mean a method of compensation that makes a monthly prepayment for services expected to be rendered in that month to a Provider on a Per Member Per Month (“**PMPM**”) basis for Members assigned to that Provider. Provider acknowledges that s/he is at risk for services covered by such Capitation.
- 1.2. **Coordination of Benefits** (“**COB**”) shall mean those provisions by which Provider, Plan and EHS, either together or separately, seek to recover costs of Covered Services provided to a Member for care that may be covered by another Plan, subject to limitations imposed by law, regulation or a contract limiting or preventing such recovery.
- 1.3. **Covered Services** shall have the meaning ascribed in the relevant Plan agreement entered into by EHS.
- 1.4. **Hospital** shall mean an acute care hospital licensed in California, approved by The Joint Commission (TJC), and certified for participation under Medicare and Medicaid (*Titles 18 and 19 of the Social Security Act*).
- 1.5. **Medically Necessary** shall mean medical, surgical, hospital or other treatment that a Member requires as determined by one or more Participating Physicians, in accordance with generally accepted medical practice standards prevailing at the time of treatment, and in conformity with the professional and technical standards adopted by EHS’s Quality Assurance and Utilization Review Committees and in accordance with Upstream Contractors and Regulatory Agencies.
- 1.6. **Member** shall mean an individual person certified as eligible for health care coverage by a Plan.
- 1.7. **Non-Covered Services** shall mean those health care services that are *not* covered benefits for a particular Plan and are therefore the financial responsibility of the Member.
- 1.8. **Plans** shall mean health maintenance organizations (HMO), preferred provider organizations (PPO), exclusive provider organizations (EPO), self-funded employers, insurance carriers, third party administrators (TPA), managed care plans, State or Federal health benefits plans, ERISA trusts, or other Plans that contract with EHS to provide patient care services to its members or beneficiaries.
- 1.9. **Primary Care Physician (PCP)** shall mean physicians practicing medicine in the specialties of Family Practice, General Practice, General Internal Medicine, and Pediatrics. Specialty Physicians are defined as physicians in all other specialties. OB/GYN and other specialty physicians may function as both PCPs and Specialty Providers as long as they satisfy all credentialing requirements.
- 1.10. **Provider** shall mean the physician or entity signing this Agreement, as well as all other affiliated Participating Physicians, Participating Providers or other entities obligated as a part of this Agreement.
- 1.11. **Participating Physicians** or **Participating Providers** shall mean any physicians, nurse practitioners, physician assistants, or other ancillary care providers who are members of or who are contracted to Provider, and who shall provide services under this Agreement.
- 1.12. **Regulatory Agencies** shall mean all applicable federal, state and local law, and all related rule and regulations promulgated by all such entities and their designees which have jurisdiction or responsibility for oversight of this Agreement. Federal regulatory agencies include but are not limited to the *Dept of Health and Human Services (HHS)*, *Dept of Justice (DOJ)*, and *Centers for Medicare and Medicaid Services (CMS)*. California agencies include the *Dept of Health Care Services (DHCS)*, *Dept of Corporations (DOC)*, *Dept of Insurance (DOI)*, and *Dept of Managed Health Care (DMHC)*.
- 1.13. **Upstream Contractors** shall mean those signatories in the chain of agreements leading back to the ultimate source

of payment for a particular patient population. As an example, the immediate Upstream Contractor to this Agreement is the contract between EHS and a Plan.

- 1.14 **Patient-Centered Medical Home** shall mean that the PCP serves as the gatekeeper for assigned Members and is responsible for coordinating all aspects of a patient's health care needs. The patient-centered medical home requires that the PCP effectively monitor and manage a patient's health care needs as delivered by the PCP and other health care professionals, including acute, chronic, preventive and end-of-life care. The services performed by the PCP in the patient-centered medical home include, but is not limited to, the following primary care functions:
- Serving as the patient's gatekeeper into the rest of the healthcare system
  - Coordinating a patient's care among various specialists
  - Providing the central record of care so a summary of all services is available in one location
  - Providing personal health care
  - Focusing on the patient rather than the disease
  - Developing a continuous healing relationship
  - Avoiding over/under treatment
  - Integrating the needs of patients with multiple conditions
  - Accessing and triaging of symptoms
  - Coordinating care for multiple diagnoses
  - Diagnosing and treating illness
  - Understanding a patient's goals
  - Enhancing trust and understanding
  - Managing the conflicts and burdens of multiple recommendations

## **SECTION II** **RESPONSIBILITIES OF EHS**

- 2.1. **EHS Responsibilities.** EHS shall be responsible to provide or arrange all marketing, administration, financial management and control, claims processing, and the operation of comprehensive quality assurance and utilization management programs consistent with the requirements of managed care agreements. EHS shall develop and maintain written policies and procedures relating to such activities.
- 2.2. **Member Enrollment.** Provider understands and accepts that Members select Provider to be their PCP based on a number of factors, including Plan benefits, physician preference by Member, and Member proximity. Provider understands that there is no guarantee of Member enrollment or referrals because of this Agreement, and that Member selection of Provider as his/her PCP is largely made solely by the Member. The parties hereto understand and agree that the terms and conditions of this Agreement are the sole and absolute source of reimbursement for the Provider and that no other consideration shall be made to Provider by EHS.

## **SECTION III** **RESPONSIBILITIES OF PROVIDER**

- 3.1. **Provision of Covered Services.** Provider shall render Covered Services to Members consistent with the scope of Provider's license, certification or accreditation, and in accordance with professionally recognized standards in effect at the time services are given in a manner that ensures availability, timely access, continuity, and cultural and linguistic sensitivity on a 24/7 basis. Provider shall provide Covered Services in accordance with, and shall otherwise comply with, all provisions of Regulatory Agencies and Upstream Contractor agreements as amended from time to time. Provider further acknowledges that it is not restricted from advising or otherwise communicating with Members about their health status, medical care or treatment regardless of benefit coverage.

The PCP serves as the gatekeeper for assigned Members and is responsible for coordinating all aspects of a patient's health care needs. The patient-centered medical home requires that the PCP effectively monitor and manage a patient's health care needs as delivered by the PCP and other health care professionals, including acute, chronic, preventive and end-of-life care.

- 3.2. **Licensure and Credentialing.** Provider and all contracted Participating Providers agree to maintain all medical and other necessary licensure for the duration of this Agreement. Provider agrees to aid in procuring all credentialing requirements in accordance with the guidelines established by the National Committee on Quality Assurance (NCQA). All Participating Physicians shall have valid California medical licenses, DEA certificates, Hospital admitting privileges or be part of an admitting panel, be board certified or eligible under his/her specialty,

and be eligible to treat Medi-Cal and/or Medicare patients in California.

- 3.3. **Record-Keeping and Access.** Provider and contracted Participating Providers agree to maintain and allow access to EHS, Plan, Upstream Contractors and Regulatory Agencies to inspect and audit each entity's books, contracts, records, medical records, patient care documentation, papers, documents other records of subcontractors or related entities, and facilities as may be necessary to fulfill all compliance and reporting obligations. Such information shall be available at all reasonable times and upon demand during normal business hours, and to the extent feasible, such records shall be in California. Record retention and the right to inspect and audit shall extend no less than ten (10) years from the end of the year in which this Agreement terminates (per *Medicare 422.504(d)(e)(4)*).
- 3.4. **Non-Payment; Hold Harmless; No Surcharges; Patient Waivers.**
- a. Provider, for itself and each of its contracted Participating Providers, agree that in no event, including but not limited to non-payment, insolvency or a breach of this Agreement, shall Provider or Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons (other than Plan or EHS) acting on their behalf for Covered Services. This provision shall not prohibit the collection of any co-payments, deductibles or coinsurance.
  - b. In the event of non-payment by Plan to EHS, or from EHS to Provider, for any reason including Plan's insolvency, EHS's insolvency or breach of this Agreement, Provider and each contracted Participating Provider shall continue to provide Covered Services (i) to all Members for the duration of the period for which payments are made to the Plan or EHS, or (ii) for Members who are hospitalized on the termination date of Plan or EHS becomes insolvent, through discharge. Provider and each Participating Provider's sole recourse for payment shall be against Plan if Plan is in default, or against EHS if EHS is in default.
  - c. Provider and all contracted Participating Providers agree that this provision shall survive termination of this Agreement, regardless of cause, and shall be construed to be for the benefit of the Member. This provision supersedes any oral or written agreements to the contrary now existing or hereafter entered into between the Provider, its Participating Providers, and a Member or persons acting on the Member's behalf.
  - d. **No Surcharges.** Provider and its Participating Providers shall not assess surcharges to Members for Covered Services. Provider will immediately refund any such monies as soon as Provider knows of the error. Provider acknowledges that, should a Plan or EHS receive notice of any such surcharge and Provider fails to reimburse the Member within fifteen (15) calendar days of notice to do so, EHS shall have the right to cancel this Agreement effective upon receipt by Provider of cancellation notice. "Surcharge" shall mean an additional fee which is charged to the Member for a covered service but which is not approved by the Director, provided for in the Plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage, as currently defined by 28 CCR 1300.45(p), or as otherwise defined by the State in the future.
  - e. **Patient Waivers.** Provider shall not charge Members for services denied payment as not being medically necessary or are not covered benefits, unless Provider has obtained a written waiver in advance from the Member clearly stating that the Member is responsible for payment and identifying the cost of those services.
- 3.5. **Insurance Coverage.** During the course of this Agreement, Provider shall maintain sufficient professional liability, general liability, and other insurance coverage of not less than one million dollars (\$1,000,000) per occurrence, three million dollars (\$3,000,000) annual aggregate, or such other amounts as may be required by Upstream Contractors or Regulatory Agencies. Provider shall provide proof of coverage on request. EHS shall be notified within ten (10) days of any reduction or cancellation of insurance coverage.
- 3.6. **Non-Discrimination.** In accordance with federal and state statutes and regulations, Provider shall not discriminate against (i) Members in connection with Provider's treatment or admission policies or practices, (ii) any EHS employee, or (iii) any employee of Provider on the basis of ancestry, race, ethnicity, creed, color, sex, age, gender, marital status, sexual orientation, national origin, religion, mental or physical disability, medical condition (such as ESRD), health status, claims experience, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment or geographic location. Provider shall not request, demand, require, or otherwise seek, directly or indirectly, the removal of any Member to whom Provider renders Covered Services pursuant to this Agreement for reasons relating to the need for, or utilization of, such Covered Services.

