AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
BETWEEN
COUNTY OF ORANGE
AND
ADVANCED MEDICAL MANAGEMENT, INC.
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

THIS AGREEMENT is entered into this 19th day of August, 2008, which date is enumerated for the purposes of reference only, by and between the County of Orange (COUNTY), and Advanced Medical Management, Inc., a California for-profit corporation (INTERMEDIARY). This Agreement shall be administered by the County of Orange Health Care Agency (ADMINISTRATOR).

W I T N E S S E T H:

WHEREAS, COUNTY desires to assure the availability of Medical Services to all indigent persons for whom COUNTY is legally responsible pursuant to State of California (State) Law; and,

WHEREAS, COUNTY has received Coverage Initiative Funding to expand eligibility requirements for a limited number of additional indigent persons and expand scope of service benefits beyond its legal responsibility pursuant to State law; and,

WHEREAS, INTERMEDIARY, upon the terms and conditions set forth herein, has offered and was selected to act as a fiscal intermediary for the services specified herein; and,

WHEREAS, All Providers, including hospitals, physicians and clinics, upon the terms and conditions herein, will be reimbursed for Medical Services provided to certain persons; and,

WHEREAS, COUNTY has entered into a separate agreement with hospital providers for provision and reimbursement of Indigent Hospital Services (MSI Hospital Agreement); and,

WHEREAS, COUNTY has entered into a separate agreement with clinic providers for provision and reimbursement of Indigent Clinical Services (MSI Clinic Agreement); and,

WHEREAS, the parties wish to provide for equitable reimbursement of those providing Medical Services with a minimum of administrative costs; and,

WHEREAS, the parties desire to state their respective rights and responsibilities as well as those of All Providers related to providing, claiming, and reimbursing Medical Services.

NOW, THEREFORE, IT IS MUTUALLY AGREED AS FOLLOWS:

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EXHIBIT F

EXHIBIT G1-G3

REFERENCED CONTRACT PROVISIONS

Term: September 1, 2008 through February 29, 2012

"Period One" means the period September 1, 2008 through February 28, 2010

"Period Two" means the period September 1, 2009 through ~~February 28~~ April 30, 2011

"Period Three" means the period ~~September~~ November 1, 2010 through ~~February 29, 2012~~ December 31, 2011

INTERMEDIARY Maximum Obligation:

	Period One	**Period Two**	**Period Three**
	$ 1,848,816	~~$1,961,733~~ $2,179,903	~~$ 1,963,530~~ $1,527,190

MSI Program Aggregate Maximum Obligation (MSI Base Funding):

	Period One	**Period Two**	**Period Three**
Aggregate MSI Maximum Obligation:	$50,684,594	~~$51,362,782~~ $59,754,659	~~$52,351,261~~ $35,567,507
Aggregate CI Maximum Obligation:	$14,808,402	~~$14,808,402~~ $17,276,469	~~$14,808,402~~ $12,340,335
Additional CI Funding Maximum Obligation	$ 8,078,732	$ 0	$ 0
Aggregate CHIP Maximum Obligation:	$ 0	$ 0	$ 0
	$ 83,338		
Total MSI Program Aggregate Maximum Obligation:	$73,655,066	~~$66,171,184~~ $77,031,128	~~$67,159,663~~ $47,907,842

Notices to COUNTY and INTERMEDIARY:

COUNTY:	County of Orange Health Care Agency MSI Program Manager 405 W. 5th Street, 6th Floor Santa Ana, CA 92701
	County of Orange Health Care Agency MIHS Operations 405 W. 5th Street, 7th Floor Santa Ana, CA 92701
INTERMEDIARY:	Advanced Medical Management, Inc. 5000 Airport Plaza Drive, Suite 150 Long Beach, CA 90815-1260 Voice: (562) 766-2000 Fax: (562) 766-2006

INTERMEDIARY'S Insurance Coverages:

Coverage	Minimum Limits
Workers' Compensation	Statutory
Employer's Liability	$1,000,000
Comprehensive General Liability Insurance (including Loss Payee Coverage)	$5,000,000

I. ALTERATION OF TERMS

This Agreement, together with Exhibits A through Exhibit F inclusive, attached hereto and incorporated herein by reference, fully expresses all understanding of COUNTY and INTERMEDIARY with respect to and the subject matter of this Agreement, and shall constitute the total Agreement between the parties for these purposes. No addition to, or alteration of, the terms of this Agreement whether written or verbal, shall be valid unless made in writing and formally approved and executed by both parties.

II. COMPLIANCE

A. COUNTY'S Health Care Agency (HCA) has established a Compliance Program for the purpose of ensuring adherence to all rules and regulations related to federal and state health care programs.

1. ADMINISTRATOR shall provide CONTRACTOR with a copy of the relevant HCA Policies and Procedures relating to the Compliance Program.

2. CONTRACTOR shall ensure that its employees, subcontractors, interns, volunteers, and members of Board of Directors or duly authorized agents, if appropriate, ("Covered Individuals") relative to this Agreement are made aware of these Policies and Procedures.

B. CODE OF CONDUCT - Under the direction of the HCA Office of Compliance, a Code of Conduct for adherence by all HCA employees and contract providers has been developed.

1. Within thirty (30) calendar days of award of this Agreement, CONTRACTOR has the option of submitting to ADMINISTRATOR a signed acknowledgement and agreement that CONTRACTOR shall comply with the “HCA Contractor Code of Conduct” specified in subparagraph B.3. below or CONTRACTOR shall submit a copy of its Code of Conduct to ADMINISTRATOR for review and comparison to federal, state and county standards by the HCA Compliance Officer.

2. If CONTRACTOR elects to submit a copy of its Code of Conduct, HCA’s Compliance Officer shall advise CONTRACTOR of any necessary changes to CONTRACTOR’S Code of Conduct to meet minimum standards and CONTRACTOR shall either take necessary action to meet said standards or shall be asked to acknowledge and agree to the “HCA Contractor Code of Conduct” specified in subparagraph B.3. below.

3. HCA CONTRACTOR CODE OF CONDUCT - CONTRACTOR and its employees and subcontractors shall:

a. Comply with all applicable laws, regulations, rules or guidelines when providing and billing for the services specified herein.

b. Conduct themselves honestly, fairly, courteously and with a high degree of integrity in their professional dealings related to this Agreement and avoid any conduct that could reasonably be

expected to reflect adversely upon the integrity of CONTRACTOR and/or COUNTY.

c. Treat COUNTY employees, clients and other COUNTY contractors fairly and with respect.

d. Not engage in any activity in violation of this Agreement, nor engage in any other conduct which violates any applicable law, regulation, rule or guideline.

e. Take precautions to ensure that claims are prepared and submitted accurately, timely and are consistent with all applicable laws, regulations, rules or guidelines.

f. Ensure that no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind are submitted.

g. Bill only for eligible services actually rendered and fully documented and use billing codes that accurately describe the services provided.

h. Act promptly to investigate and correct problems if errors in claims or billings are discovered.

i. Promptly report to HCA'S Compliance Officer any activity that CONTRACTOR believes may violate the standards of the HCA Compliance Program, or any other applicable law, regulation, rule or guideline.

j. Promptly report to HCA'S Compliance Officer any suspected violation(s) of the HCA Contractor Code of Conduct.

k. Consult with HCA'S Compliance Officer if there are any questions or uncertainties of any Compliance Program standard or any other applicable law, regulation, rule or guideline.

4. Failure of CONTRACTOR to timely submit the acknowledgement of the HCA Contractor Code of Conduct or its own Code of Conduct shall constitute a material breach of this Agreement, and failure to cure such breach within sixty (60) calendar days of such notice from ADMINISTRATOR shall constitute grounds for termination of this Agreement as to the non-complying party.

C. CONTRACTOR shall screen all Covered Individuals employed or retained to provide services related to this Agreement to ensure that they are not designated as "Ineligible Persons", as defined hereunder. Screening shall be conducted against the General Services Administration's List of Parties Excluded from Federal Programs and the Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities.

1. Ineligible Person shall be any individual or entity who:

a. is currently excluded, suspended, debarred or otherwise ineligible to participate in the federal health care programs; or

b. has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the federal health care programs after a period of exclusion,

suspension, debarment, or ineligibility.

2. CONTRACTOR shall screen prospective Covered Individuals prior to hire or engagement. CONTRACTOR shall not hire or engage any Ineligible Person to provide services relative to this Agreement.

3. CONTRACTOR shall screen all current Covered Individuals semi-annually (January and July) to ensure that they have not become Ineligible Persons.

4. Covered Individuals shall be required to disclose to CONTRACTOR immediately any debarment, exclusion or other event that makes the Covered Individual an Ineligible Person. CONTRACTOR shall notify COUNTY immediately upon such disclosure.

5. CONTRACTOR acknowledges that Ineligible Persons are precluded from providing federal and state funded health care services by contract with COUNTY in the event that they are currently sanctioned or excluded by a federal or state law enforcement regulatory or licensing agency. If CONTRACTOR becomes aware that a Covered Individual has become an Ineligible Person, CONTRACTOR shall remove such individual from responsibility for, or involvement with, HCA business operations related to this Agreement.

D. REIMBURSEMENT STANDARDS

1. CONTRACTOR shall take reasonable precaution to ensure that the coding of health care claims and billing for same are prepared and submitted in an accurate and timely manner and are consistent with federal, state and county laws and regulations. This includes compliance with federal and state health care program regulations and procedures or instructions otherwise communicated by regulatory agencies including the Centers for Medicare and Medicaid Services or their agents.

2. CONTRACTOR shall submit no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.

3. CONTRACTOR shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, CONTRACTOR shall use only correct billing codes that accurately describe the services provided.

4. CONTRACTOR shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified.

E. COMPLIANCE TRAINING - ADMINISTRATOR shall make General Compliance Training and Provider Compliance Training, where appropriate, available to Covered Individuals.

1. CONTRACTOR shall use its best efforts to encourage completion by Covered Individuals; provided, however, that at a minimum CONTRACTOR shall assign at least one (1) designated representative to complete all Compliance Trainings when offered.

2. Such training will be made available to Covered Individuals within thirty (30) calendar

days of employment or engagement.

