SUBSTANCE USE SERVICES AGREEMENT

Between

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

And

SUBSTANCE USE TREATMENT PROVIDER

This Substance Use Services Agreement (the "**Agreement**") is entered into this day of October 15, 2019, by Partnership HealthPlan of California, a public entity ("**PARTNERSHIP**") and between County of Humboldt hereinafter shall be referred to as ("**SUBSTANCE USE TREATMENT PROVIDER" OR "PROVIDER**"), a Drug-Medi-Cal provider licensed and/ or certified in the State of California, as applicable, and is eligible to participate in and meets certification standards of the Drug Medi-Cal Program to provide covered Drug Medi-Cal (DMC) services for Substance Use Disorder/Alcohol and Other Drugs Services (SUD-AODS) and that meets applicable requirements pursuant to Sections 96.126, 96.127, 96.128, 96.131 and 96.132, and all references therefrom, of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reauthorization Act, Public Law 106-310, the State of California Alcohol and/or Other Drug Program Certification Standards (2017 version), Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8; Drug Medi-Cal Certification Standards for Substance Abuse Clinics; Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1; Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq. and any and all guidelines promulgated by the State Department of Health Care Services' (DHCS) Alcohol and Drug Programs and that is provided in a manner in accordance with the standards and obligations of PROVIDER's profession.

Any inconsistency between the terms of this Agreement and the Department of Health Care Services Intergovermental Agreement (IGA), the Memorandum of Understanding (MOU) between PARTNERSHIP and the COUNTY the terms of the IGA and/or MOU will govern and control as it relates to program integrity requirements of the Drug Medi-Cal Program.

IN WITNESS WHEREOF, the subsequent Agreement between PARTNERSHIP and Substance Use Treatment Provider is entered into by and between the undersigned parties.

PROVIDER

County of Humboldt
(List Health Care Services Provider Name Above)

Signature: Estelle Fennell

Printed Name: Estelle Fennell

Title: Chair Board of Supervisors

Date: 2/14/2020

PLAN

Partnership HealthPlan of California

Signature: _____

Printed Name: _____

Title: _____

Date: _____

PROVIDER Address for Notices:

_____

_____

_____

Attn: _____

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
SUBSTANCE USE SERVICES AGREEMENT

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RECITALS

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

B. WHEREAS, PARTNERSHIP will arrange for substance use services for Medi-Cal Members as identified by the Department of Health Care Services Intergovernmental Agreement and those the Memorandum of Understanding (MOU) between the County and PARTNERSHIP;

C. WHEREAS, PARTNERSHIP and the County(ies) as approved by DHCS, have entered into that certain MOU whereby the County(ies) has delegated to PARTNERSHIP the responsibility to administer, arrange for and provide covered substance use Treatment services to an eligible Member whose place of residence is deemed to be within one of the counties covered through the DHCS Intergovermental Agreement;

WHEREAS, PARTNERSHIP through contracts wth Substance Use Treatment providers and other providers of health care services shall maintain a network of Substance Use Treatment providers that will be available to PARTNERSHIP members. The substance use provider set forth on the signature page of this Agreement agrees to provide covered services to PARTNERSHIP members;

D. WHEREAS, PROVIDER will participate in providing Covered Services set forth in this Agreement to Medi-Cal Members and will be reimbursed by PARTNERSHIP for the rendering of those Covered Services; and now:

E. WHEREAS, PROVIDER agrees to provide substance use treatment services for such Medi-Cal Members referred to them for services.

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

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms will have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended. Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Section. ***PROVIDER agrees that the Definitions set forth in Exhibit 1 of this Agreement shall specifically apply to the Drug Medi-Cal Substance Use Treatment (DMC- ODS) program.***

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

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

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

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

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

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

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

1.8 Covered Services – Drug Medi-Cal Covered Services as defined in the ASAM criteria will include mandatory Covered Services Case Management, Intensive outpatient, opoid treatment programs; outpatient; physician consultations; recovery services; and withdrawal management; perinatal residential substance abuse services; nonperinatal residential treatment services and as further described below.

Require that the medically necessary services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.
iii. Specify the extent to which the Contractor is responsible for covering medically necessary services related to the following:
a. The prevention, diagnosis, and treatment of health impairments;
b. The ability to achieve age-appropriate growth and development; and
c. The ability to attain, maintain, or regain functional capacity.

The Contractor shall deliver the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.

Mandatory DMC-ODS Covered Services include:
i. Withdrawal Management (minimum one level);
ii. Intensive Outpatient;
iii. Outpatient;
iv. Opioid (Narcotic) Treatment Programs;
v. Recovery Services;
vi. Case Management;
vii. Physician Consultation;
viii. Perinatal Residential Treatment Services (excluding room and board); a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to the DMC-ODS.
ix. Non-perinatal Residential Treatment Services (excluding room and board); a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to DMC-ODS. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference. Contractor shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) adolescents under age 21 who are eligible under the EPSDT Program.

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

1.10 Eligible Beneficiary –an Eligible Beneficiary may be considered any Beneficiary who receives Medi-Cal benefits under the terms of one of the specific aid codes set forth in the Medi-Cal Agreement between PARTNERSHIP AND DHCS, and who is certified as eligible for Medi-Cal by the State of California, and/or determined by DHCS to be eligible for substance use treatment services in the County(ies) eligible under this Agreement.

1.11 Emergency Medical Condition – A medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: i) placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; ii) serious impairment to bodily functions; or iii) serious dysfunction of any bodily organ or part.

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

1.13 Encounter Form - The CMS-1500 or UB-04 claim form used by PROVIDER to report to PARTNERSHIP regarding the provision of covered services to Medi-Cal Members.

1.14 Enrollment - The process by which an Eligible Beneficiary selects or is assigned to the PARTNERSHIP, which may include certain Fee-for-Service Medi-Cal Members who may or may not be assigned to PARTNERSHIP by DHCS..

1.15 Excluded Services - Those services for which the PARTNERSHIP is not responsible and for which it does not receive a capitation or other payments as outlined in Section 4 of this Agreement.

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

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

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

1.19 Hospital – Any acute general care or psychiatric hospital licensed and/ or certified by DHCS.

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

1.21 Medical Advisory Group - The committee of physicians and/ or other providers chosen each year from among contracting physicians and/ or other providers by the PARTNERSHIP for the purpose of advising the PARTNERSHIP. The physicians must be Board Certified.

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

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

Medical Necessity for Substance Use Services and Medically Necessary Substance Use Services means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that are deemed necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

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

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

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

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

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

(a) Non-PHC Members - Medi-Cal FFS Members receiving substance use disorder services who reside in a county participating in the PARTNERSHIP Regional Drug Medi-Cal ODS program will receive a Benficiary Handbook which will outline substance use disorder services available. Benficiary Handbook may also be referred to as the state developed model enrollee handbook.

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

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

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

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

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

1.34 Partnership HealthPlan of California (PHC) - The locally administered, prepaid Medi-Cal Managed Care program.

1.35 Physician – For purposes of this Agreement, Physician may be defined as (1) Either an Attending Physician or a Primary Care Physician, who has entered into an Agreement with PARTNERSHIP and who is licensed to provide medical care by the Medical Board of California and is enrolled in the State Medi-Cal Program; or (2) a medically licensed individual who provides supervision,

collaboration, and oversight requirements as described in this Agreement and associated Exhibits, or a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

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

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

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

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

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

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

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

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

1.44 Referral Services - Covered services, which are not Primary Care Services, and which are provided by physicians or other service certified or licensed providers after authorization by the PARTNERSHIP as a covered service

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

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

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

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

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

SECTION 2
QUALIFICATIONS, OBLIGATIONS AND COVENANTS

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

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

2.1.2 Licensure – Warrant that PROVIDER has, and will continue to have as long as this Agreement remains in effect, a currently valid unrestricted license, certification or registration in the State of California, as applicable to the Covered Services rendered. Warrant that PROVIDER has the personal capacity to perform pursuant to the terms of this Agreement; and will satisfy any continuing professional education requirements prescribed by state licensure and/or certification regulations or by PARTNERSHIP. Warrant that the PROVIDER has, and will continue to have as long as this Agreement remains in effect, eligibility to participate in any federal health programs including both Medicare and Medi-Cal Program in accordance with the program Standards of

Participation contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Code of Regulations.

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

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

2.1.5 Referrals – Unless otherwise agreed to by PARTNERSHIP except for Emergency Services and Urgent Care Services, provide DMC-ODS Covered Services to eligible Medi-Cal Members, only upon receipt of an appropriate referral (as applicable for residential services only), or such other treatment authorization as described in the PARTNERSHIP Provider Manual.