- 3.7. **Covenant Not To Solicit or Transfer Members.** The business relationship between EHS and its Members, and between EHS and the Plans with whom it contracts, is EHS property, including all Member lists accepted by Provider. During the term of this Agreement and for two (2) years after its termination, Provider and its contracted Participating Providers agree that they will not: interfere with EHS's contract and/or property rights; advise or counsel any Member or Plan to terminate their relationship with EHS; solicit any Member to become enrolled with any other Plan; or disclose proprietary EHS information. Provider acknowledges that such activity would constitute prohibited use of EHS confidential information. In addition, during this Agreement's term, Provider agrees to *not* move any EHS-affiliated membership to any other provider network in which Provider is contracted. . . Notwithstanding the above, Provider may move a Member to another provider network in the event EHS is not contracted with the other provider network and the Member cannot access Provider through EHS Plans.
- 3.8. **Right to Use Name.** Provider does hereby give EHS and its contracted Plans the right to publish Provider's name, contracted Participating Providers' names and specialties in promotional materials and directories.
- 3.9. **Quality Management Activities.** Provider agrees to participate in, cooperate with, submit all required reports and records to, and abide by the policies, procedures, decisions, rules and regulations of EHS, Plan, Upstream Contractors, and Regulatory Agencies as they pertain to quality improvement, utilization review, peer review, credentialing, Member and Provider grievances and appeals, audits, statistical activities and encounter data submission. By this reference, Provider agrees to incorporate and abide by the content of such protocols, policies, procedures and committee formats, and to any updates as may occur and be distributed from time to time.
- 3.10. **Utilization Management (UM) Activities.** Provider agrees that in addition to all other UM requirements and protocols, prior authorization is *not* required for in-network mammography screenings, routine and preventive services for women from women's health specialists, and influenza vaccinations for Medicare beneficiaries. Provider shall use best efforts to perform initial health assessments of newly enrolled Members within ninety (90) days of a Member's effective date. Provider agrees to incorporate and abide by the policies, procedures, standards and programs developed by EHS, Plans, Upstream Contractors and Regulatory Agencies with respect to required referral and linkage systems (e.g., mental health, dental, CCS, family planning, etc.), case management, and cultural and linguistic services, and any updates as may occur and be distributed from time to time.
- 3.11. **Encounter Data / Statistical Requirements.** Provider agrees to submit all encounter data in a readable, aligned, and printed in black ink format on a 1500 form or in a mutually agreed electronic format to characterize the content and purpose of each Member encounter within thirty (30) days from date-of-service or as required by Plans. If requested, Provider also agrees to provide copies of pertinent medical record information. Failure to provide said data in accordance with this section may result in reduced or delayed payment to Provider. Provider shall certify to the accuracy, completeness and truthfulness of the data when required by an Upstream Contractor or Regulatory Agency. Should EHS be subject to fines and/or withholds as a result of Provider's failure to provide this data on a timely basis, then such fines and/or withholds shall be proportionally deducted from Provider payment.
- 3.12. **Site Visits.** Provider and contracted Participating Providers agree to permit EHS, Plans, Upstream Contractors and other applicable Regulatory Agencies or their designees to permit periodic site evaluations of Provider's facilities, offices and records in accordance with the terms of this Agreement and current laws and regulations. Provider further agrees to comply with an agency's recommendations, if any.
- 3.13. **Performance Standards.** Provider shall comply and cooperate with all standards, policies and procedures as may be adopted or amended from time to time by EHS, Upstream Contractors and applicable Regulatory Agencies. In the event Provider is found to be non-compliant with these standards, Provider may be subject to sanctions in accordance with, and subject to, all appeal rights policies and procedures as implemented from time to time.

**HIPAA Compliance.** The parties acknowledge that each is a Business Associate of the other, as defined under the *Health Insurance Portability and Accountability Act of 1996* (“**HIPAA**”), and represents that each is and will be in compliance with HIPAA and all of its standards within the timeframes as required by law. Provider further acknowledges that medical records and Personal Health Information (“**PHI**”) shared between the parties shall remain confidential in accordance with HIPAA and any other laws or regulations addressing the confidentiality of medical and/or personal health information.

- 3.14. **Other Regulatory Compliance.** Provider agrees to comply with all applicable municipal and county ordinances and regulations, and all applicable state and federal laws and regulations as may be in effect now or hereafter, to the extent that they directly or indirectly bear upon the subject matter of this Agreement.
- 3.15. **Reciprocity.** For any Plan contract requiring reciprocity for which EHS is not financially responsible, Provider agrees to accept such reciprocal payments from the applicable third party as payment in full. Furthermore, Provider acknowledges that it may also receive patients from pass-through client arrangements as a result of the relationship between EHS and its back-office business process management services relationship (MSO) with SynerMed Inc. This provision shall not prohibit Provider from collecting any applicable copayments, deductibles or coinsurance.
- 3.16. **Disciplinary Action.** Provider acknowledges that Upstream Contractors, under their respective contracts, have the right to require Plan or EHS to suspend assignment of new Members, to transfer Members from to another Participating Provider, or to terminate a Participating Provider at any time, subject to such review or appeal rights as may be provided in accordance with, and subject to, policies and procedures as implemented from time to time.
- 3.17. **Provider Manual.** EHS maintains a Provider Manual in electronic form in the web portal for Participating Providers. The Provider Manual makes information available to assist Provider in implementing this Agreement and it includes resources to verify eligibility of Members, Covered Services, claims payment, referral processes, and more. In the event EHS updates the Provider Manual, such updates shall apply to Provider as allowed by regulation and the Plans.
- 3.18. **Provider Directory.** Provider agrees to comply with California Health & Safety Code Section 1367.27 (the “Provider Directory Law”) which sets forth rules and requirements with respect to the obligations of Plans to publish and maintain accurate and reliable provider directories. Provider hereby agrees to provide EHS and any Plan any and all information required under the Provider Directory Law.
- 3.19. **Notice of Panel Opening or Closure.** As required by the Provider Directory Law, Provider shall notify, or shall assist EHS in notifying, any applicable Plan within five (5) business days of Provider’s opening or closure of its panel to any Plan. Following a panel closure, Provider must direct a Member seeking Covered Services to the applicable Plan for assistance in identifying an alternative medical provider and to the Department of Managed Health Care to report any inaccuracies in the applicable Plan’s provider directory. Notwithstanding the forgoing, Provider agrees to provide EHS with a minimum of one hundred eighty (180) days written notice of the opening or closure of its panel to any Plan.