3. Such training will be made available to each Covered Individual annually.

4. Each Covered Individual attending training shall certify, in writing, attendance at compliance training. CONTRACTOR shall retain the certifications. Upon written request by ADMINISTRATOR, CONTRACTOR shall provide copies of the certifications.

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III. CONFIDENTIALITY

A. Each party shall make its best effort to maintain the confidentiality of all records, including billings and any audio and/or video recordings, in accordance with all applicable State and Federal codes and regulations, as they exist now or may hereafter be amended or changed.

B. Prior to providing any services pursuant to this Agreement, all INTERMEDIARY'S employees, subcontractors and members of Board of Directors or duly authorized agent shall agree, in writing, with INTERMEDIARY to use their respective best efforts to maintain, in accordance with applicable laws and regulations, the confidentiality of any and all information and records which may be obtained in the course of providing such services. The agreement shall specify that it is effective irrespective of all subsequent resignations or terminations of INTERMEDIARY'S employees, subcontractors, and members of Board of Directors or duly authorized agent.

IV. DELEGATION AND ASSIGNMENT

A. INTERMEDIARY may not delegate the obligations hereunder, either in whole or in part, without prior written consent of COUNTY, which consent shall not be unreasonably conditioned, withheld or delayed; provided, however, obligations undertaken by INTERMEDIARY pursuant to this Agreement may be carried out by means of subcontracts, provided such subcontracts are approved in writing by ADMINISTRATOR, meet the requirements of this Agreement as they relate to the service or activity under subcontract, and include any provisions that ADMINISTRATOR may reasonably require. This provision shall not be applicable to service agreements usually and customarily entered into by INTERMEDIARY to obtain or arrange for supplies, technical support, or professional services. No subcontract shall terminate or alter the responsibilities of INTERMEDIARY to COUNTY pursuant to this Agreement.

B. INTERMEDIARY may not assign the rights hereunder, either in whole or in part, without the prior written consent of COUNTY, which consent shall not be unreasonably conditioned, withheld, or

delayed. Any change in the control structure, including but not limited to, the sale or transfer of more than fifty percent (50%) of the assets or stocks of INTERMEDIARY, change to another corporate structure, including a change to a sole proprietorship, or a change in fifty percent (50%) or more of INTERMEDIARY'S directors at one time shall be deemed an assignment pursuant to this paragraph. Any attempted assignment or delegation in derogation of this paragraph shall be void.

V. FACILITIES, PAYMENTS AND SERVICES

COUNTY shall compensate INTERMEDIARY, and INTERMEDIARY agrees to provide the services, staffing, facilities, any equipment and supplies, and reports in accordance with this Agreement. INTERMEDIARY shall operate continuously throughout the term of this Agreement with at least the minimum number and type of staff which meet any applicable State requirements, and which are necessary for the provision of services hereunder.

VI. INDEMNIFICATION AND INSURANCE

A. Each party agrees to indemnify, and hold harmless the other party, its officers, agents and employees, directors, members, or shareholders from all liability, claims, losses and demands, including defense costs, whether resulting from court action or otherwise, arising out of the acts or omissions of the indemnifying party, its officers, agents, or employees, or arising out of the condition of property used in the performance of this Agreement. Each party agrees to provide the indemnifying party with written notification of any claim within thirty (30) calendar days of notice thereof, to allow for the indemnifying party control over the defense and settlement of the claim, and to cooperate with the indemnifying party in its defense.

B. Without limiting INTERMEDIARY'S indemnification, INTERMEDIARY shall pay for and maintain in force, a policy of comprehensive insurance (Policy) covering the loss of any monies paid or earned thereupon through this Agreement for services related to the MSI Program. Such policy shall be maintained during the term of the Agreement and any additional period during which INTERMEDIARY has any obligation to hold or disburse monies pursuant to this Agreement.

1. The Policy shall name COUNTY as loss payee, and shall cover the loss of monies for any reason including, but not limited to, loss by the INTERMEDIARY or any bank, through fraudulent or dishonest acts, destruction, disappearance, wrongful abstraction, counterfeiter, or forgery.

2. The Policy's limits of liability shall not be less than $5,000,000 and shall contain the following clauses:

a. "The County of Orange is a loss payee under this policy, in respect to the obligations of the named insured performed under contract with the County of Orange."

b. "This insurance shall not be canceled, limited or non-renewed until after thirty (30)

calendar days written notice has been given to County of Orange, HCA/MIHS Operations, 405 W. 5th Street, 7th Floor, Santa Ana, California 92701."

3. In the event the size of the Imprest Account specified in Exhibit E to this Agreement is increased, ADMINISTRATOR may require INTERMEDIARY to increase the Policy's limits of liability upon thirty (30) calendar days' written notice given INTERMEDIARY.

4. Certificates of insurance and endorsements evidencing the above coverages and clauses shall be mailed to COUNTY as referenced on Page 5 of this Agreement.

C. COUNTY warrants that it is self-insured or maintains policies of insurance placed with reputable insurance companies licensed to do business in the State of California which insures the perils of bodily injury, medical, professional liability, and property damage.

VII. INSPECTIONS AND AUDITS

A. ADMINISTRATOR, any authorized representative of COUNTY, any authorized representative of the State of California, the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States, or any of their authorized representatives, shall have access to any books, documents, and records, including, but not limited to, medical and patient records, of INTERMEDIARY which such persons deem reasonably pertinent to this Agreement, for the purpose of responding to a patient complaint or, conducting an audit, review, evaluation, or examination, or making transcripts during the periods of retention set forth in the Records Paragraph of Exhibit B to this Agreement. The above mentioned persons, may at all reasonable times, inspect or otherwise evaluate the services provided pursuant to this Agreement and the premises in which they are provided; provided, however, such inspections or evaluations shall not interfere with patient care.

1. ADMINISTRATOR shall provide INTERMEDIARY with at least fifteen (15) calendar days notice of such inspection or evaluation; provided, however, that the California Department of Health Care Services, or duly authorized representative, which may include COUNTY, shall be required to provide at least seventy-two (72) hours notice for its onsite reviews and inspections. Unannounced inspections, evaluations, or requests for information may be made in those situations where arrangement of an appointment beforehand is not possible or inappropriate due to the nature of the inspection or evaluation.

2. INTERMEDIARY agrees, until three (3) years after the termination of the contract between COUNTY and the California Department of Health Care Services for Coverage Initiative Funding, to permit the California Department of Health Care Services, or any duly authorized representative, to have access to, examine, or audit any pertinent books, documents, papers and records (collectively referred to as "records") related to this Agreement and to allow interviews of any employees who might

reasonably have information related to such records.

a. If this Agreement is terminated prior to the termination of the contract between COUNTY and the California Department of Health Care Services, INTERMEDIARY shall ensure records are made available for a period of three (3) years from the date the last service was rendered under this Agreement.

b. If any litigation, claim, negotiation, audit or other action involving records has been started before the expiration of the three (3) year period, the related records shall be retained until completion and resolution of all issues arising thereto or until the end of the three (3) year period, whichever is later.

B. INTERMEDIARY shall actively participate and cooperate with any person specified in subparagraph A. above in any evaluation of the services provided pursuant to this Agreement, and shall provide the above-mentioned persons adequate office space to conduct such evaluation and monitoring. Such space must be capable of being locked and secured to protect the work of said persons during the period of their evaluation.

C. AUDIT RESPONSE

1. Following an audit report, in the event of non-compliance with applicable laws and regulations governing funds provided through this Agreement, COUNTY may terminate this Agreement as provided for in the Termination Paragraph of this Agreement or may direct INTERMEDIARY to immediately implement appropriate corrective action. A plan of corrective action shall be submitted to ADMINISTRATOR in writing within thirty (30) calendar days after receiving notice from ADMINISTRATOR.

2. If the audit reveals that money is payable from one party to the other, that is, reimbursement by INTERMEDIARY to COUNTY, or payment of sums due from COUNTY to INTERMEDIARY, said funds shall be due and payable from one party to the other within sixty (60) calendar days of receipt of the audit results. If reimbursement is due from INTERMEDIARY to COUNTY, and such reimbursement is not received within said sixty (60) calendar days, COUNTY may, in addition to any other remedies, reduce any amount owed INTERMEDIARY by an amount not to exceed the reimbursement due COUNTY.

VIII. LICENSES AND LAW

A. INTERMEDIARY, its officers, agents, employees, affiliates, and subcontractors shall, throughout the term of this Agreement, maintain all necessary licenses, permits, approvals, certificates, accreditations, waivers and exemptions necessary for the provision of its services hereunder, and required by the laws, regulations, or requirements of the United States, the State of California,

COUNTY, and any other applicable governmental agencies. INTERMEDIARY shall notify ADMINISTRATOR immediately and in writing of its inability to obtain or maintain, irrespective of the pendency of an appeal, permits, licenses, approvals, certificates, accreditations, waivers and exemptions. Said inability shall be cause for termination of this Agreement.

B. INTERMEDIARY shall comply with all applicable governmental laws, regulations, or requirements as they exist now or may be hereafter amended or changed, including, but not limited to the applicable terms and conditions of the contract between COUNTY and the California Department of Health Care Services relating to the provision of services reimbursed with Coverage Initiative Funding.

C. Enforcement of Child Support Obligations

1. INTERMEDIARY agrees to furnish to ADMINISTRATOR within thirty (30) calendar days of award of the Agreement:

a. In the case of an individual, his/her name, date of birth, Social Security number, and residence address

b. In the case of an INTERMEDIARY doing business in a form other than as an individual, the name, date of birth, social security number, and residence address of each individual who owns an interest of ten percent (10%) or more in the contracting entity;

c. A certification that INTERMEDIARY has fully complied with all applicable federal and State reporting requirements regarding its employees;

d. A certification that INTERMEDIARY has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

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2. Failure of INTERMEDIARY to timely submit the data and/or certifications required by subparagraphs 1.a., 1.b., 1.c., or 1.d. above, or to comply with all Federal and State employee reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this Agreement, and failure to cure such breach within sixty (60) calendar days of notice from COUNTY shall constitute grounds for termination of this Agreement.