2.1.6 Case Management – For purposes of this Substance Use TreatmentServices Agreement, Case Management shall be defined as a service to assist a Eligible Benificiary to access needed medical, educational, social, prevocational, vocational, rehabilitiative or other community services or as other defined with the Intergovernement Agreement between the respective County agency and DHCS. Case Management may also include cooperation with Medi-Cal Member's Referring Physician and PARTNERSHIP in the monitoring, coordination, and case management of the Medi-Cal Member's healthcare services. PROVIDER will promptly furnish a complete written report of the services rendered to a Medi-Cal Member to the Medi-Cal Member's Referring Physician and, upon receipt of an appropriate consent, to PARTNERSHIP, on such form as may be prescribed in the PARTNERSHIP Operations Manual.

a. As applicable, PROVIDER will agree to abide by any required Case Management Protocols which are included in the PARTNERSHIP Provider Manual and are specific to Substance Use Disorder services.

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

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

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

e. Refer to Exhibit 1 for a definition of those covered Case Management services for Members receiving DMC-ODS services.

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

2.1.8 Credentialing – In accordance with 42 CFR 455 and its related subparts, PARTNERSHIP will properly screen and credential Substance Use Treatment Providers to provide covered services to Medi-Cal Members. To become a contracted Substance Use TreatmentProvider, Substance Use TreatmentProvider agrees to provide PARTNERSHIP with all necessary accreditation, licensure and/or certification documents, as applicable, and will use best efforts to notify PARTNERSHIP in advance of any change in such information. PROVIDER will successfully complete a facility site review, if deemed necessary by PARTNERSHIP in accordance with DHCS Medi-Cal Agreement. In addition, Substance Use TreatmentProvder agrees to the following:

a.) Agrees to comply with the following regulations and guidelines below or other state or federal requirements having oversight to for the covered services provided under this Agreement.

- Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;
- Drug Medi-Cal Certification Standards for Substance Abuse Clinics
- Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1,
- Standards for Drug Treatment Programs (October 21, 1981)
- Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; and
- Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.

In the event of conflicts between this Agreement and Title 22, the provisions of Title 22 shall control if they are more stringent.

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

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

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

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

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

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

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

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

2.1.17 PROVIDER will verify Medi-Cal Member eligibility with PARTNERSHIP prior to

rendering treatment. A referral is not a guarantee of Medi-Cal Member eligibility with PARTNERSHIP or eligibility in the State Medi-Cal Program.

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

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

2.2 PARTNERSHIP is responsible for:

2.2.1 Member Assignment – As applicable under certain PARTNERSHIP benefit programs, PARTNERSHIP may assign its Medi-Cal Members in the Medi-Cal Managed Care Program to a Primary Care Physician and Primary Hospital.

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

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

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

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

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

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

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

SECTION 3
SCOPE OF SERVICES

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

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

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

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

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

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

3.1.6 DMC-ODS Services –substance use treatment residential services.

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

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

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

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

3.3 Non-Discrimination

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

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

3.3.3 General Compliance. Pursuant to the requirements of this Section of the Medi-Cal Substance Use Agreement, the PROVIDER will not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, color, creed, religion, language, ancestry, marital status, sexual orientation, sexual

preference, national origin, age (over 40), sex, gender, gender identity, political affiliation, health status, or physical or mental disability, medical condition (including cancer), pregnancy, childbirth or related medical conditions, veteran's status, income, source of payment, status as a Member of PARTNERSHIP, or filing a complaint as a Member of PARTNERSHIP, and denial of family care leave. PROVIDER will ensure the evaluation and treatment of PROVIDER's employees and applicants for employment are free from discrimination and harassment. PROVIDER will comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et.seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in CCR, Title 2, Division 4, Chapter 5 are incorporated into this Agreement by reference and made a part hereof as set forth in full. PROVIDER will give notice of his obligations under this Section to labor organizations with which he has a collective bargaining or other agreement.

3.4 Quality Improvement and Utilization Management Programs – PROVIDER agrees to cooperate and to participate with PARTNERSHIP in Quality Improvement and Utilization Management Programs including but not limited to activities to improve the quality of care and services and member experience, credentialing and re-credentialing, peer review and any other activities required by PARTNERSHIP, the Government Agencies and any other regulatory and accrediting agencies, and will comply with the policies and procedures associated with these Programs. In addition, the PROVIDER will participate in the development of corrective action plans for any areas that fall below PHC standards ensuring medical records are readily available to the PHC staff as requested. PROVIDER will cooperate with collection and evaluation of data for quality performance and agrees that PARTNERSHIP may use data for quality improvement activities.

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

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

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

SECTION 4
EXCLUSIONS FROM AND LIMITATIONS OF COVERED SERVICES

4.1 Exclusions - Members in need of services, which are not Covered Services, as described in Division 3, Subdivision 1, Chapter 3, Article 4, Title 22, California Code of Regulations, will

not be reimbursed by the PARTNERSHIP. The PROVIDER will not bill and expect reimbursement by the PARTNERSHIP for the following excluded services provided to Medi-Cal Members:

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

(a) Dental Services, unless deemed as medical services and are considered Covered Benefits for Members.

(b) Long term in home waiver services and Multi-Senior Services.

(c) Substance use treatment services are not covered under this Agreement in Napa, Sonoma, Marin, Lake, Yolo, and Del Norte. Substance Use Treatmentservices are a Covered Service only in, Solano, Mendocino, Modoc, Lassen, Humboldt, Shasta, Siskiyou, and Trinity counties.

(d) In-patient Medi-Cal specialty Mental Health and out-patient mental health services provided to individuals with the diagnosis of severe and persistently mentally ill are not covered by PARTNERSHIP. Members with a diagnosis of mild to moderate mental health conditions in need of out-patient mental health services are Covered Benefits for Medi-Cal Members by PARTNERSHIP.

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

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

(g) Fabrication of optical lenses;

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

(i) Direct Observed Therapy for tuberculosis;

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

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

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

(m) Non-formulary prescription drugs that are not covered under the DMC ODS waiver shall continue to be billable to the state.

(n) Drug benefits for full-benefit dual eligible Medi-Cal Members who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 United States Code ("USC") Section 1395w-101 et seq.), except as set forth in the State Medi-Cal Contract.

4.3 Restricted Services/Special Reimbursement.

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

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

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

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

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

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

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

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

SECTION 5
PAYMENTS AND CLAIMS PROCESSING

5.1 Payment – PARTNERSHIP will reimburse PROVIDER for Covered Services provided which have been authorized by the PARTNERSHIP in accordance with PARTNERSHIP policies and procedures and upon submission of a complete CMS-1500 or UB-04 claim form along with evidence of prior authorization, if required, submission of complete data through electronic transfer, as described in Section 5.3 herein. Reimbursement will be made within thirty (30) days of receipt by PARTNERSHIP of a "clean claim". The following conditions must be met in addition to the above requirements for reimbursement of services:

5.1.1 The Medi-Cal Member is eligible for program benefits with PARTNERSHIP at the time the Covered Service is rendered by PROVIDER on the first day of the month for which PARTNERSHIP receives capitation based on the most current enrollment information from DHCS. Additionally, a Medi-Cal Member is also eligible for services if the Medi-Cal Member is not a PARTNERSHIP Member but whose place of residence is in the one of counties that participate in the DMC ODS regional drug program administered by

PARTNERSHIP will also be considered eligible for program benefits with PARTNERSHIP.

5.1.2 The service is a Covered Service under the DMC ODS Program according to the Intergovernmental Agreement between applicable County and PARTNERSHIP, PARTNERSHIP Provider Manual and policies and procedures, and State and federal regulations in effect at that time.

5.1.3 All claims for reimbursement of Covered Services must be submitted to the PARTNERSHIP within one hundred and eighty (180) days from the date of service. Claims received on the 181st day from the date of service will be denied. PARTNERSHIP will make no exceptions or pro-rated payments beyond the 6 month billing limit.

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

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

5.2.1 Fee-For-Service (FFS) –PARTNERSHIP will reimburse the PROVIDER at the rates set forth in Attachment D, Drug Medi-Cal Substance Use Provider Fee Schedule for all properly documented Drug-Medi-Cal Covered Services provided to:

a. PARTNERSHIP enrolled Medi-Cal Members and/or other Medi-Cal FFS Members eligible to receive substance use treatment services and that who reside in one of the counties under contract with PARTNERSHIP as part of the PARTNERSHIP Regional Drug Medi-Cal program and that have executed a that present with prior authorized Covered Services, which have been properly authorized in accordance with PARTNERSHIP Operations Manual.

5.3 Claim Submission – The PROVIDER will obtain, complete, and submit CMS-1500, UB-04 or universal claim forms through electronic transfer, or hard copy on as an exception for all services rendered to Medi-Cal Members including capitated services as described in the PARTNERSHIP Operations Manual.