#### **SECTION IV** **TERM AND TERMINATION**

- 4.1. **Term.** When fully executed by the parties, this Agreement shall remain in effect for an initial term of seven (7) years, and thereafter shall automatically continue for consecutive terms of similar length unless terminated as provided below. This Agreement also replaces any prior Agreements, if any, between the parties.
- 4.2. **Automatic Termination.** This Agreement shall automatically terminate and notice given if Provider, or contracted Participating Physicians, (i) ceases for any reason to be a member in good standing of a Hospital’s medical staff, subject to the provisions contained herein; (ii) license to practice medicine is revoked or subject to disciplinary action by the California Board of Medical Examiners; (iii) fails to maintain professional liability insurance; (iv) is prohibited in participating in the Medicare or Medicaid program; (v) fails to meet EHS credentialing or re-

credentialing standards; (vi) has been convicted of, or plead no contest to, a felony charge or charge of fraud, deceit, forgery, misrepresentation, moral turpitude or unprofessional conduct; (vii) does not agree to automatically amend this Agreement to maintain, or is non-compliant with all applicable municipal and county ordinances and regulations, and all applicable state and federal statutes and regulations as implemented by Regulatory Agencies; (viii) if, by allowing Provider to continue to render Covered Services to Members, the health or safety of Members would be endangered; EHS would be in violation of state licensure, federal qualification and/or NCQA accreditation standards and/or subject to sanction by any of those agencies; and/or EHS's relationship with any Plan or reputation in the community would be damaged; or (ix) if Provider executes this Agreement but fails to complete credentialing or otherwise begin building business with the IPA within a six month period.

- 4.3. **Voluntary Termination.** EHS may terminate this Agreement with ninety (90) days prior written notice sent by certified or registered mail (return receipt requested and postage prepaid) to Provider to the address set forth in Section 6.12. Provider may terminate this Agreement with one hundred eighty (180) days prior written notice sent by certified or registered mail (return receipt requested and postage prepaid) to EHS to the address set forth in Section 6.12 of its intent not to renew the Agreement at the end of the then current term.
- 4.4. **Termination for Cause.** EHS may terminate this Agreement for cause in the event that Provider breaches a material term of condition of this Agreement and fails to cure such breach within thirty (30) days after written notice of the breach. Cause may include, but is not limited to quality of care and accessibility considerations, or failure to provide credentialing or other required information, and the failure to comply with Provider Directory Law.
- 4.5. **Provider Appeals of Termination Decisions.** Provider may appeal a termination decision to the extent permitted in accordance with EHS's fair hearing rules. EHS will make best efforts to notify Provider in advance of any action taken under this provision, provided that in EHS's reasonable opinion, the health and safety of the Member's is not compromised by the delay. Nothing in this section shall be construed to prevent a Participating Provider from open clinical dialogue with a Member, including communicating medical advice and/or treatment options, regardless of cost or coverage of the options.
- 4.6. **Notification of Members.** Upon notice of termination for any reason, EHS shall notify affected Members of the termination within thirty (30) days of the effective date of termination. Provider may also notify affected Members. Affected Members are Members who have been under the ongoing care of the Provider.
- 4.7. **Transfer of Patient Care Responsibility; Member Benefit Continuation.** The parties agree that nothing in this Agreement authorizes Provider to abandon any Member who is a patient. Upon termination of this Agreement for any reason, Provider shall continue providing Covered Services to Members who retain eligibility and for whom premium is paid, or by operation of law, until such services are completed or until EHS has made arrangements for treatment by another Provider and the transfer of patient care responsibility is completed. Provider shall assist EHS in the transfer of Members' patient care responsibility to other Providers. For such activity, Provider shall continue to be compensated in accordance with the terms set forth in **Schedule A**.

## **SECTION V**

### **COMPENSATION**

- 5.1. **Compensation.** Unless otherwise provided in an applicable Plan contract, EHS agrees to pay, and Provider agrees to accept, the amounts set forth in **Schedule A**, less any applicable deductibles, copayments or dollars recovered through COB activities, and upon receipt of adequate billing information and required reports from Provider. Such payment shall be considered payment in full. Provider acknowledges and agrees that by participating in this Agreement, there are no financial incentives acting directly or indirectly as an inducement to limit Medically Necessary services. Discrepancies in the amount billed or procedures performed may be appealed to EHS's UM Committee in writing in accordance with AB1455 and their decision shall be binding. EHS's obligation to pay is conditioned upon receipt of payment from Plan. Provider acknowledges that prior authorization may be required before specific services are provided, and that not obtaining prior authorization may result in denial of claims.

- 5.2. **Incentives.** EHS may, from time to time, implement financial incentives to Provider to reward providers for services that help improve the community health of populations served. Specific measures may include those that increase quality scores for the Healthcare Effectiveness Data and Information Set (HEDIS), the Integrated Healthcare Association (IHA) pay-for-performance (P4P) program, and the Medicare 5-Star rating program, among others. Incentives are paid in addition to any compensation in this Agreement.
- 5.3. **Offsets.** In the event EHS determines that a claim has been overpaid or paid in duplicate, or that funds were paid that are not part of this Agreement, Provider shall repay such funds within thirty (30) calendar days of written notice. Provider may exercise its appeal rights during this period. Should Provider fail to repay such funds within the time specified, in addition to any contractual or legal remedy available, EHS may recover such amounts owed by way of offset or recoupment from current and future amounts due Provider as defined by SB1387.
- 5.4. **At-Risk Covered Services.** At-Risk Covered Services and the division of financial responsibility for each Plan are hereby defined in the respective Plan contracts executed by EHS. Any additions, deletions or changes will automatically become part of this definition and given to Provider.
- 5.5. **Primary Care Services.** Primary Care Services that are compensated by capitation or advanced funding methodologies are hereby defined to include those services described in the attached **Schedule A.**
- 5.6. **Payment Date.** Monthly Capitation payments to PCP will be made based on eligibility information received by EHS *around* the twentieth (20th) day of each month from each Plan or Upstream Contractor. Provider acknowledges that eligibility lists with updated information received after the processing shall result in retroactive additions and deletions from subsequent capitation.
- 5.7. **Other Incurred Costs.** At the sole discretion of EHS, any cost incurred by EHS for Primary Care Services (*Schedule A*) rendered by another provider may be subtracted from PCP Capitation payments. If a PCP cannot provide certain PCP Services (*Schedule A*), then PCP agrees to that it may be subject to a lower funding rate to compensate for those services.
- 5.8. **Reserves.** Provider acknowledges and understands that Reserves are required by Upstream Contractors and applicable Regulatory Agencies to maintain financial integrity, enable payment of claims and guarantee payment of subcontractors. Since EHS is the contracting entity, the responsibility to maintain reserve levels and financial integrity belongs to EHS.
- 5.9. **Referral Network Requirement.** EHS maintains a network of providers of various specialties that are available to treat Members who require a referral by Provider. In some cases, EHS may elect to enter into exclusive agreements with Providers for the provision of some services. Provider understands and acknowledges that he/she is required to use the EHS network of Providers, and may be required to exclusively refer Members to some Providers. In the event Provider refers a Member for non-emergency services to a provider that is not contracted with EHS, or does not refer a Member to an exclusively contracted Provider of EHS, then Provider shall be financially responsible for such referral and EHS shall have no financial responsibility to pay for such referral. At EHS's discretion, EHS retains the right to pay for such referrals on behalf of Provider and to deduct such payment from any amounts owed to Provider by EHS.

In Los Angeles County, Provider acknowledges that EHS has partnered with Pacific Alliance Medical Center to create an ambulatory ICU clinic focused exclusively on patients with multiple chronic care conditions called the Downtown Coordinated Care Center (DC3). Provider acknowledges that if EHS determines a particular Member meets the criteria for selection into the DC3, EHS shall either (1) notify the applicable health plan to transfer the member to a new PCP within the DC3, or (2) internally transfer the member within EHS to the DC3 directly.

- 5.10. **Claims Payment Timelines.** Provider agrees to submit all claims for payable services in a readable, aligned, and printed in black ink format on a 1500 form or in a mutually agreed electronic format to characterize the content and



purpose of each service as required by Plans. Medi-Cal claims *must* be submitted within six (6) months from date of service (*CCR Title 22 section 51008*). All other claims for services rendered *must* be submitted within one (1) year from date of service. Claims submitted beyond these timelines will be denied. If requested, Provider also agrees to provide copies of pertinent medical record information. Failure to provide said data in accordance with this section may result in reduced or delayed payment to Provider. Provider shall certify to the accuracy, completeness and truthfulness of the data when required by an Upstream Contractor or Regulatory Agency All clean claims will be paid within the sooner of thirty (30) working days of receipt for M-Cal and forty-five (45) working days for Medicare or in accordance with Upstream Contractors and applicable Regulatory Agencies, including all provisions of *ABI455*.

5.11 **Prior Authorizations Required**. All Providers acknowledge that prior authorization must be obtained on specialty, hospital and certain ancillary services, such as MRIs, CTs, medical genetics testing, and other ancillary services, and that all referrals must be made to contracted providers. At EHS's sole discretion, any cost incurred for unauthorized referrals may be deducted from payments owed Provider.

5.12 **Termination Effect**.