3. It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders, or as permitted by federal and/or state statute.

D. CONTRACTOR warrants that it shall make its best effort to fully comply with all federal and state statutes and regulations regarding the employment of aliens and others and that employees performing work under this Agreement meet the citizenship or alien status requirement set forth in federal statues and regulations. CONTRACTOR shall obtain, from all employees performing work

hereunder, all verification and other documentation of employment eligibility status required by federal or state statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, 8 U.S.C. § 1324 et seq., as they currently exist and as they may be hereafter amended. CONTRACTOR shall retain all such documentation for all covered employees for the period prescribed by the law.

IX. MAXIMUM OBLIGATION

A. The Maximum Obligation of COUNTY for services provided by INTERMEDIARY in accordance with this Agreement for Period One, Period Two and Period Three are as specified on Page 4 of this Agreement.

B. The Aggregate Maximum Obligation of COUNTY for MSI Program services provided in accordance with all Agreements for the Medical Services Initiative Program is as specified on Page 4 of this Agreement. This specific Agreement with INTERMEDIARY is only one of several agreements to which this Aggregate Maximum Obligation applies. It is understood by the parties that reimbursement to All Providers will only be a fraction of this Aggregate Maximum Obligation.

C. The separate and total Maximum Obligations for each Period on Page 4 shall not apply to funds which may be transferred into the Holding Account and paid by COUNTY to INTERMEDIARY for distribution to MSI Program providers in accordance with Paragraph XII. of Exhibit E to this Agreement.

D. ADMINISTRATOR may increase or decrease the Aggregate MSI, the Aggregate CI, Additional CI Funding, and the Aggregate CHIP Maximum Obligations, provided the total of any changes to these Aggregate Maximum Obligations does not exceed the Total MSI Program Aggregate Maximum Obligation of COUNTY, as specified on Page 4 of this Agreement.

X. NONDISCRIMINATION

A. EMPLOYMENT

1. During the performance of this Agreement, INTERMEDIARY shall not unlawfully discriminate against any employee or applicant for employment because of their ethnic group identification, race, religion, ancestry, color, creed, sex, marital status, national origin, age (40 and over), sexual preference, medical condition, or physical or mental disability. INTERMEDIARY shall warrant that the evaluation and treatment of employees and applicants for employment is free from discrimination in the areas of: employment, upgrade, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rate of pay or other forms of compensation; and selection for training, including apprenticeship. There shall be posted in conspicuous places, available to employees and

applicants for employment, notices from ADMINISTRATOR and/or the United States Equal Employment Opportunity Commission setting forth the provisions of this Equal Opportunity Clause.

2. All solicitations or advertisements for employees placed by or on behalf of INTERMEDIARY and its subcontractors shall state that all qualified applicants will receive consideration for employment without regard to their ethnic group identification, race, religion, ancestry, color, creed, sex, marital status, national origin, age (40 and over), sexual preference, medical condition, or physical or mental disability. Such requirement shall be deemed fulfilled by use of the phrase "an equal opportunity employer."

3. INTERMEDIARY shall give written notice of its obligations under this Equal Opportunity Clause to each labor union with which INTERMEDIARY has a collective bargaining agreement.

4. Upon a finding of discrimination by the Equal Opportunity Commission, Department of Fair Employment and Housing, or a court of competent jurisdiction, and after exhaustion of any and all appeals, this Agreement may be canceled, terminated, or suspended, in whole or in part, and INTERMEDIARY may be declared ineligible for future contracts.

B. SERVICES, BENEFITS, AND FACILITIES - INTERMEDIARY shall not discriminate in the provision of services, the allocation of benefits, or in the accommodation in facilities on the basis of ethnic group identification, race, religion, ancestry, creed, color, sex, marital status, national origin, age (40 and over), sexual preference, medical condition, or physical or mental disability in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C.A. §2000d and all other pertinent rules and regulations promulgated pursuant thereto, and as otherwise provided by State law and regulations, as all may now exist or be hereafter amended or changed.

C. PERSONS WITH DISABILITIES - INTERMEDIARY agrees to comply with the provisions of §504 of the Rehabilitation Act of 1973 (29 U.S.C.A. 794 et seq., as implemented in 45 CFR 84.1 et seq.), and the Americans with Disabilities Act of 1990 (42 U.S.C.A. 12101, et seq.), pertaining to the prohibition of discrimination against qualified persons with disabilities, as they exist now or may be hereafter amended together with succeeding legislation.

D. RETALIATION - Neither INTERMEDIARY, nor its employees or agents, shall intimidate, coerce, or take adverse action against any person for the purpose of interfering with rights secured by Federal or State laws, or because such person has filed a complaint, certified, assisted or otherwise participated in an investigation, proceeding, hearing or any other activity undertaken to enforce rights secured by Federal or State law.

XI. NOTICES

A. Unless otherwise specified in this Agreement, all notices, claims, correspondence, reports and/or statements authorized or required by this Agreement shall be effective:

1. When delivered personally; or

2. Three (3) calendar days from the date sent by certified or registered mail in the United States Postal Service, return receipt requested, postage prepaid, or first class postage prepaid, and addressed as specified on Page 4 of this Agreement; or

3. When faxed, transmission confirmed; or

4. When sent by electronic mail; or

5. When delivered by U.S. Postal Service Express Mail, Federal Express, United Parcel Service or other expedited delivery service.

B. Termination Notices shall be addressed as specified on Page 4 of this Agreement and shall be effective when faxed, transmission confirmed, or when delivered by U.S. Postal Service Express Mail, Federal Express, United Parcel Service, or other expedited delivery services.

C. Any party to this Agreement may change the address at which it wishes to receive notice by giving notice to the other party in the manner set forth above. For purposes of this Agreement, any notice to be provided by COUNTY may be given by ADMINISTRATOR.

XII. SEVERABILITY

If a court of competent jurisdiction declares any provision of this Agreement or application thereof to any party, person or circumstances to be invalid or if any provision of this Agreement contravenes any Federal, State, or County statute, ordinance, or regulation, the remaining provisions of this Agreement or the application thereof shall remain valid, and the remaining provisions of this Agreement shall remain in full force and effect, and to that extent the provisions of the Agreement are severable, unless to do so would defeat an essential business purpose of this Agreement.

XIII. STATUS OF PARTIES

Each party is, and shall at all times be deemed to be, independent and shall be wholly responsible for the manner in which it performs the services required of it by the terms of this Agreement. Each party is entirely responsible for compensating staff and consultants employed by that party. This Agreement shall not be construed as creating the relationship of employer or employee, or principal and agent, between COUNTY and INTERMEDIARY or of either party's employees, agent, consultants or subcontractors. Each party assumes exclusively the responsibility for the acts of its employees, agents, consultants, or subcontractors as they relate to the services to be provided during the course and scope of their employment.

XIV. TERM

A. The term of this Agreement shall commence and terminate as specified on Page 4 of this Agreement; provided, however, the parties, and All Providers, as defined in Exhibit B to this Agreement, submitting claims for reimbursement pursuant to this Agreement, shall continue to be obligated to comply with the requirements and perform the duties specified in this Agreement. Such duties include, but are not limited to, obligations with respect to claims processing, reimbursement, reporting, indemnification, audits, and accounting.

B. Any duties pursuant to this Agreement to deposit monies or make any payment shall not be due until ten (10) calendar days after execution of this Agreement by the parties.

C. Any administrative duty or obligation to be performed pursuant to this Agreement on a weekend or holiday may be performed on the next regular business day.

XV. TERMINATION

A. Neither party may terminate this Agreement, except for material breach of this Agreement.

B. Unless otherwise specified in this Agreement, either party may terminate this Agreement upon thirty (30) calendar days written notice given the other for material breach of the Agreement; provided, however, the allegedly breaching party has been given notice setting forth the facts underlying the claim that breach of this Agreement has occurred, and has failed to cure the alleged breach within thirty (30) calendar days. Reimbursement to INTERMEDIARY shall be adjusted to an amount consistent with the reduced term of the Agreement.

C. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service or employment deemed resulting, directly or indirectly, from Acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or suppliers, vandalism, strikes or other work interruptions by a party's officers, agents, employees, affiliates, or subcontractors, or any similar cause beyond the reasonable control of any party to this Agreement. However, all parties shall make good faith efforts to perform under this Agreement in the event of any such circumstance.

D. If a court of competent jurisdiction determines that Eligible Persons are fully covered by the State Medi-Cal Program, or any other State program, all obligations and rights related to such persons under this Agreement shall be suspended while such court order is effective, and COUNTY shall have the right to terminate this Agreement upon thirty (30) calendar days prior written notice and without any cure period. In the event of any suspension or termination pursuant to this Agreement, deposits of Funding and reimbursement to any party shall be adjusted to reflect the obligations and duties thereby reduced.

E. CONTINGENT FUNDING

1. Any obligation of COUNTY under this Agreement shall be contingent upon the following:

a. The continued availability of sufficient State and County funds for reimbursement of COUNTY'S expenditures, and

b. Inclusion of sufficient funding for the services hereunder in the applicable budget approved by the Board of Supervisors.

2. In the event such funding is subsequently reduced or terminated:

a. COUNTY may reduce MSI Base Funding and its obligations to make payments under this Agreement upon thirty (30) calendar days written notice to INTERMEDIARY.

b. COUNTY may reduce Coverage Initiative Funding and its obligations to make payments for services funded through the Coverage Initiative under this Agreement upon thirty (30) calendar days written notice to INTERMEDIARY.

F. In the event that this Agreement is terminated prior to the completion of the term as specified on Page 4 of this Agreement, ADMINISTRATOR may, at its sole discretion, reduce the Aggregate Maximum Obligation of this Agreement in an amount consistent with the reduced term of the Agreement.

G. After receiving or providing a Notice of Termination, INTERMEDIARY shall do the following:

1. Comply with termination instructions provided by ADMINISTRATOR in a manner which is consistent with recognized standards of quality of care and prudent business practice.

2. Until the date of termination, continue to provide the same level of service required by this Agreement.

3. Until the date of termination, continue to be reimbursed by COUNTY for provision of services specified herein.

4. To the extent services are terminated, cancel outstanding agreements covering procurement of services, materials, supplies, equipment, and miscellaneous items. With respect to these canceled agreements, INTERMEDIARY shall submit a written plan for settlement of all outstanding liabilities and all claims arising out of such cancellation of agreements which shall be subject to written approval of ADMINISTRATOR.