5.3.1 All claims for reimbursement of Covered Services must be submitted to the PARTNERSHIP within one hundred and eighty (180) days from the date of service. Claims received on the 181st day form the date of service will be denied. PARTNERSHIP will make no exceptions or pro-rated payments beyond the 6 month billing limit.

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

5.3.3 CMS-1500 or UB-04 forms or electronic transfer are to be used for the submission to the PARTNERSHIP of encounter data as documentation of Capitated Covered Services; if applicable, provided to Medi-Cal Members by the PROVIDER. The CMS-1500 forms or the submission by electronic transfer will be made by PROVIDER the 15th day of the month following the month of service during the term of this Agreement. As an exception PROVIDER can submit encounter data via hard copy. All forms submitted should contain the data elements as Outlined in the PARTNERSHIP Operations Manual.

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

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

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

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

5.6 Subcontracts

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

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

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

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

a. Records and Records Inspection – Make all applicable books and records available at all reasonable times for inspection, examination or copying by the Governmental Agencies; and, retain such books and records for a term of at least ten (10) years from the close of DHCS' fiscal year in which the Subcontract is in effect and submit to PROVIDER and PARTNERSHIP all reports required by PROVIDER, PARTNERSHIP or DHCS where applicable, and timely gather, preserve and provide to DHCS any records in Subcontractor's possession, in accordance with the Provider Manual, Records Related to Recovery for Litigation.

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

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

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

e. Additional Requirements – Be bound by the provisions of Section 8.7, Survival of Obligations after Termination, and Section 7.4, PROVIDER Indemnification and Hold Harmless.

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

5.7 Overpayments - PROVIDER will report all overpayments to PARTNERSHIP within 60 days of becoming aware of an overpayment from PARTNERSHIP. PROVIDER will repay all overpayments within 45 days of reporting such overpayment to PARTNERSHIP or within 45 days of receipt of a written or electronic notice from PARTNERSHIP of an overpayment. Pursuant to 42 CFR Section 438.608 (d) PARTNERSHIP is required to annually report Provider overpayments to DHCS. Overpayment is any payment made to PROVIDER by

PARTNERSHIP to which the PROVIDER is not entitled under Title XIX of the Social Security Act.

SECTION 6
RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

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

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

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

6.1.3 PROVIDER will ensure that medical records are legible.

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

6.2 Records and Records Inspection Rights.

6.2.1 Access to Records – Notwithstanding, other federal or states laws related to confidentiality of alcohol and drug abuse patient records that are subject that are made of this Agreement and as set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2, PROVIDER also agrees to permit PARTNERSHIP's Medical Director, or officers or their designees, any agency having jurisdiction over PARTNERSHIP, including and without limitation the Governmental Agencies, to inspect the premises, records and equipment of Health Care Services Provider and review all operational phases of the medical services provided to Medi-Cal Members.

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

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

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

d. Substance Use TreatmentProvider agrees, that in case of a conflict between this Agreement and any applicable privacy or security rules, laws, regulations or standards the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI, PI and PII from unauthorized disclosure.

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

a. Records will include all encounter data, working papers, reports submitted to PARTNERSHIP, financial records, all medical records, medical charts and prescription files, and other documentation pertaining to medical and non-medical services rendered to Medi-Cal Members for a term period of at least ten (10) years.

b. PROVIDER will retain all Records for a period of at least ten (10) years from the close of the State Department of Health Care Services' fiscal year in which this Agreement was in effect.

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

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

6.3 Disclosure to Government Officials - PROVIDER shall comply with all provisions of law

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

6.4 Patient Confidentiality

a. Notwithstanding any other provision of the Agreement, names of persons receiving public social services are confidential information and are to be protected from unauthorized disclosure in accordance with Title 45 CFR, Parts 160 and 164 and subparts A and E; and, 42 CFR Part 2, Welfare and Institutions Code and regulations adopted thereunder.

b. For the purpose of this Agreement, all information, records, data and data elements collected and maintained for the operation of the Agreement and pertaining to Beneficiaries will be protected by the PROVIDER and his/her staff from unauthorized disclosure.

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

d. With respect to any identifiable information concerning a Medi-Cal Member under this Agreement that is obtained by the PROVIDER, the PROVIDER (1) will not use any such information for any purpose other than carrying out the express terms of the Agreement, (2) will promptly transmit to the PARTNERSHIP all requests for disclosure of such information, (3) will not disclose except as otherwise specifically permitted by the Agreement, any such information to any party other than PARTNERSHIP, the federal government including the Department of Health and Human Services and Comptroller

General of the United States, the Department of Justice Bureau of Medi-Cal Fraud, the Department of Health Care Services or any other government entity which is statutorily authorized to have oversight responsibilities of the COHS program and contracts, without prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et. seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder, (4) will, at the expiration or termination of the Agreement, return all such information to the PARTNERSHIP or maintain such information according to written procedures sent to the PARTNERSHIP by the Department of Health Care Services for this purpose.

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

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

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

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

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

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

SECTION 7
INSURANCE AND INDEMNIFICATION

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

7.1.1 PROVIDER will carry, at its sole expense, liability insurance or other risk protection programs, in the amounts of at least Five Hundred Thousand Dollars ($500,000) per person per occurrence in aggregate, including "tail coverage" in the same amounts whenever claims made malpractice and/ or errors and omissions is involved.

Notification of PARTNERSHIP by PROVIDER of cancellation or material modification of the insurance coverage or the risk protection program will be made to PARTNERSHIP at least thirty (30) days prior to any cancellation. Documents evidencing professional liability insurance or other risk protection required under this Subsection will be provided to PARTNERSHIP upon execution of this Agreement.

7.2 Other Insurance Coverage - In addition to Section 7.1.1 above, PROVIDER will also maintain, at its sole expense, a policy or program of general liability insurance (or other risk protection) with minimum coverage including and no less than One Hundred Thousand Dollars ($100,000) per person for the protection of the interest and property of PROVIDER's property together with a Combined Single Limit Body Injury Liability and Property Damage Insurance of not less than One Hundred Thousand Dollars ($100,000) for its members and employees, PARTNERSHIP Members, PARTNERSHIP and third parties, namely, personal injury on or about the premises of the PROVIDER, and general liability.

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

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

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

a. PROVIDER claims. Any and all claims and losses accruing or resulting to PROVIDER or any of its Subcontractors or any person, firm, corporation or other entity furnishing or supplying work, services, materials or supplies in connection with the performance of this Agreement.

b. Third Party claims. Any and all claims and losses accruing or resulting to any person, firm, corporation, or other entity injured or damaged by PROVIDER, its agents, employees and Subcontractors, in the performance of this Agreement.

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

SECTION 8
TERM, TERMINATION, AND AMENDMENT

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

8.2 Termination Without Cause – Either party upon ninety (90) days prior written notice to the other party may terminate this Agreement without cause.

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

8.3.1 The suspension or revocation of PROVIDER's license to practice medicine in the State of California; the suspension or termination of PROVIDER's membership on the active medical staff of any hospital; or the suspension, revocation or reduction in PROVIDER's clinical privileges at any hospital; or suspension, exclusion and/or disbarment from federal health programs, including Medicare and the California State Medi-Cal Program; or if PROVIDER'S name is found on the following Medi-Cal Suspended and Ineligible Provider list posted at http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; or loss of malpractice insurance; or failure to meet PARTNERSHIP's credentialing or re-credentialing criteria including but not limited to certification requirements for participation in the DHCS Drug Medi-Cal program.

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

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

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

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

8.3.6 If PROVIDER breaches Article 9.10, Marketing Activity and Patient Solicitation. An immediate termination for cause made by PARTNERSHIP pursuant to this will not be

subject to the cure provisions specified in Section 8.4 Termination for Cause with Cure Period.

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

8.5 Continuation of Services Following Termination – Should this Agreement be terminated, PROVIDER will, at PARTNERSHIP's option, continue to provide Covered Services to Medi-Cal Members who are under the care of PROVIDER at the time of termination until the services being rendered to the Medi-Cal Members by PROVIDER are completed, unless PARTNERSHIP has made appropriate provision for the assumption of such services by another physician and/or provider. PROVIDER will ensure an orderly transition of care for Medi-Cal Members, including but not limited to the transfer of Medi-Cal Member medical records. Payment by PARTNERSHIP for the continuation of services by PROVIDER after the effective date of termination will be subject to the terms and conditions set forth in this Agreement including, without limitation, the compensation provisions herein. The costs to the physician of photocopying such records will be reimbursed by the PARTNERSHIP at a cost not to exceed $.10 per page.