- a. Upon notice of termination, no further capitation or incentive payments shall be made. All Reserves and revenues shall be retained to pay claims.
- b. If Provider has terminated when the Reserves are below the required level and Provider has payable claims, EHS may, at its sole discretion, recoup Provider's share of under-funding by either adjusting the payment of outstanding amounts due Provider, or by requesting that Provider directly reimburse EHS. In the event that Provider fails to make such payments when due, EHS shall be entitled to maximum rate allowed by law until paid, including the cost of collection, and, if necessary, reasonable attorney's fees.

5.13 **Modification**. At the sole discretion of EHS and its Board of Directors, **Schedule A** may be modified from time to time, with prior written notice to Provider.

## **SECTION VI** **MISCELLANEOUS**

6.1. **Mutual Indemnification**. Each party agrees to indemnify, defend and hold harmless the other, its agents, employees, shareholders, directors and representatives from and against any and all liability or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature, including but not limited to bodily or personal injury, death, property damage, or other damages arising from the performance of or failure to perform under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the other, its agents, employees, shareholders, directors and representatives. This provision shall survive termination of this Agreement.

6.2. **Arbitration**. The Parties agree to meet and confer in good faith to resolve any problems or disputes that may arise. In the event it cannot be resolved in this way, the problem or dispute shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association, and judgment by the arbitrator(s) may be entered in any court having jurisdiction thereof. Such arbitration shall occur in Los Angeles County, California, unless mutually agreed to have such proceeding in some other locale. Either party may initiate arbitration by making a written demand for arbitration on the other. The arbitrator(s) may, in any such proceeding, award attorney's fees and costs to the prevailing party. The arbitrator's decision shall be final and binding.

6.3. **Independent Contractor Status**. In the performance of the work, duties and obligations of this Agreement, it is mutually agreed and understood that Provider is at all times acting and performing as an independent contractor. EHS shall neither have nor exercise control or direction over Provider's work or functions, except that the interest of EHS is to assure that medical services are rendered in a competent, efficient and satisfactory manner. Provider shall not have any claim against EHS for vacation, sick leave, retirement, pension, social security, disability, workers' compensation or unemployment benefits of any kind.

- 6.4. **Binding Agreement and Assignment.** This Agreement shall be binding upon, and shall inure to the benefit of the parties to it, and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, Provider may not assign or delegate any of its duties hereunder (including, without limitation, the provision of any Covered Services) to a third party without the prior written consent of EHS and any applicable Plan.
- 6.5. **Validity.** The invalidity and non-enforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision shall not operate as or be construed as a waiver of any subsequent breach thereof.
- 6.6. **Subcontracts.** No subcontracts to this Agreement may be allowed without the express written permission of EHS.
- 6.7. **Other Plan Agreements.** As EHS enters into new Plan agreements, notice shall be distributed to Provider and Provider agrees to participate as a contracted participating provider.
- 6.8. **Amendments.**
- a. EHS reserves the right to amend this Agreement by giving Provider thirty (30) days written notice of such amendment or by mutual written consent of the parties. Notwithstanding the preceding, no amendments of any terms which are in conflict with the terms of EHS' contract with a Plan or a Plan's contract with an Upstream Contractor shall be binding without the written consent of the Plan.
  - b. It is recognized and acknowledged by all parties that as specific agreements are executed between EHS and other Plans, additional contractual requirements may be necessary. Provider agrees to promptly execute any Amendments that do not substantially alter this Agreement. Any Amendments not executed within thirty (30) days of receipt shall be deemed approved and become a part of this Agreement.
  - c. This Agreement shall be automatically amended as changes are made in order to remain in contractual compliance with all applicable municipal and county ordinances and regulations, and all applicable state and federal statutes and regulations as implemented by Upstream Contractors and Regulatory Agencies (collectively "Compliance Regulation"). Such amendments shall for purposes of Compliance Regulation bind the parties whether or not provided for directly in this Agreement. The Compliance Regulation in effect at the time of execution of this Agreement is set forth in **Schedule D** which is incorporated herein. Alternatively, EHS may post such new **Schedule D** on the provider portal of the web site used by EHS for its providers and notify Provider of such posting, and such posting of a new **Schedule D** shall be deemed part of this Agreement.
- 6.9. **Entire Agreement.** This instrument and the exhibits, schedules and attachments hereto contains the entire agreement between the parties and supersedes all prior understandings, agreements and representations, written or oral, on the same subject matter, and shall be governed under the laws of California except as preempted by Federal law.
- 6.10. **Agreement Confidentiality.** The terms and conditions of this Agreement shall be held strictly confidential. A breach shall be considered a material breach and a condition of immediate termination of this Agreement.
- 6.11. **Proprietary Information.** Provider shall maintain all Member information, including but not limited to, the Member's name, address, telephone number and any other information that identifies a particular Member ("Member Information") in compliance with all applicable confidentiality and Member record and accuracy requirements. Provider shall also maintain confidential all other "EHS Trade Secret Information". For the purposes of this Agreement, "EHS Trade Secret Information" shall include, but shall not be limited to all EHS agreements with Plans, EHS's information systems, EHS's policies and procedures, intellectual property for and related to the implementation of the terms and conditions of this Agreement, financial terms of service agreements held by EHS or its Client Entities with hospitals and other health care providers, and any records, files or forms provided by EHS or its Client Entities to Provider. Provider shall not disclose, directly or indirectly, allow the disclosure of any Member information or EHS Trade Secret Information for his/her own benefit or gain either during the term of this Agreement or after the termination of this Agreement, except that Provider may use the Member information herein for the treatment of a Member as medically indicated and necessary

6.12. **Notices.** Except as set forth in Section 4.3, all notices (including amendments) required or permitted to be given hereunder by either party to the other shall be in writing and shall be deemed to be duly given (i) on the date of delivery if personally delivered by hand; (ii) upon the fifth day after such notice is deposited in the United States mail; (iii) on the date of delivery if sent by a nationally recognized overnight express courier; or (iv) by email or facsimile, upon confirmation (including automatic confirmation of delivery in the case of facsimiles and the absence of an “undeliverable” return email in the case of emails) of successful transmission of such notice or amendment. Notices and amendments shall be delivered to Provider at the mailing address, email address or facsimile number provided by Provider to EHS. Written notices shall be sent to the following addresses:

Provider (please print legibly):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Health Systems Medical Group, Inc.:

**EHS Medical Group**

1600 Corporate Center Drive

Monterey Park, California 91754

Attn: Executive Vice President

6.13 **Schedules and Exhibits.**

Schedule A – Provider Compensation

- Exhibit 1 – All Programs
- Exhibit 2 – Routine PCP Services
- Exhibit 3 – Non-Capitated Covered Services Reimbursement Schedule

Schedule B – List of Participating Providers

Schedule C – Credentialing

- Information Release / Acknowledgments
- Provider Data Form

Schedule D – Compliance Regulation

*[The remainder of this section is intentionally left blank.]*

SCHEDULE A  
EXHIBIT 1  
PROVIDER COMPENSATION  
ALL PROGRAMS

For More Information  
On Provider  
Compensation  
Please Contact  
Norm Davidson  
VP of Contracting  
At  
[ndavidson@synermed.com](mailto:ndavidson@synermed.com)

**SCHEDULE B**  
**LIST OF PARTICIPATING PROVIDERS WITHIN PROVIDER GROUP OR IPA**

If Provider is a medical group or independent practice association (IPA) with greater than one (1) physician or physician extender, and this Professional Service Agreement applies to all physicians and providers within the group or IPA, write below or attach a list that includes the names, addresses, phone numbers, license numbers, and specialties of all participating physicians (primary and specialty) and other providers. Indicate each Provider's Board certification or eligibility. *Use additional sheets as necessary.* Each physician and participating provider must individually complete all credentialing requirements to accompany this Agreement.

Practice / Group Name: \_\_\_\_\_

Tax ID #: \_\_\_\_\_

Tax ID # (if different): \_\_\_\_\_

Office 1 Address: \_\_\_\_\_

Office 2 Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone 2: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax 2: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

**Participating Providers Associated With This Contract:**

1. \_\_\_\_\_

6. \_\_\_\_\_

2. \_\_\_\_\_

7. \_\_\_\_\_

3. \_\_\_\_\_

8. \_\_\_\_\_

4. \_\_\_\_\_

9. \_\_\_\_\_

5. \_\_\_\_\_

10. \_\_\_\_\_

SCHEDULE C

**INFORMATION RELEASE / ACKNOWLEDGEMENTS**

**Please Complete for Each Participating Provider**

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, "**Healthcare Organizations**," ) for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, *California Business and Professions Code Section 809 et seq.*, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided. I understand that I will be notified of and have the right to review any information obtained from outside verification sources by the Healthcare Organization. I understand that I shall be afforded the opportunity to correct any information that is erroneous. I also have a right to request the status of my application.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the un-stayed suspension, revocation or non-renewal of my license to practice medicine (ii) any suspension, revocation or non-renewal of my DEA or other controlled substances registration; or (iii) any cancellation or non-renewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the State Medical Board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original; however, original signatures are required.