H. The rights and remedies of COUNTY with respect to termination of this Agreement due to a violation of the Health Insurance Portability and Accountability Act are as set forth in Exhibit A to this Agreement and are in addition to the rights and remedies of COUNTY provided in this Termination paragraph.

I. The rights and remedies of COUNTY and INTERMEDIARY provided in this Termination Paragraph shall not be exclusive, and are in addition to any other rights and remedies provided by law or

under this Agreement.

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XVI. THIRD PARTY BENEFICIARY

No party hereto intends that this Agreement shall create rights hereunder in third parties including, but not limited to, any subcontractors or any patients provided services hereunder.

XVII. WAIVER OF DEFAULT OR BREACH

Waiver by either party of any default by any other party shall not be considered a waiver of any other or subsequent default. Waiver by either party of any breach by any other party of any provision of this Agreement shall not be considered a waiver of any other or subsequent breach. Waiver by any party of any default or any breach by any other party shall not be considered a modification of the terms of this Agreement.

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IN WITNESS WHEREOF, the parties have executed this Agreement, in the County of Orange, State of California.

ADVANCED MEDICAL MANAGEMENT, INC.

DATE: _____

PRINTED NAME: _____

BY: _____

TITLE: _____

DATE: _____

PRINTED NAME: _____

BY: _____

TITLE: _____

COUNTY OF ORANGE

BY: _____
CHAIRMAN OF THE BOARD
OF SUPERVISORS

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIR OF THE BOARD PER G.C. SEC. 25103, RESO 79-1535
ATTEST:

BY: _____
DARLENE J. BLOOM
Clerk of the Board of Supervisors
of Orange County, California

APPROVED AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

BY:_____ DATED:_____

DEPUTY

If Contractor is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, Chief Executive Officer, the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer. If the Agreement is signed by one (1) authorized individual only, a copy of the corporate resolution or by-laws whereby the board of directors has empowered said authorized individual to act on its behalf by his or her signature alone is required.

EXHIBIT A
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
BUSINESS ASSOCIATE TERMS AND CONDITIONS
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

I. GENERAL PROVISIONS

A. The parties agree that the terms used, but not otherwise defined, in this Exhibit A to the Agreement shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Health Information, 45 Code of Federal Regulations (CFR), Parts 160 and 164, otherwise known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, as it may exist now or be hereafter amended.

B. It is agreed by both parties that INTERMEDIARY is a Business Associate of COUNTY for the purposes of this Agreement.

C. It is understood by both parties that INTERMEDIARY is not a Covered Entity, as defined by HIPAA, and is responsible for complying with said regulations for purposes of safeguarding any Protected Health Information (PHI) generated by INTERMEDIARY for its own purposes.

D. It is understood by both parties that the Privacy Rule does not pre-empt any State and/or Federal laws, rules or regulations that impose more stringent requirements with respect to confidentiality of client information.

II. OBLIGATIONS AND ACTIVITIES OF INTERMEDIARY AS BUSINESS ASSOCIATE

A. INTERMEDIARY agrees not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

B. INTERMEDIARY agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement.

C. INTERMEDIARY agrees to mitigate, to the extent practicable, any harmful effect that is known to INTERMEDIARY of a use or disclosure of PHI by INTERMEDIARY in violation of the requirements of this Agreement.

D. INTERMEDIARY agrees to report to COUNTY within ten (10) calendar days any use or disclosure of PHI not provided for by this Agreement of which INTERMEDIARY becomes aware.

E. INTERMEDIARY agrees to ensure that any agent, including a subcontractor, to whom it

provides PHI received from COUNTY, or PHI created or received by INTERMEDIARY on behalf of
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COUNTY, agrees to the same restrictions and conditions set forth in the business associate provisions of the Privacy Rule that apply through this Agreement.

F. INTERMEDIARY agrees to provide access, within fifteen (15) calendar days of receipt of a written request by COUNTY, to PHI in a Designated Record Set, to COUNTY or, as directed by COUNTY, to an individual client in order to meet the requirements under 45 CFR Section 164.524.

G. INTERMEDIARY agrees to make any amendment(s) to PHI in a Designated Record Set that COUNTY directs or agrees to pursuant to 45 CFR Section 164.526 at the request of COUNTY or an individual client, within thirty (30) days of receipt of said request by COUNTY.

H. INTERMEDIARY agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by INTERMEDIARY on behalf of, COUNTY available to COUNTY and the Secretary of the Department of Health and Human Services, in a time and manner as determined by COUNTY, or as designated by the Secretary, for purposes of the Secretary determining COUNTY'S compliance with the Privacy Rule.

I. INTERMEDIARY agrees to document any disclosures of PHI and information related to such disclosures as would be required for COUNTY to respond to a request by an individual client for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

J. INTERMEDIARY agrees to provide COUNTY or an individual client, as directed by COUNTY, in a time and manner to be determined by COUNTY, that information collected in accordance with subparagraph II.I. of this Exhibit A to the Agreement, in order to permit COUNTY to respond to a request by an individual client for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

III. SECURITY RULE

A. Security. INTERMEDIARY shall establish and maintain appropriate administrative, physical and technical safeguards that reasonably and appropriately protects the confidentiality, integrity and availability of electronic protected health information. INTERMEDIARY shall follow generally accepted system security principles and the requirements of the final HIPAA rule pertaining to the security of health information.

B. Agents and Subcontractors. INTERMEDIARY shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect that information

C. Security Incidents. INTERMEDIARY shall report any security incident of which it becomes

aware to Client. For purposes of this agreement, a "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations. This does not include trivial incidents that occur on a daily basis, such as scans, "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by INTERMEDIARY.

IV. PERMITTED USES AND DISCLOSURES BY INTERMEDIARY

Except as otherwise limited in this Agreement, INTERMEDIARY may use or disclose PHI to perform functions, activities, or services for, or on behalf of, COUNTY as specified in this Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by COUNTY or the Minimum Necessary policies and procedures of COUNTY.

V. OBLIGATIONS OF COUNTY

A. COUNTY shall notify INTERMEDIARY of any limitation(s) in COUNTY'S notice of privacy practices in accordance with 45 CFR Section 164.520, to the extent that such limitation may affect INTERMEDIARY'S use or disclosure of PHI.

B. COUNTY shall notify INTERMEDIARY of any changes in, or revocation of, permission by an individual client to use or disclose PHI, to the extent that such changes may affect INTERMEDIARY'S use or disclosure of PHI.

C. COUNTY shall notify INTERMEDIARY of any restriction to the use or disclosure of PHI that COUNTY has agreed to in accordance with 45 CFR Section 164.522, to the extend that such restriction may affect INTERMEDIARY'S use or disclosure of PHI.

D. COUNTY shall not request INTERMEDIARY to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by COUNTY.

VI. BUSINESS ASSOCIATE TERMINATION

A. In addition to the rights and remedies provided in the Termination paragraph of this Agreement, upon COUNTY'S knowledge of a material breach by INTERMEDIARY of the requirements of this Exhibit A to the Agreement, COUNTY shall:

1. Provide an opportunity for INTERMEDIARY to cure the breach or end the violation and terminate this Agreement if INTERMEDIARY does not cure the breach or end the violation within thirty (30) calendar days; or

2. Immediately terminate this Agreement if INTERMEDIARY has breached a material term of this Exhibit A to the Agreement and cure is not possible; or

3. If neither termination nor cure is feasible, COUNTY shall report the violation to the Secretary of the Department of Health and Human Services.

B. Upon termination of this Agreement, all PHI provided by COUNTY to INTERMEDIARY, or

created or received by INTERMEDIARY on behalf of COUNTY, shall either be destroyed or returned to COUNTY as provided in the Termination paragraph of this Agreement, and in conformity with the Privacy Rule. This provision shall apply to PHI that is in the possession of subcontractors or agents of INTERMEDIARY. If it is infeasible to return or destroy PHI, INTERMEDIARY shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as INTERMEDIARY maintains such PHI.

EXHIBIT B
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

I. DEFINITIONS

The parties agree to the following terms and definitions, and to those terms and definitions that, for convenience, are set forth elsewhere in this Agreement.

A. "Administrative Days" means those days of acute inpatient care provided to an inpatient who is appropriate for, and awaiting, placement at a lower level of care.

B. "All Providers" or "Providers" means Physicians, Contracting Hospitals, Contracting Clinics, Receiving Hospitals and Other Providers.

C. "Allowable Charges" or "Allowable Costs" means

1. For Physicians and Clinics, including Contracting Clinics, means a maximum of one hundred thirty percent (130%) of the national Medicare Resource Based Relative Value Scale (RBRVS), less the required co-payment as specified herein, for charges that are determined by INTERMEDIARY to be attributable to reimbursable services to Eligible Persons in accordance with all Agreements for the MSI Program.

2. For Contracting Hospitals means a maximum of one hundred percent (100%) of the Contracting Hospital's actual costs according to the most recent Hospital Annual Financial Data report issued by the Office of Statewide Health Planning and Development (OSHPD), as calculated using a cost-to-charge ratio, for the charges that are determined by INTERMEDIARY to be attributable to reimbursable services to Eligible Persons in accordance with all Agreements for the MSI Program.

D. "Case Management Clinic" means a Contracting Clinic that has entered into a separate agreement with ADMINISTRATOR for the purpose of accepting MSI Patients transferred or diverted from Contracting Hospital emergency departments in accordance with Paragraph II.D of Exhibit B to the MSI Clinic Agreement.

E. "CI Claimable Services" means Medical Services provided to all persons meeting CI Eligibility as specified in Paragraph II.B. of Exhibit D to this Agreement and COUNTY'S contract with Department. CI Claimable Services may also include Medical Services provided on or after September 1, 2008 to MSI Eligible Persons who also meet all CI Eligibility requirements set forth in Paragraph II.B. of Exhibit D to this Agreement and COUNTY'S contract with Department.

F. "Clinic" means any provider registered with the MSI Program that is not considered to be a

Contracting Clinic or a Physician.

G. "Clinic Claim(s)" means a claim submitted by a Contracting Clinic for reimbursement of Medical Services.

H. "Clinic Funding" means the amount of MSI Base Funding identified by COUNTY for reimbursement of Medical Services provided by Contracting Clinics.