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

8.7 Survival of Obligations After Termination – Termination of this Agreement will not affect any right or obligations hereunder which will have been previously accrued, or will thereafter arise with respect to any occurrence prior to termination. Such rights and obligations will continue to be governed by the terms of this Agreement. The following obligations of PROVIDER will survive the termination of this Agreement regardless of the cause giving rise to termination and will be construed for the benefit of the Medi-Cal Member: 1) Section 8.5, Continuation of Services Following Termination; 2) Section 6.2, Records and Records Inspection; 3) 5.7, Overpayments and, 4) Section 7.3, Hold Harmless. Such obligations and the provisions of this Section will supersede any oral or written agreement to the contrary now existing or hereafter entered into between PROVIDER and any Medi-Cal Member or any persons acting on their behalf. Any modification, addition, or deletion to the provisions referenced above or to this Section will become effective on a date no earlier than thirty (30) days after the DHCS has received written notice of such proposed changes. PROVIDER will assist PARTNERSHIP in the orderly transfer of Medi-Cal Members to the provider they choose or to whom they are referred. Furthermore, PROVIDER shall assist PARTNERSHIP in the transfer of care as set

forth in the Provider Manual, in accordance with the Phase-out Requirements set forth in the Medi-Cal Contract.

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

8.9 Termination or Expiration of PARTNERSHIP's Medi-Cal Agreement – In the event the Medi-Cal Agreement terminates or expires, prior to such termination or expiration, PROVIDER will allow DHCS and PARTNERSHIP to copy medical records of all Medi-Cal Members, at DHCS' expense, in order to facilitate the transition of such Medi-Cal Members to another health care system. Prior to the termination or expiration of the Medi-Cal Agreement, upon request by DHCS, PROVIDER will assist DHCS in the orderly transfer of Medi-Cal Member's medical care by making available to DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any of the PROVIDER's Subcontractors, necessary for efficient case management of Medi-Cal Members, as determined by DHCS. Costs of reproduction of all such medical records will be borne by DHCS. Under no circumstances will a Medi-Cal Member be billed for this service. Termination will require sixty (60) days advance written notice of intent to terminate, transmitted by PARTNERSHIP to PROVIDER by Certified U S Mail, Return Receipt Requested, addressed to the office of PROVIDER, as provided in Section 9.4.of this Agreement.

SECTION 9
GENERAL PROVISIONS

9.1 Assignment. Assignment or delegation of this Agreement will be void unless prior written approval is obtained from DHCS.

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

9.2.1 If PROVIDER does not give written notice of termination within thirty (30) days, as authorized by Section 8, PROVIDER agrees that any such amendment by PARTNERSHIP will be a part of the Agreement. If PROVIDER does not agree to the amendment, PROVIDER may term this Agreement in accordance with Section 8.2.

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

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

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

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

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

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

California Department of Health Care Services Medi-
Cal 1501 Capitol Avenue, P.O. Box 997413
Sacramento, CA 95899-74133

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

Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

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

9.5 Entire Agreement – This Agreement, together with the Attachments and the PARTNERSHIP Operations Manual and policies and procedures, contains the entire agreement between PARTNERSHIP and PROVIDER relating to the rights granted and the obligations assumed by

this Agreement. Any prior agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement no expressly set forth in this Agreement are of no force or effect.

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

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

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

9.9 Reporting Fraud, Waste and Abuse – PROVIDER is responsible for reporting all cases of suspected fraud, waste and abuse, as defined in 42 CFR Section 455.2 and 438.608 where there is reason to believe that an incident of fraud and/or abuse has occurred by Medi-Cal Members or by PARTNERSHIP contracted physicians or providers, within 10 days to PARTNERSHIP for investigation.

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

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

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

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

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

9.12 Proprietary Information – With respect to any identifiable information concerning a Medi-Cal Member that is obtained, PROVIDER and its Subcontractors will not use any such information

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

9.13 Non-Exclusive Agreement – To the extent compatible with the provision of Covered Services to Medi-Cal Members for which PROVIDER accepts responsibility hereunder, PROVIDER reserves the right to provide professional services to persons who are not Medi-Cal Members including Eligible Beneficiaries. Nothing contained herein will prevent PROVIDER from participating in any other prepaid health care program.

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

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

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

9.17 Compliance with Laws - PROVIDER shall comply with all laws and regulations applicable to its operations and to the provision of services hereunder.

9.18 Compliance with Agreement - If PARTNERSHIP determines that PROVIDER is in breach of this Agreement for failure to comply the terms of this Agreement, then PARTNERSHIP with good cause, upon written notice to the PROVIDER and in accordance with Section 9 of the Agreement may seek to impose an administrative and/or financial sanctions and/or penalties against PROVIDER due to non-compliance or failure to comply with applicable federal or state statutes, regulations, rules, contractual obligations, and as applicable, PHC policies and procedures as solely determined by PARTNERSHIP. Any monetary sanction imposed on PARTNERSHIP by a state or federal agency due to Specialist's non-compliance with the terms and provisions of this Agreement may result in a financial penalty to the Specialist as solely determined by PARTNERSHIP. PARTNERSHIP'S written notice will outline the specific reasons, in PARTERNSHIP'S determination, the PROVIDER is in non-compliance of this Agreement. Required actions for the PROVIDER to cure the breach will be set forth in the

written notice. In the event the PROVIDER fails to cure those specific claims set forth by PARTNERSHIP within twenty (20) days of the receipt of the notice, PARTNERSHIP reserves the right to impose an administrative and/or financial sanctions and/or penalties against PROVIDER and up to and including termination of the Agreement immediately upon notice to the PROVIDER. Notice an administrative and/or financial sanction and/or penalty will include the following information:

a. Effective date
b. Detailed findings of non-compliance
c. Reference to the applicable statutory, regulatory, contractual, PHC policy and procedures, or other requirements that are the basis of the findings
d. Detailed information describing the sanction(s)
e. Timeframes by which the organization or individual shall be required to achieve compliance, as applicable
f. Indication that PHC may impose additional sanctions if compliance is not achieved in the manner and time frame specified; and
g. Notice of a contracted provider's right to file a complaint (grievance) in accordance with PHC policy and procedure.

9.19 Ownership Disclosure - PROVIDER will provide, as applicable, the ownership disclosure statement(s), the business transactions disclosure statement(s), the convicted offenses disclosure statement(s), and the exclusion from state or federal health programs disclosure statement(s), prior to the Effective Date, on an annual basis, upon any change in information, and upon request, if required by law or by PARTNERSHIP's Contract with Medi-Cal PROVIDER non-capitated agreement 6-1-13 Page 32 the State of California for the provision of Medi-Cal Services. Legal requirements include, but are not limited to, Title 22 CCR Section 51000.35, 42 USC Sections 1320 a-3 (3) and 1320 a-5 et seq., and 42 CFR Sections 455.104, 455.105 and 455.106. PROVIDER shall also provide, as applicable, the "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions" and shall comply with its instructions, if required by law or by PARTNERSHIP's Contract with the State of California for the provision of Medi-Cal Services. Such Debarment Certification and its instructions are set forth in the Provider Manual.

SECTION 10
GRIEVANCES AND APPEALS

10.1 Appeals and Grievances.

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

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

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

10.3 Arbitration – If the parties cannot settle grievances or disputes between them in an informal and expeditious fashion, the dispute will be submitted, upon the motion of either party, to arbitration under the appropriate rules of the American Arbitration Association (AAA). All such arbitration proceedings will be administered by the AAA; however, the arbitrator will be bound by applicable state and federal law, and will issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that all arbitration proceeding will take place in Fairfield, California, that the appointed arbitrator will be encouraged to initiate hearing proceedings within thirty (30) days of the date of his/her appointment, and that the decision of the arbitrator will be final and binding as to each of them. The party against whom the award is rendered will pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award, or take an appeal pursuant to the provisions of the California Civil Code.

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

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

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

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

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

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

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

SECTION 11
RELATIONSHIP OF PARTIES

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

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

11.3 PROVIDER-Patient Relationship – This Agreement is not intended to interfere with the professional relationship between any Medi-Cal Member and his or her PROVIDER. PROVIDERS will be responsible for maintaining the professional relationship with Medi-Cal Members and are solely responsible to such Medi-Cal Members for all medical services provided. PARTNERSHIP will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Medi-Cal Member resulting from the acts or omissions of PROVIDER. PROVIDERS are allowed to freely communicate with patients regarding their health status, medical care and treatment options, alternative treatment, and medication treatment regardless of benefit coverage limitations.

Patients must be informed of risks, benefits and consequences of the treatment options, including the option of no treatment and make decisions about ongoing and future medical treatments. PROVIDER must provide information regarding treatment options, including the option of no treatment in a culturally competent manner. Health care professionals must ensure that patients with disabilities have effective communication throughout the health system in making decisions regarding treatment options.