Print Name Here: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PROVIDER DATA FORM  
FOR CREDENTIALING PURPOSES**  
Please Complete for Each Participating Provider



To begin your credentialing process, use this simple, standardized form. Please note that the top portion of this form is required information. Each participating provider must complete a separate form. Please print legibly.

DATE:			
Last Name:	First Name:	Middle Initial:	
Date of Birth:	Primary Telephone No.:		
Primary Office Street Address:			Suite #:
Primary Office City:	State:	County:	Zip:
Provider Type (MD, DO, DC, DDS, DMD, DPM, etc) :			
Specialty:	Applying As: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Allied Health Professional		
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, board name:		
Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, CAQH Provider ID:		

If you are not registered with CAQH, please provide the following additional information, which is necessary to register you with the CAQH Universal Credentialing DataSource.

Primary Fax No.:	Email Address:
Social Security No.:	DEA Certificate No.:
State License No.:	Licensed State:
UPIN:	Tax ID:

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with any of the above organizations. If applicable, please contact the health plan directly to request contracting information.

**SCHEDULE D**  
**COMPLIANCE REGULATION**

The following addenda are incorporated into this Agreement hereto and are effective as of the date indicated.

Addendum D-1- Medicare Advantage First Tier- Downstream Provider Contract Addendum

Addendum D-2 – Cal Mediconnect Program Requirements



## ADDENDUM D-1

### MEDICARE ADVANTAGE FIRST TIER ENTITY-DOWNSTREAM PROVIDER CONTRACT ADDENDUM

This Medicare Advantage First Tier Entity-Downstream Provider Contract Addendum (“Addendum”) is by and between EHS (“First Tier Entity”) and Provider (“Downstream Provider”), and is intended to add contract language required by the Centers for Medicare and Medicaid Services, (“CMS”) for participation in the Medicare Advantage (“MA”) program.

Whereas, CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization and all providers, including Downstream Providers, to comply with the Medicare laws, regulations, and CMS instructions, including but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003. (Pub.L.108-73) (“MMA”); and

Whereas, Downstream Provider desires to provide services to Medicare beneficiaries who enroll in the Medicare Advantage program; and

Whereas, First Tier Entity desires that Downstream Provider provide services to Medicare beneficiaries who enroll in the Medicare Advantage program; and

Whereas, Downstream Provider and First Tier Entity agree to comply with the terms and conditions specified by CMS in the form of this Addendum to the Agreement between Downstream Provider and First Tier Entity.

NOW, THEREFORE, the parties agree as follows:

#### DEFINITIONS

Agreement (including all in-force amendments and addenda) means the agreement between the First Tier Entity and Downstream Provider that specifies the contractual relationship between the First Tier Entity and Downstream Provider for the provision of services to Enrollees.

Downstream Provider means an entity or individual that is contracted by a First Tier Entity to provide services to Enrollees. A Downstream Provider may be, but is not limited to, physicians, ancillary providers, and other health care providers.

First Tier Entity means the entity that contracts with a Medicare Advantage Organization, (MAO) to provide services to Enrollees. A First Tier Entity may be, but is not limited to, medical groups, individual practice associations (“IPAs”), and hospitals.

Centers for Medicare and Medicaid Services (“CMS”) means the agency within the Department of Health and Human Services that administers the Medicare program.

Completion of Audit means completion of audit by the Department of Health and Human Services, the General Accounting Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

Final Contract Period means final contract period between CMS and the Medicare Advantage Organization with whom the First Tier Entity has entered into an Agreement.

Medicare Advantage Organization (“MAO”) means a health plan that has entered into a contract with CMS to provide services to Medicare beneficiaries under the Medicare Advantage program.

Medicare Advantage (“MA”) is an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Member means an individual who has enrolled in or elected coverage through a Medicare Advantage Organization. A Member is also known as an Enrollee.

## REQUIRED PROVISIONS

Downstream Provider and First Tier Entity agree to the following:

1. Downstream Provider agrees to retain and to grant the Department of Health and Human Services (HHS), the Comptroller General or their designees the right to inspect, evaluate, and audit any pertinent information, including books, contracts, medical records, patient care documentation, and records of subcontractors or related entities for a period of (10) years from the end of the Final Contract Period or Completion of Audit, whichever is later, for Members enrolled in a Medicare Advantage Organization.. This increase in the duration of the record retention period applies to all new records as well as to all records required to be retained under any prior addendum as of the date first written above. [42 CFR 422.504 (e) (4)].
2. Downstream Provider agrees to abide by all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, safeguard the privacy of the beneficiary’s information, and maintain records and information in an accurate and timely manner. [42 CFRs 422.118 and 422.504 (a)(13)].
3. Downstream Provider agrees it may not under any circumstances, including nonpayment of moneys due the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. Members who are dually eligible for Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member’s contract with the Health Plan, or charges for services not covered under the Member’s contract, may be excluded from this provision. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii)).
4. Downstream Provider agrees that its performance or other activity are consistent and comply with the First Tier Entity’s contractual obligations with the Medicare Advantage Organization, which includes the First Tier Entity’s agreement that its performance or other activity are consistent and comply with the Medicare Advantage Organization’s contractual obligations with CMS. [42 CFRs 422.504(i) (3) (iii) and 422.504(i) (4)].
5. First Tier Entity agrees to pay Downstream Provider promptly as agreed to in the Agreement between First Tier Entity and Downstream Provider or, if not specified otherwise, within sixty (60) calendar days. [42 CFR 422.520(b)].
6. Downstream Provider agrees to comply with CMS reporting requirements as specified in Sec 422.310 (risk adjustment data) and Sec 422.516 (informational data). [42 CFR 422.504(a) (8)].
7. Downstream Provider agrees to comply with all Medicare laws, regulations, and CMS instructions, including but not limited to, all CMS accountability provisions, which may be more fully documented in the Medicare Advantage Organization’s policies and procedures. [42 CFRs 422.504(i)(3)(ii) and 422.504(i)(4)(v)].

8. Should First Tier Entity delegate selection of providers to the Downstream Provider, and Medicare Advantage Organization and First Tier Entity retain the right to approve, suspend, or terminate such arrangement, as agreed to in the Agreement, Provider must comply with applicable delegation requirements between Medicare Advantage and First Tier Entity. [42 CFR 422.504(i)(5)].
9. If applicable, First Tier Entity specifies the Downstream Provider's delegated activities and reporting responsibilities, as agreed to in the Agreement. [42 CFRs 422.504(i)(3)(ii); 422.504(i)(4)(i)].
10. If applicable, CMS, Medicare Advantage Organization, and First Tier Entity reserve the right to revoke the delegated activities and reporting requirements in instances when CMS, Medicare Advantage Organization, or First Tier Entity determines that Downstream Provider has not performed satisfactorily, as agreed to in the Agreement. [42 CFRs 422.504(i)(3)(ii); 422.504(i)(4)(ii)].
11. If applicable, Medicare Advantage Organization, or First Tier Entity if Medicare Advantage Organization has delegated this function to First Tier Entity, will monitor the performance of the Downstream Provider on an ongoing basis, as agreed to in the Agreement. [42 CFRs 422.504(i)(3)(ii); 422.504(i)(4)(iii)].
12. If applicable, Medicare Advantage Organization, or First Tier Entity if Medicare Advantage Organization has delegated this function to First Tier Entity, will review and approve the Downstream Provider's credentialing process and will audit the Downstream Provider's credentialing process on an ongoing basis, as agreed to in the Agreement. [42 CFRs 422.504(i)(3)(ii); 422.504(i)(4)(iv)].
13. Downstream Provider agrees that cost sharing for dual eligible Members is limited to the Medicaid (including Medi-Cal) cost sharing limits; and that for those dual-eligible Members the Downstream Provider will accept the Medicare Advantage Organization or First Tier Entity payment as payment-in-full or will separately bill the appropriate state source for any amounts above the Medicaid (or Medi-Cal) cost sharing.

Except as provided in this Addendum, all other provisions of the Agreement between First Tier Entity and Downstream Provider not inconsistent herein shall remain in full force and effect. This Addendum shall remain in force as a separate but integral addition to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

**ADDENDUM D-2**  
**CAL MEDICCONNECT PROGRAM REQUIREMENTS**

This Cal MediConnect First Tier Entity-Downstream Provider Contract Addendum (“Addendum”) is by and between EHS (“FIRST TIER ENTITY”) and PROVIDER (“DOWNSTREAM PROVIDER”), and is intended to add contract language required by the Centers for Medicare and Medicaid Services, (“CMS”) Department of Health Care Services (DHCS) among other various federal and state agencies, for participation in the Cal MediConnect Program.