I. "Consultation" means the rendering by a specialty physician of an opinion or advice, or prescribing treatment by telephone, when determined to be medically necessary by the on-duty emergency department physician and specialty physician, as appropriate. Such Consultation includes review of the patient's medical record, and the examination and treatment of the patient in person, when appropriate, by a specialty physician who is qualified to give an opinion or render treatment necessary to stabilize the patient.

J. "Continuously" means without interruption, twenty-four (24) hours per day throughout the term of this Agreement.

K. "Contracting Clinic" means a Clinic that has executed a Clinic Services for the Medical Services Initiative Program Agreement with COUNTY for specific services provided by clinics.

L. "Contracting Hospital" means a hospital that has executed a Hospital Services for the Medical Services Initiative Program Agreement with COUNTY for corresponding services provided by hospitals.

M. "Contract Rate" means:

1. For Hospitals means one hundred percent (100%) of Points for Services provided by Contracting Hospitals or other such reimbursement system as may be agreed upon pursuant to the MSI Hospital Agreement.

2. For Other Providers~~, except those providing Dental Services,~~ means:

a. ~~o~~One hundred percent (100%) of the National Medicare Resource Based Relative Value Scale (RBRVS) or other reimbursement system as may be agreed upon pursuant to this Agreement, for services provided by Physicians.

b. ~~, and the~~The applicable National Medicare Rate for services claimed by providers of ~~home health services and~~ durable medical equipment.

c. ~~providers; the~~The applicable Medi-Cal Rate for ambulance services.

d. The applicable Medi-Cal Rate or other reimbursement system as may be agreed upon pursuant to this Agreement for home health services.

e. For pharmacy charges claimed through INTERMEDIARY:

1) For the period September 1, 2008 through August 31, 2009, ~~; and pharmacy services~~ at the rates determined by COUNTY'S pharmacy benefits manager.

2) For the period September 1, 2009 through June 30, 2011, ASP + 6%. Claims

containing pharmaceutical codes that do not have ASP pricing will be paid at AWP – 16% (brand) and AWP – 60% (generic).

3) Pharmaceuticals related to home health services claims shall be paid at AWP – 16% (brand) and AWP – 60% (generic).

f. One hundred percent (100%) of the State Medi-Cal (Denti-Cal) rates for providers of Dental Services.

g. Where applicable, By Report, Unlisted procedures will be reimbursed at 35% of billed charges.

~~3. For providers of dental services, means 100% of State Medi-Cal (Denti-Cal) rates for those services.~~

N. "Coverage Initiative" or "CI" means funding provided through COUNTY'S contract with Department for expanded health care coverage including increasing the number of MSI Eligibles who are provided Medical Services, including preventative services and early intervention.

O. "Dental Funding" means the amount MSI Base Funding identified by COUNTY specifically for the reimbursement of Dental Services as set forth in Exhibit C to this Agreement.

P. "Dental Services" means Medical Services relating to or used on the teeth necessary to protect life, prevent significant disability, or prevent serious deterioration of health. As result of CI Funding, Dental Services may also include preventive services and early intervention as set forth in Exhibit C to this Agreement.

Q. "Department" means the California Department of Health Care Services.

R. "Emergency Service" means a Basic Emergency Medical Service, or a Comprehensive Emergency Medical Service, as provided for in Title 22, Sections 70411 et seq.

S. "Emergency Services and/or Care" means lawfully provided medical screening, examination, and evaluation by a physician, or other physician-supervised personnel in a hospital to determine if an emergency medical condition exists, and includes treatment necessary to relieve the condition; provided, however, such treatment shall be within the capabilities required of the hospital as a condition of its emergency medical services permit, on file with the Office of Statewide Health Planning and Development.

T. "Final Settlement" means the final reimbursement to All Providers, as specified in Paragraph XI. of Exhibit E to this Agreement.

U. "Fiscal Year" or "FY" means the period commencing July 1 and ending June 30.

V. "Funds" means any payments, transfers, or deposits made by COUNTY, and any refunds, repayments, adjustments, earned interest or other payments made by, or recovered from All Providers, patient, third-party, or other entity as the result of any duty arising from this Agreement.

W. "General Relief" means the cash assistance program approved by COUNTY'S Board of

Supervisors for needy persons who do not qualify for other cash assistance programs.

X. "Hospital Funding" means the amount of MSI Base Funding identified by COUNTY for reimbursement of Medical Services provided by Contracting Hospitals.

Y. "Maintenance of Effort" or "MOE" means the minimum amount non-federal MSI funding required during each Program Year, in accordance with COUNTY'S contract with Department, to maintain the same level of MSI Funding that was actually expended for the MSI Program during FY 2006-07.

Z. "Medical Service(s)" means a medical service necessary to protect life, prevent significant disability, or prevent serious deterioration of health. As a result of CI Funding, Medical Services may also include preventative services and early intervention. Guidelines for Reimbursable Medical Services are set forth in Exhibit C to this Agreement.

AA. "MSI" means Medical Services Initiative

AB."MSI Clinic Agreement" means the Agreement between the COUNTY and Contracting Clinics for Clinic Services for the Medical Services Initiative Program dated August 19, 2008.

AC."MSI Eligible"or "Eligible Person," means, in accordance with Exhibit D to this Agreement, an adult, legal resident between and including the ages of twenty-one (21) and sixty-four (64) years who lacks sufficient financial resources to pay for Medical Services, who does not meet federal linkage requirements for Medi-Cal Eligibility, and who completes the MSI eligibility process and meets the eligibility standards set forth in Title 22 of the California Code of Regulations (Title 22) and as established by the County and described in this Agreement

AD. "MSI Hospital Agreement" means the Agreement between COUNTY and Contracting Hospitals for Hospital Services for the Medical Services Initiative Program dated August 19, 2008.

AE. "MSI Patient" means a person who is either MSI Eligible or MSI Pending.

AF. "MSI Pending" means an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years who lacks sufficient financial resources to pay for Hospital Services, who does not meet federal linkage requirements for Medi-Cal eligibility, and who has completed an MSI Eligibility application which has been submitted for approval.

AG. "MSI Program" means all hospital services, physician services, administrative services, and other non-hospital services for which reimbursement is authorized by this Agreement and all other agreements for the MSI Program.

AH. "Non-Contracting Hospital" means any hospital that has not executed a Hospital Services for the Medical Services Initiative Program Agreement with COUNTY.

AI. "On-Call Physician" means a physician available for medical consultation to Emergency Services staff by telephone and, when jointly determined to be medically necessary by the On-Call and the on-duty Emergency Service physicians, to personally examine and treat the patient.

AJ. "Other Provider" means a laboratory, urgent care center, imaging center, ambulance operator, home health services provider, or a supplier of durable medical equipment.

AK. "Outpatient Funding" the amount of MSI Base Funding identified by COUNTY for reimbursement of Medical Services provided by Other Providers.

AL. "Physician(s)" means any licensed medical doctor registered with the MSI Program.

AM. "Physician Claim" means a claim submitted by a Physician or Clinic for reimbursement of Medical Services..

AN. "Physician Funding" means the amount of MSI Base Funding identified by COUNTY for reimbursement of Medical Services provided by Physicians and Clinics.

AO. "Prior Agreement" means the Agreement between COUNTY and Advanced Medical Management, Inc., dated July 1, 2006, for the provision of Fiscal Intermediary Services for the Medical Services for Indigents Program.

AP. "Prior Clinic Agreement" means the Agreement between COUNTY and Contracting Clinics dated July 1, 2006, for the provision of Clinic Services for the Medical Services for Indigents Program.

AQ. "Program Year" means:

1. For Period One, September 1, 2008 through August 31, 2009
2. For Period Two, September 1, 2009 through October 31, 2010
3. For Period Three, November 1, 2010 through June 30, 2011. ~~the period commencing September 1 and ending August 31.~~

AR. "Qualified Clinic(s)" means a fully licensed community clinic or federally qualified health center that has been licensed by the State of California or the Federal Government, has provided services to MSI eligible patients for twelve consecutive months, and has received eligibility identification training by the Hospital Association of Southern California (HASC), Orange County office or by any other means approved, in writing, by ADMINSTRATOR.

AS. "Quarter" means:

1. For Periods One and Two, a three (3) month period beginning September 1, December 1, March 1 or June 1. The last Quarter for Period Two will be September 1, 2010 through October 31, 2010.~~; e.g., Fourth Quarter means the period covering June, July, and August.~~

2. For Period Three:
   a. Quarter 1 = November 1, 2010 through December 31, 2010
   b. Quarter 2 = January 1, 2011 through March 31, 2011
   c. Quarter 3 = April 1, 2011 through June 30, 2011

AT. "Receiving Hospital" means a hospital that has entered into a separate agreement with ADMINISTRATOR for the purpose of accepting MSI Patients transferred or diverted from Referring Hospital in accordance with the MSI Hospital Agreement. Said MSI Patients shall not be considered

Transfer Patients.

AU. "Recovery Accounts" means separate hospital, physician, ancillary services, and administrative accounts for monies recovered by INTERMEDIARY from Contracting Hospitals, Receiving Hospitals, Other Providers, or third party payors.

AV. "Skilled Nursing Facility (SNF)" means a health facility or distinct part of a hospital which provides, under a separate agreement with COUNTY, continuous skilled nursing and supportive care to MSI Eligibles in lieu of acute hospitalization.

AW. "Special Permit Medical Service" means a burn center service, cardiovascular surgery service, radiation therapy service, trauma center service, renal transplant center service, acute psychiatric service, or a service provided by a hospital with a special rehabilitation unit licensed in accordance with appropriate laws and, if applicable, with Section 70351 et seq. of Title 22. Special Permit Medical Service shall also include such types or kinds of transfers as may be approved in writing by ADMINSTRATOR.

AX. "Special Permit Transfer" means a MSI Patient, who needs a Special Permit Medical Service that is not available from a Hospital, which another Hospital elects to accept for treatment.