ATTACHMENT A
NONDISCRIMINATION CLAUSE
(OPC – 1)

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

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

ATTACHMENT B
INFORMATION REGARDING OFFICERS, OWNERS, AND STOCKHOLDERS

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

ATTACHMENT C
FACILITY OR SERVICE LOCATIONS

List the facility site name(s), location(s) that apply to this Agreement. Add page if additional site information if applicable.

Tax Identification number: _____

Provider Type: _____

Billing NPI: _____

Facility or Provider Name: _____

Address: _____
Street

_____
City State Zip Code

County: _____

Phone number: _____

Fax number: _____

PHC Number# (internal use only) _____

ATTACHMENT D

Partnership HealthPlan of California (PHC)

Fee Schedule

For

County of Humboldt

EFFECTIVE DATE: _____

Below is the PHC rate of reimbursement for drug treatment/substance abuse services. Claims will be processed in accordance with State criteria related for reimbursement of Drug-Medi-Cal covered services.

Drug Medi-Cal billing criteria can be located here:
http://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf

Routine Updates: PARTNERSHIP reserves the right, but not the obligation, to perform other updates as may be necessary to remain consistent with DHCS Drug- Medi-Cal billing guideline, coding changes. PARTNERSHIP will use reasonable commercial efforts to implement the updates in its systems within 60 days after the effective date of any billing criteria modifications mandated by the State.

HCPCS Codes and approved modifiers: All approved HCPCS Codes and modifiers and as may be amended from, time to time are located here:
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_Information_Notice_17-045.pdf

PLEASE CHECK ALL LEVELS OF CARE PROVIDED BY PROVIDER:

TYPE OF SERVICE **(Check all that apply)**	**PLACE AN (X) IN EACH BOX FOR THE SERVICES PROVIDED BY YOUR ORGANIZATION**	**Patient Demographic (Place the Number in the Box) 1. Adolescents (A) 2. Women (W) 3. Pregnant Women (PW) 4. Men (M)**
Outpatient Treatment		
Intensive Outpatient		
Perinatal Outpatient		
Perinatal Intensive Outpatient		
Perinatal Residential 3.1		
Recovery Support Services		
Case Management		
Physician Consultation		
Residential 3.1		
Residential 3.5		
Withdrawal Management		

ATTACHMENT D

Partnership HealthPlan of California (PHC)

Substance Use Treatment

Fee Schedule

For

County of Humboldt

EFFECTIVE DATE: _____

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1. Outpatient Visit/Case Management/Recovery Services/Physician Services

Service	Allowed Rate
Outpatient	**$34.67**
Intensive Outpatient	**$29.78**
Perinatal Outpatient	**$34.67**
Perinatal Intensive Outpatient	**$29.78**
Recovery Services	**$14.88**
Case Management	**$34.67**
Physician Consultation	**$49.13**

(1)Refer to the Fee Schedule Additional Specifications and Billing Criteria for billing requirements.

2. Withdrawal Management/Residential Services/Partial Hospitalization

Service	Allowed Rate
Withdrawal Management –WM	N/A
Residential 3.1	N/A
Residential 3.5	N/A
Perinatal Residential 3.1	N/A
Outpatient Partial Hospitalization 2.5	N/A

(1)Refer to the Fee Schedule Additional Specifications and Billing Criteria for billing requirements.

3. Narcotic Treatment Program (NTP)(*)

(*) PROVIDER must be a Drug Medi-Cal certified NTP provider to be reimbursed for NTP services.

Service	Unit of Service	Non-perinatal	Perinatal
Narcotic Treatment Program -Methadone	Daily	Current State published rate	Current State published rate
NTP-Individual Counseling	One 10 minute increment	Current State published rate	Current State published rate
NTP-Group Counseling	One 10 minute increment	Current State published rate	Current State published rate
Intensive Outpatient Treatment	Face to Face/Visit	Current State published rate	Current State published rate
Naloxone	Face to Face/Visit	Current State published ate	Current State published rate
Residential –for EPSDT Beneficiaries	Daily	Current State published rate	Current State published rate
Outpatient Drug Free (OP) Individual	Face to Face/Visit (per person)	Current State published rate	Current State published rate
ODF Group Counseling	Face to Face/Visit (per person)	Current State published rate	Current State published rate

Service	Unit of Service	Non-perinatal	Perinatal
Narcotic Treatment Program – Buprennorphine (Mono) (1)	Daily	Current State published rate	Current State published rate
Narcotic Treatment Program – Buprennorphine-Naloxone –Combination (2)	Daily	Current State published rate	Current State published rate
NTP- Disulfiram (3)	Daily	Current State published rate	Current State published rate
NTP – Naloxone -2 pack Nasal Spray (4)	Dispensed according to need	Current State published rate	Current State published rate

[1] Buprenorphine-Mono: Average daily dose of 16 milligrams, sublingual tablets
[2] Buprenorphine-Naloxone Combination
[3] Disulfiram: Average daily dose between 250 and 500 milligrams
[4] Naloxone: One dose equal to 4 milligrams per 0.1 milliliter

ATTACHMENT D

FEE SCHEDULE ADDITIONAL SPECIFICATIONS AND BILLING CRITERIA

For additional information, please see the DMC Billing Manual (DMC-ODS instructions start on Page 30)
https://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf
https://www.dhcs.ca.gov/provgovpart/Pages/DMC_ODS_Webinars.aspx

Outpatient Services (ASAM Level 1)
Outpatient services includes intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention, and treatment planning. Additionally, discharge services are provided to beneficiaries up to nine hours a week for adults, and less than six hours a week for adolescents.

For individual counseling, one unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service.

For group counseling, one or more therapists treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Counties should calculate the units to submit on a claim using the following formula: Number of minutes for the group/number of beneficiaries = Total minutes per beneficiary.
Group Formula Example:
15 minutes transportation to site
+ 90 minute group
+ 15 minutes transportation back to the facility site
= 120 minutes/number of beneficiaries in group (10)
= 12 minutes per beneficiary
+ 5 minutes for documentation time
17 minutes
This claim can be billed at 1.13 units for each person in the group

Intensive Outpatient Treatment (ASAM Level 2.1)
Structured programming services are provided to beneficiaries a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents. Services consist of intake, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention, treatment planning, and discharge services. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Units of service for group counseling should be calculated using the same formula as described in outpatient services.

Residential Treatment (ASAM Level 3.1, 3.3, and 3.5)
This treatment is a non-institutional, 24-hour non-medical, short-term program that provides rehabilitation services which includes intake, individual and group counseling, patient education,

family therapy demonstration approval, safeguarding medications, collateral services, crisis intervention, treatment planning, transportation services, and discharge services. Residential services may be provided to non-perinatal and perinatal beneficiaries in facilities with no bed capacity limit.

Withdrawal Management (Levels 1, 2, and 3.2)
Withdrawal Management services includes intake, observation, medication services, and discharge services. Counties must be certified to provide residential detoxification or non-residential detoxification services. Contact DHCS SUD Compliance Division at (916) 322-2911 for questions regarding certification for this service.

(1) Recovery Services
The components of recovery services are outpatient counseling services, recovery monitoring, substance abuse assistance, education and job skills, family support, support groups, and ancillary services. Recovery services may be billed for individual and group counseling, case management, and recovery monitoring/substance abuse assistance. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Units of service for group counseling should be calculated using the same formula as described in outpatient services.

(2) Case Management
Case management is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management services includes comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transition to a higher or lower level SUD of care; development and periodic revision of a client plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring the beneficiary's progress; patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service.

(*) Physician Consultation
Physician consultation services are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS Waiver beneficiaries. Physician consultation services can only be billed by and reimbursed to DMC providers. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service.

Notes:

(1) Recovery Support Services only billable once a patient comples the treatment program.

(2) Case Management and Physician Consultations only payable when billed as an outpatient service and are not separately payable when billed as as part of inpatient residential and/or withdrawal management residential services

ATTACHMENT E

Partnership HealthPlan of California (PHC)

340B Program Disclosure

PARTNERSHIP is required, pursuant to its Medi-Cal Agreement with DHCS, to ensure that claims/encounter data for outpatient drugs from entities participating in the federal 340B Drug Pricing Program (340B Covered Entities) contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC 256b(a)(5)(A)(i). 340B Covered Entities must ensure program integrity and maintain accurate records documenting compliance with all 340B Drug Pricing Program requirements. One of the federal 340B Drug Pricing Program requirements is the Duplicate Discount Prohibition (42 USC 256b(a)(5)(A)), whereby 340B Covered Entities must have mechanisms in place to prevent duplicate discounts, as manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug.

PARTNERSHIP is also required to comply with the provisions of Cal. W&I Code 14105.46, which requires covered entities to dispense, when able, only 340B drugs to Medi-Cal beneficiaries and identify 340B drugs on claims submitted to the Medi-Cal program. PARTNERSHIP maintains and operates a 340B Compliance Program, which DHCS determined to be in compliance with the above requirements. Information regarding PARTNERSHIP's 340B Compliance Program is available online at http://www.partnershiphp.org/Providers/Pharmacy/Pages/340B-Compliance-Program.aspx.