Whereas, DOWNSTREAM PROVIDER desires to provide services to Cal MediConnect beneficiaries who enroll in the Cal MediConnect programs; and

Whereas, FIRST TIER ENTITY desires that DOWNSTREAM PROVIDER provide services to Cal MediConnect beneficiaries who enroll in the Cal MediConnect program; and

Whereas, DOWNSTREAM PROVIDER and FIRST TIER ENTITY agree to comply with the terms and conditions specified by CMS, DHCS and other state and federal agencies in the form of this Addendum to the Agreement between DOWNSTREAM PROVIDER and FIRST TIER ENTITY.

NOW, THEREFORE, the parties agree as follows:

DOWNSTREAM PROVIDER shall comply, and shall cause its Affiliated Providers and Downstream Entities and subcontractors to comply, with the following requirements for the provision of Health Services to FIRST TIER ENTITY’s Cal MediConnect Members and for the provision of Delegated Activities in connection with FIRST TIER ENTITY’s Cal MediConnect Program, in addition to all other applicable provisions in the Agreement.

1. **DOWNSTREAM PROVIDER Obligations.**

- 1.1. **Maintenance of Records and Audits.** DOWNSTREAM PROVIDER shall maintain (and shall cause Downstream Entities to maintain) such operational, financial, administrative, or medical records, contracts, books, files, and other documentation as legally or reasonably required to be maintained in connection with services performed under the Agreement, including with respect to Health Services furnished and Delegated Activities performed. At a minimum, such records shall be sufficient to allow FIRST TIER ENTITY and or Healthplan to determine whether DOWNSTREAM PROVIDER and its Downstream Entities are performing their obligations under the Agreement consistent with the terms of the Agreement and in accordance with Applicable Requirements and to confirm that the data submitted by DOWNSTREAM PROVIDER for reporting and other purposes is accurate.

DOWNSTREAM PROVIDER shall give (and shall cause Downstream Entities to give) DHCS, CMS, HHS, the Comptroller General, and Healthplan or their designees the right to access, audit, evaluate, and inspect any books, contracts, computer or electronic systems, and records, including medical records, patient care documentation, Encounter Data, and other records of the DOWNSTREAM PROVIDER or any Downstream Entity or its transferee that pertain to any aspect of the Agreement, including without limitation: Delegated Activities performed, Health Services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Agreement, or that the Secretary of HHS may deem necessary to enforce its contract with Healthplan.

DOWNSTREAM PROVIDER agrees to permit (and shall cause Downstream Entities to permit) DHCS, DMHC, CMS, HHS, the Comptroller General, and Healthplan or their designees to conduct on-site evaluations of DOWNSTREAM PROVIDER and Downstream Entity personnel, physical premises, facilities, and equipment to assess and audit DOWNSTREAM PROVIDER’s performance under the Agreement and with Applicable Requirements and to comply with the agencies’ recommendations based on such onsite evaluation, if any.

DOWNSTREAM PROVIDER shall immediately notify FIRST TIER ENTITY of receipt of any non-routine request from DHCS, CMS, HHS, the Comptroller General, or their designees for records or other information relating to DOWNSTREAM PROVIDER or a Downstream Entity's services under the Agreement and/or for access to DOWNSTREAM PROVIDER or Downstream Entity personnel, physical premises, facilities, and/or equipment. DOWNSTREAM PROVIDER shall notify FIRST TIER ENTITY of the date and time of any scheduled onsite evaluation and allow FIRST TIER ENTITY's participation in connection with the same.

The terms of this Section 1.1 ("Maintenance of Records and Audits") shall remain in effect for a period of the longer of (i) ten (10) years following the termination of the agreement between DHCS, CMS, and Healthplan; or (ii) completion of an audit; or (iii) such other time period as required by law or regulation, including for the reasons specified in 42 C.F.R. 422.504(e)(4).

- 1.2. Confidentiality of Medical Records and Enrollment Information. DOWNSTREAM PROVIDER shall comply (and shall cause its Downstream Entities to comply) with all Applicable Requirements regarding health care privacy and security, including without limitation the confidentiality and security provisions stated in the regulations at 42 CFR 422.118, 422.504(a)(13), and 423.136, as amended, for any medical records or other health and enrollment information DOWNSTREAM PROVIDER or its Downstream Entities maintain with respect to FIRST TIER ENTITY's Cal MediConnect Program Members. Additionally, with respect to such Members, DOWNSTREAM PROVIDER and Downstream Entities must establish procedures that are consistent with FIRST TIER ENTITY and or Plan's Cal MediConnect Program policies and procedures and DOWNSTREAM PROVIDER Manual to do the following:
- a. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. DOWNSTREAM PROVIDER must safeguard the privacy of any information that identifies a particular Member and have procedures that specify:
    - i. For what purposes the information will be used within the organization; and
    - ii. To whom and for what purposes it will disclose the information outside the organization.

- b. Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas consistent with law. DOWNSTREAM PROVIDER must:
  - i. Maintain the records and information in an accurate and timely manner.
  - ii. Ensure timely access by Members to the records and information that pertain to them.

This Section 1.2 (“Confidentiality of Medical Records and Enrollment Information”) shall survive termination of the Agreement, regardless of the cause giving rise to termination. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.

- 1.3. Subcontracting. DOWNSTREAM PROVIDER agrees that it will not contract with any person or entity to furnish functions, activities or services (including DOWNSTREAM PROVIDER Services) under the Agreement unless (i) such entity is specifically obligated, through a written agreement executed between such entity and DOWNSTREAM PROVIDER (or such entity and a Downstream Entity), to comply with all of the provisions contained herein, and (ii) such written agreement specifically permits FIRST TIER ENTITY to approve, suspend, or terminate the agreement. DOWNSTREAM PROVIDER agrees to promptly provide FIRST TIER ENTITY with a copy of any such written agreement, upon request.
- 1.4. Member Non-Liability. DOWNSTREAM PROVIDER agrees to and shall ensure that all Downstream Entity Subcontracts contain language to hold harmless and protect FIRST TIER ENTITY’s Cal MediConnect Program Members from incurring financial liabilities that are the legal obligation of the FIRST TIER ENTITY or DOWNSTREAM PROVIDER. In no event, including but not limited to, nonpayment or breach of an agreement by the FIRST TIER ENTITY, DOWNSTREAM PROVIDER, or other intermediary, or the insolvency of FIRST TIER ENTITY, DOWNSTREAM PROVIDER, or other intermediary, shall DOWNSTREAM PROVIDER bill, charge, collect a deposit from, or receive other compensation or remuneration from a Member. DOWNSTREAM PROVIDER or Downstream Entity shall not take any recourse against the Member, or a person acting on behalf of the Member, for services provided. This provision does not prohibit collection of applicable coinsurance, deductibles, or co-payments, as specified in the Plan’s Cal MediConnect Program Evidence of Coverage. This provision also does not prohibit collection of fees for non-covered services, provided the Member was informed in advance of the cost and elected to have non-covered services rendered.

DOWNSTREAM PROVIDER also agrees to and shall ensure that all Downstream Entity Subcontracts contain language specifically stating that Healthplan's Cal MediConnect Members will not be held liable for Medicare Part A and B cost sharing. Specifically, Health Services for Medicare Parts A and B must be provided at zero cost to FIRST TIER ENTITY's Cal MediConnect Members.

DOWNSTREAM PROVIDER further agrees that (i) this Section 1.4 shall survive the termination of the Agreement, regardless of the cause giving rise to termination and shall be construed for the benefit of FIRST TIER ENTITY's Cal MediConnect Members, and (ii) this Section 1.4 supersedes any oral or written contrary agreement now existing or hereafter entered into between DOWNSTREAM PROVIDER or Downstream Entity and Member or a person acting on a Member's behalf.

1.5. Compliance by DOWNSTREAM PROVIDER. DOWNSTREAM PROVIDER shall comply (and shall cause its Downstream Entities to comply) with all Applicable Requirements, including without limitation with all applicable Federal and State laws, regulations, including but not limited to (as applicable) 42 C.F.R. Sections 423.504, 423.505, and 438.6(l), and CMS and DHCS instructions.

All functions, services or other activities performed by DOWNSTREAM PROVIDER and Downstream Entities under the Agreement with respect to FIRST TIER ENTITY's Cal MediConnect Program shall be consistent with, and comply with, Plan's contractual obligations to CMS and DHCS. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.

1.6. Exclusion Screening and Related Requirements. DOWNSTREAM PROVIDER hereby represents and warrants that neither it nor any of its Downstream Entities, nor any of their respective employees, contractors, or agents is excluded under the HHS Office of Inspector General's List of Excluded Individuals/Entities (the "OIG List"), or is otherwise excluded from participation in any Federal health care program (as such term is defined in 42 U.S.C. 1320a, 7, b, (f) ("Federal Health Care Program"), or debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency.