AY. "Specialized Receiving Hospital" means any Contracting Hospital or Non-Contracting Hospital that has identified specific services it can provide; is willing to accept additional MSI Eligibles requiring these specific services from other Contracting Hospitals, and; has entered into a separate agreement with ADMINISTRATOR for the purpose of accepting said MSI Eligibles in accordance with Paragraph II.F of Exhibit A to the MSI Hospital Agreement. Said MSI Eligibles shall not be considered Transfer Patients.

AZ. "Third Party-Covered Claim" means a claim for reimbursement of Medical Services, which services are covered, at least in part, by a non-COUNTY third party payor.

BA. "Transfer Patient" means a person accepted by a Contracting Hospital, or transferred by a hospital to another hospital or health facility.

BB. "Utilization Management Department" or "UMD" means the COUNTY contracted staff responsible for the coordination of services as well as the concurrent and retrospective utilization review of the medical appropriateness, level of care, and utilization of all services provided to MSI Patients by All Providers per the current MSI Utilization Management Agreement.

BC. "Medical Home/Primary Care Provider" means a Physician or Contracting Clinic that coordinates a cooperative team of healthcare professionals, takes collective responsibility for the care provided to the MSI Patient, and arranges for appropriate care with other qualified providers as needed.

II. PHYSICIAN, CLINIC AND OTHER PROVIDER OBLIGATIONS

A. Physicians, Clinics and Other Providers billing for Medical Services for which reimbursement

is provided through this Agreement, shall provide Medical Services to all indigent persons covered by this Agreement presenting for treatment. As a condition of reimbursement for Medical Services provided by Physicians, Clinics and Other Providers to MSI Eligibles, Physicians, Clinics and Other Providers shall comply with this Agreement, including Exhibit E hereto. Claims for such services shall be processed and reimbursed by INTERMEDIARY from the appropriate funding category in accordance with Paragraph IV of Exhibit B to this Agreement. ADMINISTRATOR may direct INTERMEDIARY to withhold or delay payment due any Physician, Clinic or Other Provider for failure to comply with the terms of this Agreement.

1. Reimbursement provided through this Agreement shall be payment of last resort. Physicians, Clinics and Other Providers shall bill and attempt collection of third-party or primary other insurance (POI) covered claims to the full extent of such coverage and, upon submission of any claim, shall submit to INTERMEDIARY, proper documentation demonstrating compliance with this requirement.

2. Acceptance by Physician, Clinic and Other Providers of reimbursement made by INTERMEDIARY for services provided in accordance with this Agreement shall be deemed satisfaction in full, with respect to the COUNTY'S obligations for the services for which payment was made, except as follows:

a. Claims covered by any third-party, primary, or other insurance or a third-party settlement, including those received by or on behalf of an MSI Patient. Physician, Clinic and Other Providers shall attempt to bill and collect to the full extent of coverage those claims covered by all known third-party, primary, or other insurance or third-party payors. If Physician, Clinic and Other Providers becomes aware of any third-party, primary, or other insurance or a third-party settlement, including those received by or on behalf of an MSI Patient after reimbursement is made by INTERMEDIARY, nothing herein shall prevent Physician, Clinic and Other Providers from pursuing reimbursement from these sources; provided, however, that Physician, Clinic and Other Providers shall comply with Paragraph VII.G. of Exhibit E to this Agreement. Nothing in this paragraph shall prohibit Physician, Clinic and Other Providers from applying any unreimbursed portion of Physician, Clinic and Other Providers' charges toward Physician, Clinic and Other Providers' charity and write-off policy."

b. Co-Payments

1) Effective September 1, 2009, Physician shall collect, from MSI Patients, a five dollar ($5.00) co-payment for any or all Medical Services provided by Physician. Inability of Physician to collect said co-payment shall not be a barrier to care for MSI Patients presenting for Medical Services; however, Physician, may pursue such payment from the MSI Patients after care is provided. Said co-payments, whether or not they are collected from the MSI Patient by Physician, shall be deducted from payments otherwise provided in accordance with this Agreement.

2) Clinics and/or Other Providers may collect from MSI Patients, as directed by ADMINISTRATOR, a co-payment in an amount determined by ADMINISTRATOR for any or all Medical Services provided by Clinics and/or Other Providers. Inability of Clinics and/or Other Providers to collect said co-payment shall not be a barrier to care for MSI Patients presenting for Medical Services; however, Clinics and/or Other Providers, may pursue such payment from the MSI Patients after care is provided. Said co-payments, whether or not they are collected from the MSI Patient by Clinics and/or Other Providers shall be deducted from payments otherwise provided in accordance with this Agreement.

3) ADMINISTRATOR may modify co-payment amounts, or delete the requirement for a co-payment, upon thirty (30) days notice to Physician, Clinics, and/or Other Providers.

B. All Providers shall make their best efforts to provide services pursuant to this Agreement in a manner that is culturally and linguistically appropriate for the population(s) served. All Providers shall maintain documentation of such efforts which may include, but not be limited to: records of participation in COUNTY-sponsored or other applicable training; recruitment and hiring policies and procedures; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged.

C. All Providers shall not conduct any proselytizing activities, regardless of funding sources, with respect to any person who has received services under the terms of this Agreement. Further, All Providers agree that the funds provided hereunder shall not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

D. ADMINISTRATOR, any authorized representative of COUNTY including INTERMEDIARY, any authorized representative of the State of California, the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States, or any of their authorized representatives, shall have access to any books, documents, and records, including, but not limited to, medical and patient records, of Physician, Clinic or Other Providers which such persons deem reasonably pertinent to this Agreement, for the purpose of responding to a patient complaint or, conducting an audit, review, evaluation, or examination, or making transcripts during the periods of retention set forth in Paragraph II.D. below of this Exhibit B to this Agreement. The above mentioned persons, may at all reasonable times, inspect or otherwise evaluate the services provided pursuant to this Agreement and the premises in which they are provided; provided, however, such inspections or evaluations shall not interfere with patient care.

1. These audits, reviews, evaluations, or examinations may include, but are not limited to, the following:

a. Level and quality of care, including the necessity and appropriateness of the services provided.

b. Financial records when determined necessary to protect public funds.

c. Internal procedures for assuring efficiency, economy, and quality of care.

d. Grievances relating to medical care, and their disposition, or other types of complaints or problems.

2. ADMINISTRATOR shall provide Physician, Clinic or Other Provider with at least fifteen (15) days written prior notice of such inspection or evaluation; provided, however, that Department, or duly authorized representative, which may include COUNTY, shall be required to provide at least seventy-two (72) hours notice for its onsite reviews and inspections. Unannounced inspections, evaluations, or requests for information may be made in those situations where arrangement of an appointment beforehand is not possible or inappropriate due to the nature of the inspection or evaluation.

3. Physician, Clinic and Other Provider agree, until three (3) years after the termination of the contract between COUNTY and the California Department of Health Care Services for Coverage Initiative Funding, to permit the California Department of Health Care Services, or any duly authorized representative, to have access to, examine, or audit any pertinent books, documents, papers and records (collectively referred to as "records") related to this Agreement and to allow interviews of any employees who might reasonably have information related to such records.

a. If this Agreement is terminated prior to the termination of the contract between COUNTY and the California Department of Health Care Services, Physician, Clinic and Other Provider shall ensure records are made available for a period of three (3) years from the date the last service was rendered under this Agreement.

b. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the three (3) year period, the related records shall be retained until completion and resolution of all issues arising there from or until the end of the three (3) year period, whichever is later.

E. Physician, Clinic and Other Provider shall actively participate and cooperate with any person specified in subparagraph B. above in any evaluation of the services provided pursuant to this Agreement, and shall provide the above-mentioned persons adequate office space to conduct such evaluation. Such space must be capable of being locked and secured to protect the work of said persons during the period of their evaluation.

F. Physician, Clinic and Other Provider shall maintain records that are adequate to substantiate the services for which claims are submitted for reimbursement under this Agreement and the charges thereto. Such records shall include, but not be limited to, individual patient charts and utilization review records.

1. Physician, Clinic and Other Provider shall keep and maintain records of each service

rendered, the MSI Patient to whom the service was rendered, the date the service was rendered, and such additional information as COUNTY or Department may require.

2. Physician, Clinic and Other Provider shall maintain books, records, documents, and other evidence, accounting procedures, and practices sufficient to reflect properly all direct and indirect cost of whatever nature claimed to have been incurred in the performance of this Agreement and in accordance with Medicare principles of reimbursement and generally accepted accounting principles.

3. Physician, Clinic and Other Provider shall ensure the maintenance of medical records required by Sections 70747 through and including 70751 of the California Code of Regulations, as they exist now or may hereafter be amended, and other records related to a MSI Patient's eligibility for services, the service rendered, the medical necessity of the service, and the quality of the care provided. Records shall be maintained in accordance with Section 51476 of Title 22 of the California Code of Regulations, as it exists now or may hereafter be amended.

4. Records Retention

a. All financial records connected with the performance of this Agreement shall be retained by the parties, at a location in the County of Orange, for a period of seven (7) years after termination of this Agreement.

b. All patient records connected with the performance of this Agreement shall be retained by the parties, at a location in the County of Orange, for a period of seven (7) years after termination of this Agreement.

c. Records which relate to litigation or settlement of claims arising out of the performance of this Agreement, or costs and expenses of this Agreement as to which exception has been taken by COUNTY or State or Federal governments, shall be retained by Physician, Clinic and Other Provider until disposition of such appeals, litigation, claims or exceptions is completed.

G. All Providers shall comply with the requirements of Section 114 of the Clean Air Act, as amended, and Section 308 of the Federal Water Pollution Control Act, respectively relating to inspection, monitoring, entry, reports and information, as well as other requirements specified in Section 114 of the Clean Air Act and Section 308 of the Federal Water Pollution Control Act, and all regulations and guidelines issued there under.

H. No services shall be performed in a facility on the Environmental Protection Agency (EPA) List of Violating Facilities until the EPA eliminates the name of such facility from such listing.

I. All Providers shall use their best efforts to comply with clean air standards and clean water standards at the facility in which services are being performed.

J. The Orange County Medical Association (OCMA) shall provide administrative support services that directly support the purposes of this Agreement. Such services shall include, but not be limited to referral services, and assistance for all physicians practicing in Orange County, provider

training/education, and activities that facilitate communication between patients, providers, and the parties to this Agreement.