If PROVIDER bills PARTNERSHP for outpatient drugs discounted under the federal 340B Drug Pricing Program, PROVIDER must comply with all federal 340B Drug Pricing Program requirements including, but not limited to, the inclusion of the appropriate 340B identifiers on the claims submitted to classify the claims as 340B.

PROVIDER may submit a request to have PARTNERSHIP retroactively reclassify a claim as 340B in instances where PROVIDER failed to include the appropriate 340B identifier on a submitted claim. The addition of the appropriate 340B identifier by PARTNERSHIP to a previously paid outpatient drug claim is subject to a service fee payable to PARTNERSHIP under the terms and conditions set forth in the PARTNERSHIP's Medi-Cal Provider Manual and PARTNERSHIP's 340B Compliance Program Policy.

PROVIDER acknowledges and agrees that it has been made aware of and received information related to PARTNERSHIP's 340B Compliance Program as described above at least fifteen (15) business days prior to execution of this Agreement. Failure by the PROVIDER to execute PARTNERSHIP's 340B Compliance Program Agreement will result in additional administrative fees above the 340B Compliance Fees outlined in the 340B Compliance Program Policy should PROVIDER's claims require reclassification as 340B by PARTNERSHIP.

ATTACHMENT X

NETWORK PROVIDER
MEDI-CAL REQUIREMENTS

This Attachment X sets forth the applicable requirements that are mandated by the DHCS Medi-Cal Contract with Partnership Healthplan (the "Medi-Cal Contract"), State and Federal Laws and Regulations and DHCS all Plan Letter # 19-001. This Attachment X is included in this agreement to reflect compliance with laws and DHCS's requirements for "PROVIDER" as a contracted Network Provider. Any citations in this attachment are to the applicable sections of the Medi-Cal Contract or applicable law. This attachment will automatically be modified to conform to subsequent changes in law or government program requirements. In the event of a conflict between this attachment and any other provision of the Agreement, this attachment will control with respect to Medi-Cal. Any capitalized term utilized in this attachment will have the same meaning ascribed to it in the Agreement unless otherwise set forth in this attachment. If a capitalized term used in this attachment is not defined in the Agreement or this attachment, it will have the same meaning ascribed to it in the Medi-Cal Contract.

1. The parties acknowledge and agree that this Agreement specifies the services to be provided by PROVIDER. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.1; 22 CCR 53250(c)(1).)

2. This Agreement will be governed by and construed in accordance with all laws and applicable regulations governing the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.2; 22 CCR 53250(c)(2).)

3. This Agreement will become effective only upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the Agreement, and has failed to approve or disapprove the proposed Agreement with sixty (60) calendar days of receipt, as set forth in in the Medi-Cal Contract, Exhibit A, Attachment 6, Provision 14.C.1.

4. Amendments to this Agreement will be submitted to DHCS for prior approval at least thirty (30) calendar days before the effective date of any proposed changes governing compensation, services, or term, as set forth in the Medi-Cal Contract, Exhibit A, Attachment 6, Provision 14.C.2. Proposed changes that are neither approved nor disapproved by DHCS shall become effective by operation of law thirty (30) calendar days after DHCS has acknowledged receipt or upon the date specified in the Agreement amendment, whichever is later. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.3; 22 CCR 53250(c)(3).)

5. The parties acknowledge and agree that the term of the Agreement, including the beginning and end dates as well as methods of extension, renegotiation and termination, are included in this Agreement. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.4; 22 CCR 53250(c)(4).)

6. In the event and to the extent PROVIDER is at risk for non-contracting emergency services, PROVIDER shall comply with the Medi-Cal Contract requirements with respect to Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.5.)

7. PROVIDER agrees to submit reports as required by PARTNERSHIP. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.6; 22 CCR 53250(c)(5).)

8. PROVIDER will comply with all monitoring provisions in the Medi-Cal Contract and any monitoring requests by DHCS. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.7.)

9. PROVIDER agrees to make all of its premises, facilities, equipment, books, records, contracts, computer, and other electronic systems pertaining to the goods and services furnished under the terms of the Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2 Provision 20 [Inspection Rights]: (a) By PARTNERSHIP, DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), or their designees; (b) At all reasonable times at PROVIDER's place of business or at such other mutually agreeable location in California; (c) In a form maintained in accordance with the general standards applicable to such book or record keeping; (d) For a term of at least ten (10) years from final date of the Agreement period or from the date of completion of any audit, whichever is later; (e) Including all Encounter Data for a period of at least ten (10) years; (f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit PROVIDER at any time; (g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate PROVIDER from participation in the Medi-Cal program; seek recovery of payments made to PROVIDER; impose other sanctions provided under the State Plan, and direct PARTNERSHIP to terminate the Agreement due to fraud. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.8; Exhibit E, Attachment 2, 20, 22 CCR 53250(e)(1); 42 CFR 438.3(h).)

10. The parties acknowledge and agree that this Agreement contains full disclosure of the method and amount of compensation or other consideration to be received by PROVIDER from PARTNERSHIP. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.9; 22 CCR 53250(e)(2).)

11. PROVIDER agrees that it will maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the subcontractor: (a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Agreement, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees; (b) Retain all records and documents for a minimum of ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.10; 22 CCR 53250(e)(3); 42 CFR 438.3(u).)

12. PROVIDER agrees to assist PARTNERSHIP in the transfer of care pursuant to applicable provisions of the Medi-Cal Contract in the event of the Medi-Cal Contract termination. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.11.)

13. PROVIDER agrees to assist PARTNERSHIP in the transfer of care in the event of sub-subcontract termination for any reason. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.12.)

14. PROVIDER agrees to notify DHCS in the event this Agreement is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.13; 22 CCR 53250(e)(4).)

Department of Health Care Services
Medi-Cal Managed Care Division
MS: 4407, P.O. Box 997413
Sacramento, CA 95899-7413
Attention: Contracting Officer

15. PROVIDER agrees that assignment or delegation of the Agreement will be void unless prior written approval is obtained from DHCS. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.14; 22 CCR 53250(e)(5).)

16. PROVIDER agrees to hold harmless both the State and Members in the event PARTNERSHIP cannot or will not pay for services performed by PROVIDER pursuant to this Agreement. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.15; 22 CCR 53250(e)(6).)

17. PROVIDER agree to not balance bill any Medi-Cal member

18. PROVIDER agrees to timely gather, preserve and provide to DHCS, any records in PROVIDER's possession in accordance with the Medi-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.16.)

19. PROVIDER agrees to provide interpreter services for Members at all PROVIDER sites. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.17.)

20. PROVIDER agrees to provide cultural competency sensitivity, and diversity training to its workforce. (Medi-Cal Contract, Exhibit A, Attachement 9, 13.E.)

21. PROVIDER agrees to comply with language assistance standards developed pursuant to Health & Safety Code section 1367.01.

22. The parties acknowledge and agree that this Agreement and PARTNERSHIP's PROVIDER Manual contains PROVIDER's right to submit a grievance and PARTNERSHIP's formal process to resolve provider grievances. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.18.)

23. PROVIDER agrees to participate and cooperate in PARTNERSHIP's Quality Improvement System. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.19.)

24. If PARTNERSHIP delegates Quality Improvement Activities, PROVIDER and PARTNERSHIP will enter into a separate delegation agreement that contains the provisions stipulated in the Med-Cal Contract. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.20.)

25. To the extent that PROVIDER is responsible for the coordination of care for Members, PARTNERSHIP agrees to share with the PROVIDER any utilization data that DHCS has provided to PARTNERSHIP, and PROVIDER agrees to receive the utilization data provided and use it as the PROVIDER is able for the purpose of Member care coordination. (Medi-Cal contract, Exhibit A, Attachment 6, 14.B.23 and 42 CFR 438.208).

26. Before the requirement would be effective, PARTNERSHIP agrees to inform PROVIDER of new requirements added by DHCS through subsequent contract amended to PARTNERSHIP's contract with DHCS, and PROVIDER agrees, to the extent possible, to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. PROVIDER also agrees to comply with all applicable requirements imposed by subsequent federal and state laws and regulations, and MMCD Policy Letters. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.21.)

27. PROVIDER agrees to provide PARTNERSHIP with the disclosure statement set forth in 22 CCR 51000.35, included in Attachment A, prior to commencing services under this Agreement. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.B.23.)