DOWNSTREAM PROVIDER shall not employ or contract with, and shall ensure that its Downstream Entities do not employ or contract with, individuals or entities that are excluded under the OIG list or otherwise excluded from participation in Medi-Cal, Medicare or other Federal or State Health Care Programs, or are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency ("Excluded Individuals").

- a. DOWNSTREAM PROVIDER shall, and shall cause its Downstream Entities to:

Review the OIG List and the U.S. General Services Administration's Parties List System prior to the initial hiring of any employee or the engagement of any contractor to furnish services to FIRST TIER ENTITY under the Agreement, and monthly thereafter, to ensure compliance with this Section 1.6 ("Exclusion Screening and Related Requirements").

- i. Immediately notify FIRST TIER ENTITY upon discovering that it, or any of its employees or contractors, has furnished services to FIRST TIER ENTITY under the Agreement as or through an Excluded Individual; and
  - ii. Immediately remove such Excluded Individual from any work related, directly or indirectly, to services furnished under the Agreement and take appropriate corrective action.
  - iii. If DOWNSTREAM PROVIDER or a Downstream Entity fails to comply with the requirements of this Section 1.6, Healthplan reserves the right to require DOWNSTREAM PROVIDER to:

Make repayment associated with use of the Excluded Individual, pay FIRST TIER ENTITY and or Plan immediately for any sanctions that may be imposed on Healthplan by the HHS OIG or CMS or DHCS for violation of this provision, and consider such non-compliance as a material breach.
- b. DOWNSTREAM PROVIDER agrees that FIRST TIER ENTITY shall not be obligated to make payment under the Agreement to the extent any such payment is prohibited by law, including where Health Services are provided to Healthplan's Cal MediConnect Members, in whole or in part, by an Excluded Individual.

1.7. Benefit Continuation. DOWNSTREAM PROVIDER agrees, and will require its Downstream Entities to agree, to provide for the continuation of FIRST TIER ENTITY's Cal MediConnect Member health care benefits, for all such Members, for the duration of the contract period for which CMS and or Plan payments have been made, and for such Members who are hospitalized on the date FIRST TIER ENTITY's and or Plan's contract with CMS terminates, or in the event of an insolvency of FIRST TIER ENTITY and or Plan, through the date of the Member's discharge.

1.8. Reporting and Disclosure; Submission of Encounter and Other Data. As applicable, DOWNSTREAM PROVIDER shall comply, and will require Downstream Entities to comply with Applicable Requirements for submitting Encounter Data with respect to DOWNSTREAM PROVIDER's participation in FIRST TIER ENTITY's Cal MediConnect Program.



As applicable, DOWNSTREAM PROVIDER shall submit (and cause relevant Downstream Entities to submit) Encounter Data, medical records, and such other information and data as may be reasonably requested by FIRST TIER ENTITY and or Healthplan, including, without limitation and as applicable, as may be requested in connection with FIRST TIER ENTITY and or Healthplan's reporting and other obligations under 42 CFR 422.516 and Healthplan's Utilization Review/Quality Improvement programs or to respond to CMS and DHCS requests for information and/or surveys. Such information shall be submitted by DOWNSTREAM PROVIDER and its Downstream Entities in compliance with Applicable Requirements.

DOWNSTREAM PROVIDER shall certify, and cause its Downstream Entities to certify, that any data and other information submitted to FIRST TIER ENTITY and or Healthplan are complete, truthful, and accurate based on best knowledge, information and belief.

DOWNSTREAM PROVIDER shall cooperate and assist with, FIRST TIER ENTITY's and or Healthplan's requests for information and shall promptly submit Encounter Data, medical records, and such other information as requested by FIRST TIER ENTITY and or Healthplan to allow FIRST TIER ENTITY and or Healthplan to respond in a timely manner to any data validation audits or requests for information by CMS and DHCS, and to monitor and audit the obligation of DOWNSTREAM PROVIDER to provide reliable, complete, truthful, and accurate data and other information in accordance with Applicable Requirements.

This Section 1.8 ("Reporting and Disclosure; Submission of Encounter and Other Data") shall survive termination of the Agreement, regardless of the cause giving rise to termination.

- 1.9. Grievance and Appeals. DOWNSTREAM PROVIDER shall cooperate, and will require its Downstream Entities, as applicable, to cooperate with FIRST TIER ENTITY 's and or Healthplan's grievance and appeals procedures, and shall comply with CMS and DHCS requirements as applicable for processing grievances and appeals with respect to DOWNSTREAM PROVIDER's participation in FIRST TIER ENTITY's Healthplan's Cal MediConnect Program.
- 1.10. Marketing Requirements. DOWNSTREAM PROVIDER shall not engage (and shall cause its Downstream Entities not to engage) in marketing of FIRST TIER ENTITY's and or Healthplan's Cal MediConnect Program, except in the manner and to the extent expressly requested by FIRST TIER ENTITY and or Healthplan. If DOWNSTREAM PROVIDER or a Downstream Entity is asked to assist FIRST TIER ENTITY and or Healthplan with marketing of FIRST TIER ENTITY 's and or Healthplan's Cal MediConnect Program, DOWNSTREAM PROVIDER shall, and will require its Downstream Entities to, comply with all Applicable Requirements, including without limitation, applicable statutes and regulations as well as CMS and DHCS marketing requirements.
- 1.11. Delegation of Responsibilities. If DOWNSTREAM PROVIDER is delegated any activities or responsibilities under FIRST TIER ENTITY's contract with the plan and or Healthplan's contracts with CMS or DHCS, including for the provision of Health Services for Cal MediConnect Members, then the following shall apply to DOWNSTREAM PROVIDER's participation in FIRST TIER ENTITY's and or Healthplan's Cal MediConnect Program:

DOWNSTREAM PROVIDER shall comply with delegated activities and reporting requirements as specified in any Exhibit, including as specified in FIRST TIER ENTITY'S NCQA/Medi-Cal/Medicare Delegated Activities Grid and NCQA/Medi-Cal/Medicare Reporting Requirements.

- a. DOWNSTREAM PROVIDER understands and agrees that FIRST TIER ENTITY and or Healthplan has the right to revoke delegated activities and/or reporting requirements or institute other remedies in any instance where CMS, DHCS, or FIRST TIER ENTITY and or Healthplan determine that DOWNSTREAM PROVIDER or a Downstream Entity has not satisfactorily performed any delegated activity or reporting requirement. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.
- b. DOWNSTREAM PROVIDER understands and agrees that FIRST TIER ENTITY and or Healthplan shall monitor DOWNSTREAM PROVIDER and Downstream Entity performance of delegated activities and reporting requirements on an ongoing basis, including for the purposes of identifying potential fraud, waste, and abuse, and that FIRST TIER ENTITY and or Healthplan shall be authorized in contracts between DOWNSTREAM PROVIDER and its Downstream Entities (and between Downstream Entities and their contractors) to engage in such monitoring and may impose corrective action as necessary. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.
- c. If DOWNSTREAM PROVIDER is delegated the credentialing process, DOWNSTREAM PROVIDER understands and agrees that FIRST TIER ENTITY and or Healthplan shall review and approve DOWNSTREAM PROVIDER's credentialing process and will audit DOWNSTREAM PROVIDER's credentialing process on an ongoing basis. If DOWNSTREAM PROVIDER is not delegated the credentialing process, FIRST TIER ENTITY will review the credentials of DOWNSTREAM PROVIDERs Affiliated DOWNSTREAM PROVIDERs. DOWNSTREAM PROVIDER understands and agrees that it is a condition of payment that services be provided by an appropriately licensed individual, as required by law, and that claims should not be made for Health Services furnished to FIRST TIER ENTITY's Cal MediConnect Members by individuals not so licensed. DOWNSTREAM PROVIDER further understands and agrees that any payments made in connection with claims submitted for such services shall be considered overpayments under the Agreement. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.

- d. DOWNSTREAM PROVIDER shall process claims for the DOWNSTREAM PROVIDER Services furnished to FIRST TIER ENTITY's Cal MediConnect Members for which DOWNSTREAM PROVIDER is financially responsible. DOWNSTREAM PROVIDER shall process such claims pursuant to the prompt payment requirements set forth below:

With respect to claims for Health Services submitted by non-contracting and contracting DOWNSTREAM PROVIDERS, DOWNSTREAM PROVIDER is required to pay 95% of "Clean Claims" as defined in 42 C.F.R. 422.500 within thirty (30) calendar days of receipt. Interest will be paid on all clean claims submitted by non-contracting DOWNSTREAM PROVIDERS that are not paid within thirty (30) calendar days of receipt. All other claims from non-contracted and contracted DOWNSTREAM PROVIDERS must be paid or denied within sixty (60) calendar days from the date of receipt.