K. The Orange County Coalition of Community Clinics (COCCC) shall provide administrative support services that directly support the purposes of this Agreement. Such services shall include, but not be limited to referral services and assistance for all Clinics practicing in Orange County, irrespective of whether or not CLINIC is a Contracting Clinic; provider training/education; and activities that facilitate communication between patients, providers, and the parties to this Agreement

L. All Providers shall assist COUNTY and INTERMEDIARY in the conduct of any appeal hearings conducted by COUNTY or INTERMEDIARY in accordance with this Agreement.

M. As a condition of receiving reimbursement, Physicians, Clinics and Other Providers shall be required to register with INTERMEDIARY for the MSI Program and provide all requested information by logging on to http://ochealthinfo.com/medical/msi/providers/registration.htm .

1. Upon approval of ADMINISTRATOR, at ADMINISTRATOR'S sole discretion, INTERMEDIARY shall reimburse certain Physicians, Clinics and/or Other Providers specified by ADMINISTRATOR at rates negotiated by ADMINISTRATOR, which rates may be the same as those specified in this Agreement. Such arrangements shall be limited to either types of specialties and/or geographic areas for which certain services are not otherwise available, or coordination of certain services so as to allow better coordination of patient care and/or management, utilization and distribution of funds available through this Agreement.

2. As a condition of negotiating any additional agreement for certain services, ADMINISTRATOR may require Physician, Clinic or Other Provider to meet additional requirements that may not be otherwise specified in this Agreement or the MSI Provider Manual. For non-hospital laboratories, this may include the ability to electronically transmit patient specific test results to COUNTY'S contracted provider of its patient record system.

III. INTERMEDIARY OBLIGATIONS

A. INTERMEDIARY shall perform as fiscal intermediary on behalf of All Providers and COUNTY. INTERMEDIARY shall reimburse All Providers in accordance with this Agreement and all other agreements for the MSI Program in which INTERMEDIARY is defined. ADMINISTRATOR shall provide copies of all such agreements to INTERMEDIARY.

B. During the term of this Agreement, and for such time thereafter as required by this Agreement, INTERMEDIARY shall perform the services herein including, but not limited to, the following:

1. Receiving, compiling, preserving, and reporting information and data.

2. Receiving eligibility data, performing utilization review, and processing, denying, approving all claims submitted in accordance with Exhibit E.

3. Providing a process for patient appeals of denied services.

4. Receiving, maintaining, collecting, and accounting for Funds.

5. Reimbursing Claims and making other required payments.

C. INTERMEDIARY shall keep a copy of its current Operations Manual at its main facility which shall include INTERMEDIARY'S policies and procedures relating to its operations, including, but not limited to the activities specified herein.

D. Patient Appeals - INTERMEDIARY shall provide a formal opportunity for patients to appeal denial of services or payment to their providers (Appeals System). The Appeals System shall meet the requirements, if any, established by any court with jurisdiction and the following submission requirements:

1. INTERMEDIARY shall advise MSI Patients on all Notices of Action (NOA) that if the MSI Patient wishes to appeal a service or payment denied by INTERMEDIARY, the MSI Patient must submit the request for appeal within thirty (30) days of the date of the NOA.

2. All appeals must include an Appeal Form, provided on the back of the NOA, from the MSI Patient requesting the appeal and must be accompanied by the corresponding medical records. The MSI Patient request for appeal and the medical records may be sent separately; provided, however, that both must be received by INTERMEDIARY within the thirty (30) day timeframe.

a. Untimely Appeal - INTERMEDIARY may deny any requests for appeal that do not meet the submission requirements. Patient Appeals shall be deemed on time:

1) When delivered personally, within thirty (30) day timeframe; or

2) If the date sent by first-class, certified or registered mail in the United States Postal is within the thirty (30) day timeframe; or

3) When faxed, transmission confirmed, within the thirty (30) day timeframe; or

4) When sent by electronic mail, within the thirty (30) day timeframe; or

5) When delivered by U.S. Postal Service Express Mail, Federal Express, United Parcel Service or other expedited delivery service within the thirty (30) day timeframe.

b. INTERMEDIARY shall not be required to provide any timeline extensions, including, but not limited to, the following:

1) If the MSI Patient sends the Appeal Form, but does not also send the medical records.

2) If the MSI Patient arranges for medical records to be sent, but no Appeal Form or NOA is attached in reference to the medical records.

3) If the MSI Patient calls and states they did not receive the NOA advising them of the service and/or payment denial.

c. Nothing herein shall prevent INTERMEDIARY from contacting any MSI Patient

regarding an incomplete appeal and requesting the required information be submitted within the original thirty (30) day timeframe.

E. INTERMEDIARY shall be responsible for prior-authorization of non-formulary medications for the MSI Program for the period September 1, 2008 through November 30, 2010.

1. Requests from Providers for consideration of non-formulary medications shall be sent to INTERMEDIARY along with a copy of the MSI Patient's medical record. INTERMEDIARY shall review the chart for medical necessity and, if the requested non-formulary medication is approved, shall
enter into the MSI Program's database with its Pharmacy Benefits Manager and override the system to allow for coverage of the medication for that specific client/instance.

2. INTERMEDIARY shall not deny a non-formulary request without presenting it to the Medical Review Committee as specified in Paragraph VI of Exhibit B to this Agreement.

3. INTERMEDIARY shall provide staff who, at a minimum, meet the qualifications for a licensed nurse.

F. INTERMEDIARY shall provide, with respect to All Providers, such printing, mailing, and training as may be reasonably required by COUNTY and reasonably within the capacity of INTERMEDIARY to undertake.

G. At no additional cost to COUNTY, INTERMEDIARY shall maintain a telephone number dedicated to facilitating communication with All Providers. INTERMEDIARY shall notify, in writing, All Providers of such phone number and its hours of operation. INTERMEDIARY shall refer requests for patient information to the County of Orange Custodian of Records.

H. INTERMEDIARY shall make its best efforts to provide services pursuant to this Agreement in a manner that is culturally and linguistically appropriate for the population(s) served. INTERMEDIARY shall maintain documentation of such efforts which may include, but not be limited to: records of participation in COUNTY-sponsored or other applicable training; recruitment and hiring policies and procedures; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged.

I. INTERMEDIARY shall not conduct any proselytizing activities, regardless of funding sources, with respect to any person who has been referred to INTERMEDIARY by COUNTY under the terms of this Agreement. Further, INTERMEDIARY agrees that the funds provided hereunder shall not be used to promote, directly or indirectly, any religion, religious creed or cult, denomination or sectarian institution, or religious belief.

IV. FUNDING AND PAYMENTS

A. INTERMEDIARY Payments

1. For services provided in accordance with this Agreement and all other agreements for the MSI Program, COUNTY shall reimburse INTERMEDIARY monthly in arrears, as follows:

a. For Period One: $102,712 per month ~~for Period One~~, up to a total maximum of $1,848,816.

b. For Period Two: $104,282 per month for the period September 1, 2009 through February 28, 2011 and $109,085 per month for the period March 1, 2011 through April 30, 2011, ~~Period Two, up to a total maximum of $1,877,076,~~ plus a one-time payment of $84,657 for unanticipated expenses related to programming and claims management due to unanticipated increases in MSI Program enrollment. The total of all payments for Period Two shall not exceed a maximum of $2,179,903.

c. For Period Three: $109,085 per month ~~for Period Three~~, up to a total maximum of $1,527,190, which ~~$1,963,530. CONTRACTOR agrees the maximum for Period Three~~ includes a one-time payment of $18,072 for ~~un~~anticipated expenses related to programming and reporting needs due to the ~~expanded~~ new Coverage Initiative ~~w~~Waiver effective November 1, 2010.~~and COUNTY'S separate Agreement with CONTRACTOR for MSI Patient and Provider Support Services.~~

2. For each Period, the final monthly payment to INTERMEDIARY shall not be made until ADMINISTRATOR determines that INTERMEDIARY has satisfactorily completed its Final Settlement duties for the applicable Period in accordance with this Agreement.

B. "MSI Base Funding" – means the Total MSI Program Aggregate Maximum Obligation of COUNTY for reimbursement of all MSI Program services, except those provided by INTERMEDIARY, which shall be as specified on Page 4 of this Agreement. The parties agree that the funds may be deposited into a Holding Account in accordance with Paragraph XII of Exhibit E to this Agreement and may be added to the MSI Base Funding as specified herein.

C. MSI Trust Fund and Allocations

1. COUNTY shall establish an interest-bearing trust fund (MSI Trust Fund) into which it shall transfer, monthly, one- twelfth ($1/12^{th}$) of the following amounts of the MSI Base Funding, herein referred to as the "Monthly Trust Fund Transfer." The total amount of all such Transfers shall be as follows:

a. "CHIP-MSI Trust Fund Account" - Said deposit shall not be greater than the actual allocation received by COUNTY as determined by the actual allocation letter received by COUNTY from the State Department of Health Services. Said deposits shall not commence until said allocation letter, and corresponding funding, is received by COUNTY.

1) An estimated $83,338 for Period One
2) An estimated $0 for Period Two
3) An estimated $0 for Period Three

b. The remainder of the Monthly Trust Fund Transfer shall be deposited as follows, which amounts may be modified by ADMINISTRATOR during Preliminary Final Settlement in accordance with Exhibit E of this Agreement to ensure full expenditure of CI Funding allocated to COUNTY each Program Year and ability of COUNTY to meet its MOE requirement:

1) "Hospital Trust Fund Account"
   a) $33,977,901for Period One Program Year
   b) ~~$35,311,235~~ $40,918,663 for Period Two Program Year
   c) ~~$35,644,568~~ $24,429,712 for Period Three Program Year
2) "Physicians Trust Fund Account"
   a) $12,106,693 for Period One Program Year
   b) ~~$12,106,693~~ $14,254,475 for Period Two Program Year
   c) ~~$12,886,693~~ $8,591,129 for Period Three Program Year
3) "Clinic Trust Fund Account"
   a) $2,300,000 for Period One Program Year
   b) ~~$2,300,000~~ $2,553,333 for Period Two Program Year
   c) ~~$1,520,000~~ $1,013,333 for Period Three Program Year
4) "Outpatient Trust Fund Account"
   a) $2,000,000 for Period One Program Year
   b) ~~$1,344,854~~ $1,678,187 for Period Two Program Year
   c) ~~$2,000,000~~ $1,333,333 for Period Three Program Year
5) "Dental Trust Fund Account"
   a) $300,000 for Period One Program Year
   b) ~~$300,000~~ $350,000 for Period Two Program Year
   c) ~~$300,000~~ $200,000 for Period Three Program Year

2. Except as otherwise specified above, Monthly Trust Fund Deposits shall commence by September 10, 2008, and continue thereafter by the tenth (10th) day of each month through and including August 10, 2009 for Period One Program Year; by September 10, 2009, and continue thereafter by the tenth (10th) day of each month through and including ~~August~~ October 10, 2010 for Period Two Program Year; and by ~~September~~ November 10, 2010, and continue thereafter by the tenth (10th) day of each month through and including ~~August~~ June 10, 2011 for Period Three Program Year.