28. This Agreement and all information received from PROVIDER in accordance with the subcontract requirements under the Medi-Cal Contract shall become public record on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of PROVIDER, stockholders owning more than 5 percent of the stock issued by PROVIDER and major creditors holding more than 5 percent of the debt of PROVIDER will be attached to the Agreement at the time the Agreement is presented to DHCS. (Medi-Cal Contract, Exhibit A, Attachment 6, 14.E; Welfare & Institutions Code 14452.)

29. PROVIDER shall notify PARTNERSHIP and DHCS within ten (10) calendar days of discovery that any third party may be liable for reimbursement to PARTNERSHIP and/or DHCS for Covered Services provided to a Plan Member, such as for treatment of work related injuries or injuries resulting from tortious conduct of third-parties. PROVIDER is precluded from receiving duplicate payments for Covered Services provided to Plan Members. If this occurs, PROVIDER may not retain the duplicate payment. Once the duplicate payment is identified, PROVIDER must reimburse PARTNERSHIP. If PROVIDER fails to refund the duplicate payment, PARTNERSHIP may offset payments made to PROVIDER to recoup the funds. (APL 17-021; Welfare & Institutions Code 14124.70 – 14124.791). The DHCS notice is to be sent to:

    Department of Health Care Services
    Third Party Liability and Recovery Division
    Workers' Compensation Recovery Program, MS 4720
    P.O. Box 997425
    Sacramento, CA 95899-7425

30. PROVIDER shall report PROVIDER preventable condition ("PPC")-related encounters in a form and frequency as specified by PARTNERSHIP and/or DHCS. (Medi-Cal Contract, Exhibit A, Attachment 8, 15; 42 CFR 438.3(g).)

31. PROVIDER shall (i) report to PARTNERSHIP when PROVIDER has received an overpayment, (ii) return the overpayment to PARTNERSHIP within sixty (60) calendar days after the date on which the overpayment was identified, and (iii) notify PARTNERSHIP in writing of the reason for the overpayment. (42 CFR 438.608(d)(2).)

32. PROVIDER will immediately report to PARTNERSHIP the discovery of a security incident, breach or unauthorized access of Medi-Cal Member protected health information (as defined in 45 CFR 160.103) or personal information (as defined in California Civil Code Section 1798.29). (Exhibit G, Provision H.1.)

33. PROVIDER will submit network data as directed by PARTNERSHIP for PARTNERSHIP to meet its administrative functions and requirements set forth in the Medi-Cal Contract. PROVIDER certifies that all data, including Encounter Data, submitted is complete, accurate, reasonable, and timely. PROVIDER will promptly make any necessary corrections to the data, as requested by PARTNERSHIP, so that PARTNERSHIP may correct any deficiencies identified by DHCS in the time period required by DHCS. (Medi-Cal Contract, Exhibit A, Attachment 3, 2.C and 2.G; APL 14-019, CFR 438.242 and 438.606.)

34. PROVIDER must be enrolled (and maintain enrollment) in the Medi-Cal Program through DHCS in accordance with its provider type. If requested by PARTNERSHIP, PROVIDER shall provide verification of enrollment. (APL 17-019; 42 CFR 438.602(b).)

35. PROVIDER represents and warrants that PROVIDER and its affiliates are not debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal

Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or guidelines implementing Executive Order No. 12549. Further, PROVIDER represents and warrants that PROVIDER is not excluded from participation in any health care program under section 1128 or 1128A of the Act. (42 CFR 438.610.)

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EXHIBIT 1

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

DRUG MEDI-CAL

ADDITIONAL TERMS AND SPECIFICATIONS

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1. Definitions.

Definitions of covered treatment modalities and services are found in Title 22 and are incorporated by this reference.

"ASAM" the American Society of Addiction Medicine.

"ASAM Criteria" is a comprehensive set of guidelines developed by the American Society of Addiction Medicine for the assessment, service planning, placement, and continued stay and transfer/discharge of individuals with addiction and
co-ocurring conditions.

"Authorization" is the approval process for DMC Services prior to the submission of a DMC claim.

"Beneficiary" means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

"Case Management" means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

"Certified Provider" means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the State to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

"Covered Services" means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code, Section 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver standard terms and conditions.

"Drug Medi-Cal Program -DMC" - means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

"Drug Medi-Cal Termination of Certification" means the provider is no longer certified to participate in the Drug Medi-Cal program upon the State's issuance of a Drug Medi-Cal certification termination notice.

"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)" means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal- covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

"Medical Necessity" means those substance use disorder services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

"Medical Necessity Criteria" means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Adults shall meet the ASAM Adult Dimensional Admission Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent diagnostic admission criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health

"Minor Consent DMC Services" are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.

"Narcotic Treatment Program" means an outpatient clinic licensed and/ or certified by the State to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

"Non-Perinatal Residential Program" services are provided in DHCS licensed and/ or certified residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

"Perinatal DMC Services" means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

"Postpartum", as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.

"Physician Consultation" services are to support DMC physicians with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

2. Covered Services.

PARTNERSHIP will establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Mandatory Covered Services in the PARTNERSHIP'S service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3). PARTNERSHIP will deliver the Covered Services within a continuum of care as defined in the ASAM criteria. Mandatory Covered Services include:

1. Withdrawal Management (minimum one level);
2. Intensive Outpatient;
3. Outpatient;

4. Opioid (Narcotic) Treatment Programs;

5. Recovery Services;

6. Case Management;

7. Physician Consultation;

8. Perinatal Residential Substance Abuse Services (excluding room and board); and

9. Room and board shall be reimbursable through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) treatment funding allocated to the Contractor.

10. Nonperinatal Residential Substance Abuse Services (excluding room and board);

11. Room and board will be reimbursable through the SAPT BG treatment funding allocated to PARTNERSHIP.

PARTNERSHIP will comply with federal and state mandates to provide Substance Usetreatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) adolescent under age 21 who are eligible under the EPSDT Program.

3. Drug Medi-Cal Scope of Covered Services

A. Early Intervention (ASAM Level 0.5)

PARTNERSHIP's staff shall provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use conditions.

PARTNERSHIP shall identify Members at risk of developing a SUD or those with an existing SUD and offer those Members: screening for adults and youth, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.

B. Outpatient Services (ASAM Level 1.0)

Outpatient services consist of up to nine (9) hours per week of medically necessary services for adults and less than six (6) hours per week of services for adolescents.

PARTNERSHIP shall ensure that its providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination.

Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

C. Intensive Outpatient Services (ASAM Level 2.1)

Intensive outpatient involves structured programming provided to Members as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal Members. Adolescents are provided a minimum of six (6) and a maximum of 19 services per week.

Intensive outpatient services shall include: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination.

Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

D. Outpatient Partial Hospitalization (ASAM Level 2.5)

20 or more hours of clinically intensive counseling sessions per week and may include intake; individual and/or group counseling; patient education, family therapy, medication services, collateral services such as sessions with therapists or counselors focused on the treatment needs supporting Members treatment goals; crisis intervention; treatment planning and discharge services.

E. Residential Treatment Services (ASAM Levels 3.1, 3.2, 3.5)

1. Residential 3.1 –Low Intensity –24 hour program with available trained staff; at least 5 hours of clinical service per week and preparation for outpatient treatment.

2. Residential 3.2 – Residential Withdrawal Management – will include intake, observation, medication services and discharge services when determined medically necessary by PARTNERSHIP Medical Director and/or PROVIDER Medical Director (as applicable).

3. Residential 3.5 –High Intensity -24-Hour care with trained counselors to stabilize imminent danger and preparation for outpatient treatment.

Residential services are short-term program that provides rehabilitation services to Members with substance use Treatment diagnosis when determined by PARNTERSHIP Medical Director or designee, or the PROVIDER Medical Director (as applicable) and provided by a licensed and/ or certified residential facility with DMC certification and has been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

Residential services may include intake; individual and group counseling; patient education, family therapy; collateral services such as sessions with therapists or counselors focused on the treatment needs supporting Members treatment goals; crisis intervention; treatment planning; transportation services; and discharge services.

The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents per 365 days period; unless medical necessity authorizes a one-time extension of up to 30 days per 365 day period.

Only two non-continuous 90-day regimens may be authorized in a one-year period (365 days.) The average length of stay for residential services is 30 days.

Perinatal Members may receive a longer length of stay based on medical necessity.

Adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of treatment.

F. Case Management

Case management services are defined as a service that assist a Member access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

Services may be provided either by persons specifically designated as case managers or by Provider staff in the course of their delivery of treatment. Case Management services may include, depending on medical necessity and assessment of individual nedds: comprehensive and periodic assessments; assistance to transition to higher level or lower level of care; communication, coordination, referral and other activities; monitoring of service delivery; monitoring of Member progress; patient advocacy and/or referrals to physical or mental health; transportation and primary care services.

Case management services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor.

Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

G. Physician Consultation

Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice with regards to designing treatment plans for specific DMC-ODS Members. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

PARTNERSHIP may contract with one or more physicians or pharmacists in order to provide consultation services. PARTNERSHIP will only allow DMC providers to bill for physician consultation services.

H Recovery Services

Recovery Services shall include:

1. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;

2. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

3. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

4. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

5. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

6. Support Groups: Linkages to self-help and support, spiritual and faith-based support; and

7. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

Recovery services can be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the PARTNERSHIP will provide Members with recovery services.

Additionally, PARTNERSHIP will arrange and authorize recovery services to Members as medically necessary.

Provide Members with access to recovery services after completing their course of treatment.

Provide recovery services either face-to-face, by telephone, or by telehealth with the beneficiary.

I. Withdrawal Management

PARTNERSHIP will arrange for at least one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by the PROVIDER Medical Director or Licensed Practitioner of the Healing Arts as medically necessary, and in accordance with the beneficiary's individualized beneficiary plan.

PARTNERSHIP will ensure that all Members that are receiving both residential services and WM services are monitored during the detoxification process.

PARTNERSHIP will arrange for medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

J. Opioid (Narcotic) Treatment Program Services (NTP)

Pursuant to W&I Code, Section 14124.22, a Narcotic Treatment Program provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal Members who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. Narcotic treatment providers shall refer all Medi-Cal Members that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.

The diagnosis and treatment of concurrent health conditions of Medi-Cal Members that are not enrolled in managed care plans by a Narcotic Treatment Program provider may be provided within the Medi-Cal coverage limits. When the services are not part of the Substance Use treatment reimbursed pursuant to W&I Code, Section 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:

- Medical treatment visits;
- Diagnostic blood, urine, and X-rays;
- Psychological and psychiatric tests and services;
- Quantitative blood and urine toxicology assays; and
- Medical supplies.

A NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary forSubstance Use treatment services, if the NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.

PARTNERSHIP will contract with licensed and/ or certified NTP providers to offer services to Members who meet medical necessity criteria requirements. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed and/ or certified prescriber.

- Covered medications to patients covered under the DMC formulary include methadone, buprenorphine, naloxone, and disulfiram.

- Services provided as part of an NTP shall include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services.

- Members shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided.

EXHIBIT 2

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA"), effective as of _____ ("Effective Date") is entered into by and between PARTNERSHIP HEALTHPLAN OF CALIFORNIA (the "Plan" or "Covered Entity") and COUNTY OF HUMBOLDT ("Business Associate"). PARTNERSHIP HEALTHPLAN OF CALIFORNIA and COUNTY OF HUMBOLDT may be referred to individually as a "Party" or collectively as "Parties."

WHEREAS, the Parties have entered into a Master Services Agreement effective ("Agreement") which may require Business Associate's use or disclosure of protected health information ("PHI") in performance of the services described in the Agreement on behalf of the Plan.

WHEREAS, the Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

WHEREAS, this BAA, in conjunction with the HIPAA Rules, sets forth the terms and conditions pursuant to which PHI (in any format) that is created, received, maintained, or transmitted by, the Business Associate from or on behalf of the Plan, will be handled between the Business Associate, the Plan and with third parties during the term of the Agreement(s) and after its termination.

NOW THEREFORE, the Parties hereby agree as follows:

1. DEFINITIONS

1.1 The following terms used in this BAA shall have the same meaning as those terms in the HIPAA Rules: Availability, Breach, Confidentiality, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Integrity, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

2. SPECIFIC DEFINITIONS

2.1 Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this BAA, shall mean COUNTY OF HUMBOLDT.

2.2 Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this BAA, shall mean PARTNERSHIP HEALTHPLAN OF CALIFORNIA.

2.3 HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

2.4 Services. "Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to the Plan under the Agreement, including those set forth in this BAA, as amended by written consent of the parties from time to time.

3. RESPONSIBILITIES OF BUSINESS ASSOCIATE

Business Associate agrees to:

3.1 Not use or disclose PHI other than as permitted or required by the BAA or as required by law.

3.2 Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the BAA.

3.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan. Business Associate shall comply with the applicable standards at Subpart C of 45 CFR Part 164.

3.4 Promptly report to the Plan any use or disclosure of PHI not provided for by the BAA of which it becomes aware, including, but not limited to, Breaches or suspected Breaches of unsecured PHI under 45 CFR 164.410, and any Security Incident or suspected Security Incidents of which it becomes aware. Business Associate shall report the improper or unauthorized use or disclosure of PHI within 24 hours to the Plan. Business Associate shall take all reasonable steps to mitigate any harmful effects of such Breach or Security Incident. Business Associate shall indemnify the Plan against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI including, but not limited to, the costs of notifying individuals affected by a Breach.

3.5 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

3.6 Make available PHI in a designated record set to the Plan as necessary to satisfy the Plan's obligations under 45 CFR 164.524;

3.7 Make any amendment(s) to PHI in a designated record set as directed or agreed to by the Plan pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the Plan's obligations under 45 CFR 164.526.

3.8 Forward any requests from a Plan member for access to records maintained in accordance with the BAA as soon as they are received. The Plan will maintain responsibility for making determinations regarding access to records.

3.9 Direct any requests for an amendment from an individual as soon as they are received to the Plan. The Business Associate will incorporate any amendments from the Plan immediately upon direction from the covered entity.

3.10 Maintain and make available the information required to provide an accounting of disclosures to the Plan as necessary to satisfy the Plan's obligations under 45 CFR 164.528.

3.11 Forward any requests from a Plan member for an accounting of disclosures maintained in accordance with the BAA as soon as they are received. The Plan will maintain responsibility for making determinations regarding the provision of an accounting of disclosures.

3.12 To the extent the Business Associate is to carry out one or more of the Plan's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

3.13 Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Business Associate may only use or disclose PHI as necessary to perform the services set forth in the Agreement.

4.2 Business Associate must obtain approval from the Plan before providing any de- identified information in accordance with 45 CFR 164.514(a)-(c). Business Associate, if approved, will obtain instructions for the manner in which the de-identified information will be provided.

4.3 Business Associate may use or disclose PHI as required by law.

4.4 Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Plan's minimum necessary policies and procedures.

4.5 Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Plan except for the specific uses and disclosures set forth below.

4.6 Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

5. PROVISIONS FOR COVERED ENTITIY TO INFORM BUSINESS ASSOCIATE OF PRIVACY PRACTICES AND RESTRICTIONS

5.1 The Plan shall notify Business Associate of any limitations in the notice of privacy practices under 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

5.2 The Plan shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.3 The Plan shall notify Business Associate of any restriction on the use or disclosure of PHI that the Plan has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 The Plan shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity.

7. TERM AND TERMINATION

7.1 Term. The Term of this BAA shall be effective as of the effective date of the Drug Medi-Cal Health Services Provider Agreement signed by the parties and shall terminate on the expiration date of the Agreement or on the date the Plan terminates for cause as authorized in Paragraph 7.2 below, whichever is sooner.

7.2 Termination for Cause. Business Associate authorizes termination of this BAA by the Plan, if the Plan determines, in its sole discretion, that Business Associate has violated a material term of this BAA and either:

7.2.1.1 The Plan provides Business Associate an opportunity to cure the Breach or end the violation within a time specified and Business Associate does not cure the Breach or end the violation within the time specified by the Plan; or

7.2.1.2 The Plan immediately terminates this BAA upon notice if the Plan determines, in its sole discretion, that a cure is not possible.

7.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate, with respect to PHI received from the Plan, or created, maintained, or received by Business Associate on behalf of the Plan, shall:

7.3.1.1 Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

7.3.1.2 Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the Business Associate still maintains in any form;

7.3.1.3 Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

7.3.1.4 Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at section 4 of this BAA which applied prior to termination; and

7.3.1.5 Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

7.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA.

8. MISCELLEANEOUS

8.1 No Third Party Members. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of Parties, any rights, remedies, obligations or liabilities whatsoever.

8.2 Regulatory References. A reference in this BAA to a section in the HIPAA Rules means the section as in effect or as amended.

8.3 Amendment. The Parties agree to take such action as is necessary to amend this BAA from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

8.4 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

8.5 Counterparts; Facsimile Signatures. This BAA may be executed in any number of counterparts, each of which will be deemed an original and all of which together will constitute one and the same document. This BAA may be executed and delivered by facsimile or in PDF format via email, and any such signatures will have the same legal effect as manual signatures. If a Party delivers its executed copy of this BAA by facsimile signature or email, such party will promptly execute and deliver to the other party a manually signed original if requested by the other party.

Acknowledged and agreed:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA	**COUNTY OF HUMBOLDT**
By: _____	By: Estelle Fennell
Print Name: _____	Print Name: Estelle Fennell
Title: _____	Title: Chair Board of Supervisors
Date: _____	Date: 2/14/2020