- e. Where claims for Health Services are submitted by a contract DOWNSTREAM PROVIDER, DOWNSTREAM PROVIDER shall process and pay such claims in accordance with the terms set forth in this Exhibit and the Agreement for claims processing.

This provision shall only apply to DOWNSTREAM PROVIDER's participation in FIRST TIER ENTITY's Cal MediConnect Program.

- 1.12. Compliance Program and Anti-Fraud Initiatives. DOWNSTREAM PROVIDER shall (and shall cause its Downstream Entities to):

- a. Institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with Applicable Requirements and the incidence of fraud, waste, and abuse relating to the operation of FIRST TIER ENTITY's Cal MediConnect Program in compliance with 42 C.F.R. 422.503(b)(4)(vi).

For all officers, directors, employees, contractors, and agents of DOWNSTREAM PROVIDER or Downstream Entity, require participation in (a) effective compliance and anti-fraud training and education that is consistent with guidance that CMS and DHCS have or may issue with respect to compliance and anti-fraud and abuse initiatives and (b) such education and training shall be a part of orientation and shall occur at least annually thereafter for all officers, directors, employees, contractors, and agents of DOWNSTREAM PROVIDER and Downstream Entities. Upon DOWNSTREAM PROVIDER's request, FIRST TIER ENTITY and or Healthplan shall make its Fraud, Waste, and Abuse training available to DOWNSTREAM PROVIDER for its use in complying with this Section.

In addition, DOWNSTREAM PROVIDER and Downstream Entities shall furnish, upon request, supporting documentation that evidences compliance with the training requirement, including without limitation, copies of the relevant training materials and attendee sign-in sheets or other verification of completion of training.

- 1.13. Reporting Potential Fraud, Waste, or Abuse or Non-Compliance. DOWNSTREAM PROVIDER shall promptly report to FIRST TIER ENTITY any instances where DOWNSTREAM PROVIDER, after reasonable and timely inquiry, suspects (i) potential fraud, waste, and abuse or non-compliance with Applicable Requirements by DOWNSTREAM PROVIDER, a Downstream Entity, or others, including Members, or (ii) overpayments by CMS.
- 1.14. Federal Funds. DOWNSTREAM PROVIDER acknowledges that payments for Health Services provided under the Agreement are, in whole or in part, from federal funds.
- 1.15. Cultural and Linguistic Requirements. DOWNSTREAM PROVIDER shall provide all Health Services while in compliance with Section 1.25 of this Agreement “Cultural and Linguistic Information.” DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain a provision addressing cultural competency, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. DOWNSTREAM PROVIDER and all Downstream Entity Subcontractors shall provide interpreter services for all Members at all DOWNSTREAM PROVIDER sites
- 1.16. EMTALA Obligations. DOWNSTREAM PROVIDER agrees that medical DOWNSTREAM PROVIDER EMTALA obligations must be clearly stated and must not create any conflicts with EMTALA required hospital actions. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.
- 1.17. No Enrollment Limitation. DOWNSTREAM PROVIDER agrees that DOWNSTREAM PROVIDERS, including, but not limited to PCPs, are prohibited from closing or otherwise limiting their acceptance of Members as patients unless the same limitations apply to all commercially insured members.
- 1.18. Refusal to Contract or Pay. DOWNSTREAM PROVIDER agrees that there will be no refusal to contract or pay an otherwise eligible health care DOWNSTREAM PROVIDER for the provision of Health Services solely because such DOWNSTREAM PROVIDER has in good faith:
  - a. Communicated with or advocated on behalf of one or more of his/her prospective, current, or former patients regarding the provisions, terms, or requirements of FIRST TIER ENTITY’s and or Healthplan’s Cal MediConnect Program as they relate to the needs of such DOWNSTREAM PROVIDER’s patients; or
  - b. Communicated with one or more of his/her prospective, current, or former patients with respect to the method by which such DOWNSTREAM PROVIDER is compensated by FIRST TIER ENTITY and or Healthplan for Health Services provided to the patient.

DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.

- 1.19. Indemnification. DOWNSTREAM PROVIDER agrees that DOWNSTREAM PROVIDER is not required to indemnify FIRST TIER ENTITY and or Healthplan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges incurred in connection with any claim or action brought against FIRST TIER ENTITY and or Healthplan based on Healthplan's management decisions, utilization review provisions, or other policies, guidelines, or actions. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.
- 1.20. Downstream Subcontracts. DOWNSTREAM PROVIDER shall comply with and ensure that all Downstream Entity Subcontracts contain the following language:
- a. The term of the subcontract, including the beginning and ending dates as well as the methods of extension, renegotiation, and termination;
  - b. Full disclosure of the method and amount of compensation or other consideration to be received from Healthplan;
  - c. DOWNSTREAM PROVIDER or Downstream Entity shall gather, preserve, and provide to FIRST TIER ENTITY and or Healthplan in a timely manner, any records in DOWNSTREAM PROVIDER's or Downstream Entity's possession;
  - d. Language that requires DOWNSTREAM PROVIDER or Downstream Entity to assist DOWNSTREAM PROVIDER in the transfer of care in the event of sub-subcontract termination for any reason;
  - e. DOWNSTREAM PROVIDER shall notify DHCS in the event that the agreement with the Healthplan in this Amendment is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached;
  - f. Assignment or delegation of the provision of Services under this Amendment is null and void unless prior written approval is obtained from FIRST TIER ENTITY;
- 1.21. Transfer of Care. DOWNSTREAM PROVIDER shall assist FIRST TIER ENTITY and or Healthplan in the transfer of care as set forth in the 3-Way Contract and FIRST TIER ENTITY and or Healthplan's policies and procedures. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.

2. FIRST TIER ENTITY Obligations.

2.1. FIRST TIER ENTITY Responsibility. Notwithstanding any relationship(s) that the FIRST TIER ENTITY may have with related entities, DOWNSTREAM PROVIDER, or Affiliated DOWNSTREAM PROVIDERS, the Healthplan is ultimately responsible for adhering to and otherwise fully complying with all terms and conditions of the Healthplan's contract with CMS. Any services or other activities performed by DOWNSTREAM PROVIDER or Downstream Entities under the Agreement shall be consistent, and comply, with FIRST TIER ENTITY's contractual obligations to Plan and Healthplan's contractual obligations to CMS.

2.2. Prompt Payment. FIRST TIER ENTITY shall pay DOWNSTREAM PROVIDER under the payment terms of this Agreement.

With respect to claims for Health Services submitted by non-contracting and contracting DOWNSTREAM PROVIDERS, DOWNSTREAM PROVIDER is required to pay 95% of "Clean Claims" as defined in 42 C.F.R. 422.500 within thirty (30) calendar days of receipt. Interest will be paid on all clean claims submitted by non-contracting DOWNSTREAM PROVIDERS that are not paid within thirty (30) calendar days of receipt. All other claims from non-contracted and contracted DOWNSTREAM PROVIDERS must be paid or denied within sixty (60) calendar days from the date of receipt.

DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain a prompt payment provision.

2.3. Termination of CMS Contract. In the event that Healthplan's contract with CMS is terminated or not renewed and or FIRST TIER ENTITY's contract with Plan is terminated or not renewed, the provisions of this Exhibit shall automatically terminate subject to any provisions that expressly survive termination. Notwithstanding the foregoing, termination, or expiration of this Agreement shall not terminate any provision of this Agreement that by its terms is to survive or be performed following termination or expiration, unless otherwise expressly agreed in writing by the Parties.

2.4. Termination of this Agreement with DOWNSTREAM PROVIDER. In the event that this Agreement is terminated between DOWNSTREAM PROVIDER and FIRST TIER ENTITY, such termination shall be according to Section 5 "Termination of Agreement," including but not limited to Section 5.2.1, providing for identification of reasons for For Cause termination. DOWNSTREAM PROVIDER shall ensure that all Downstream Entity Subcontracts contain this provision.

2.5. Amendment. Any change, including any addition and/or deletion, to any provision(s) of this Exhibit that is required by law, regulation, or CMS direction or program instruction shall be deemed to be part of this Exhibit effective immediately without further action required to be taken by either Party to amend the Agreement with such change(s) effective for as long as such law, regulation, or CMS direction or program instruction is in effect and applicable to the operation and enforcement of the Agreement.

For the Cal MediConnect Program, the provisions in this Exhibit shall supersede any inconsistent provisions in the Agreement. This Amendment shall remain in force as a separate but integral addition to the Agreement to ensure compliance with required CMS and Medicare provisions, and shall continue concurrently with the term of the Agreement or the termination of the Healthplan's contract with CMS and or FIRST TIER ENTITY's contract with Plan is terminated or not renewed, whichever occurs first, unless otherwise specified.

In the event any provision of this Exhibit conflicts with the provisions of any applicable statute or regulation, the provisions of the statute or regulations shall have full force and effect.