3. Monies in the MSI Trust Fund shall be treated in the same fashion as all other monies held by COUNTY in trust funds, and COUNTY may commingle said monies with other monies for purposes of investment.

a. Interest earned on the MSI Trust Fund monies shall first be allocated proportionately based on the total funds moved to the MSI Trust Fund pending transfer to INTERMEDIARY for deposit

into the Holding Account in accordance with subparagraph XII.B.3.b.2 of Exhibit E to this Agreement and the balance of all other funds in the MSI Trust Fund. The interest earned and apportioned to funds pending transfer to the Holding Account may be, in whole or part and at ADMINISTRATOR'S sole discretion, transferred to the Holding Account with any transferred principal, retained by COUNTY to offset any portion of it administrative expenses, or applied by COUNTY towards the MOE requirement for any Program Year.

b. Interest earned on the balance of all other funds in the MSI Trust Fund monies, after interest is apportioned to the funds pending transfer to the Holding Account, shall be apportioned seventy percent (70%) to the Hospital Trust Fund Account and thirty percent (30%) to the Physicians Trust Fund Account.

c. No interest shall be credited to the MSI Funds before they are deposited in the MSI Trust Fund, nor before this Agreement becomes effective as specified in the Term Paragraph of this Agreement.

4. Of the balance of the MSI Base Funding, COUNTY shall allocate the Coverage Initiative Funding as follows, which amounts may be modified by ADMINISTRATOR during Preliminary Final Settlement in accordance with Paragraph XII of Exhibit E of this Agreement to ensure full expenditure of CI Funding allocated to COUNTY each Program Year and ability of COUNTY to meet its MOE requirement. The total of said amounts shall not be greater than the actual allocation received by COUNTY from Department. Said amounts shall not be available until CI Funding is received by COUNTY.

a. Hospital Funding
   1) $5,377,238 for Period One Program Year
   2) ~~$3,943,071~~ $4,839,277 for Period Two Program Year
   3) ~~$5,377,238~~ $4,481,032 for Period Three Program Year

b. Physician Funding
   1) $6,726,958 for Period One Program Year
   2) ~~$9,815,815~~ $11,171,090 for Period Two Program Year
   3) ~~$8,131,648~~ $6,776,373 for Period Three Program Year

c. Clinic Funding
   1) $917,312 for Period One Program Year
   2) ~~$667,312~~ $820,197 for Period Two Program Year
   3) ~~$917,312~~ $764,427 for Period Three Program Year

d. Outpatient Funding
   1) $382,204 for Period One Program Year
   2) ~~$382,204~~ $445,905 for Period Two Program Year

3) ~~$382,204~~ $318,503 for Period Three Program Year

e. Dental Funding

1) $1,404,690 for Period One

2) $0 for Period Two

3) $0 for Period Three

5. The total of all funding identified by County, excluding those amounts specified in subparagraphs IV.C.4 and C.5 of this Exhibit B to the Agreement, is as follows:

a. Hospital Funding

1) $39,355,139 for Period One Program Year, plus CHIP funding maintained separately

2) ~~$39,254,306~~ $45,757,940 for Period Two Program Year, plus CHIP funding maintained separately

3) ~~$41,021,806~~ $28,910,744 for Period Three Program Year, plus CHIP funding maintained separately

b. Physician Funding

1) $18,833,651 for Period One Program Year

2) ~~$21,922,508~~ $25,425,565 for Period Two Program Year

3) ~~$21,018,341~~ $15,367,502 for Period Three Program Year

c. Clinic Funding

1) $3,217,312 for Period One Program Year

2) ~~$2,967,312~~ $3,373,531 for Period Two Program Year

3) ~~$2,437,312~~ $1,777,760 for Period Three Program Year

d. Outpatient Funding

1) $2,382,204 for Period One Program Year

2) ~~$1,727,058~~ $2,124,092 for Period Two Program Year

3) ~~$2,382,204~~ $1,651,837 for Period Three Program Year

e. Dental Funding

1) $1,704,690 for Period One Program Year

2) ~~$300,000~~ $350,000 for Period Two Program Year

3) ~~$300,000~~ $200,000 for Period Three Program Year

6. Additional CI Funding received by COUNTY from Department for services provided during the period September 1, 2007 through August 31, 2008 shall be allocated in accordance with the procedures specified in Paragraph XII.H. of Exhibit E to this Agreement.

D. MSI Funding Disbursements

1. Hospital Funding and CHIP-MSI Trust Fund Account Funds – Disbursements to

Contracting Hospitals shall be in accordance with the MSI Hospital Agreement.

2. Physician Funding

a. In accordance with Exhibit E to this Agreement, COUNTY shall pay amounts from COUNTY'S available Physician Funding to INTERMEDIARY, which funds shall be used by INTERMEDIARY to reimburse Physician Claims for Eligible Persons.

b. Reserve – Until Final Settlement, COUNTY may not pay any monies to INTERMEDIARY for reimbursement of Physician Claims, if such payment would reduce the Physicians Trust Fund Account balance to less than $1,250,000 for any Period, unless otherwise authorized in writing by ADMINISTRATOR. This reserve is intended to ensure that adequate Funds are available to satisfy any obligation of the Physicians Trust Fund Account to pay for the physicians' share of additional payments to INTERMEDIARY and Other Providers, as provided herein.

3. Clinic Funding – Disbursements to Contracting Clinics shall be in accordance with the MSI Clinic Agreement.

4. Outpatient Funding

a. In accordance with Exhibit E to this Agreement, COUNTY shall pay amounts from COUNTY'S available Outpatient Funding to INTERMEDIARY, which funds shall be used by INTERMEDIARY to reimburse non-hospital based outpatient service providers not otherwise specified in this Agreement and approved in writing by ADMINISTRATOR, including, but not limited to, laboratories, imaging, surgery, and urgent care centers which may include professional services; as negotiated by ADMINISTRATOR. At sole discretion of ADMINISTRATOR, INTERMEDIARY may be directed to reimburse ambulance, home health providers, and durable medical equipment from available Outpatient Funding. Said direction may be provided at any time during term of this Agreement.

b. INTERMEDIARY shall, from the available Outpatient Funding reimburse those ambulance costs associated with the transfer of MSI Eligibles from UCI Medical Center to a Receiving Hospital, or the transportation costs associated with the transfer of MSI Eligibles to a Specialized Receiving Hospital.

c. In the event that the total of all payments to non-hospital outpatient providers is less than the amount of Outpatient Funding available, at ADMINISTRATOR'S sole discretion, the balance of MSI Funds shall either carry forward and be included in as Outpatient Funding in a subsequent agreement, moved to another Funding category to ensure expenditure of MOE, or shall be retained by COUNTY.

d. In the event that the total of all claims for Outpatient Funding exceeds the amount of Outpatient Funding available for the Program Year, any additional payments for non-hospital based outpatient services shall be made proportionately from available Hospital Funding and Physician

Funding, in accordance with all claims submitted for Outpatient Funding

e. Pharmacy Claims – INTERMEDIARY shall, with available Outpatient Funding, reimburse those outpatient pharmaceutical costs typically not claimed through the COUNTY'S Pharmacy Benefits Manager for the MSI Program, including, but not limited to, chemotherapy and other injectable drugs provided in Physician offices.

1) Except as otherwise authorized, in writing, by ADMINISTRATOR, reimbursement of pharmaceutical costs by INTERMEDIARY shall not exceed that which would otherwise be paid by COUNTY'S Pharmacy Benefits Manager. ADMINISTRATOR shall provide INTERMEDIARY the reimbursement rates in effect with COUNTY'S Pharmacy Benefits Manager and any exceptions.

2) Upon written authorization from ADMINISTRATOR, other pharmaceutical costs or costs from other non-hospital outpatient provider
may be paid by INTERMEDIARY.

5. Dental Funding

a. In accordance with Exhibit E to this Agreement, COUNTY shall pay amounts from COUNTY'S available Dental Funding to INTERMEDIARY, which funds shall be used by INTERMEDIARY to reimburse Contracting Clinics for Dental Services.

b. At sole discretion of ADMINISTRATOR, INTERMEDIARY may be directed to reimburse other community providers of Dental Services. Said direction may be provided at any time during term of this Agreement.

c. In the event that the total of all claims for Dental Services exceeds the amount of Dental Funding available for the Program Year, any additional payments for Dental Services shall be made from available Clinic Funding; provided, however, at ADMINISTRATOR'S sole discretion, the scope of allowable Dental Services may be reduced to ensure adequate funds are available to satisfy the obligations of the Clinic Funding.

d. In the event that the total of all payments for Dental Services is less than the amount of Dental Funding available, at ADMINISTRATOR'S sole discretion, the balance shall be added to the Clinic Funding.

6. Other MSI Funding Obligations – The parties understand that should any or all of the following expenses occur, reimbursement for such expenses shall be deducted seventy percent (70%) from the Hospital Funding, and thirty percent (30%) from the Physician Funding prior to Final Settlement unless otherwise specified.

a. Ambulance, Home Health and Durable Medical Equipment Providers - COUNTY shall pay INTERMEDIARY Funds necessary to cover reimbursements to ambulance operators, home health providers, and durable medical equipment providers. In order to ensure availability of services, COUNTY may enter into separate agreements with providers of such services. Said agreements shall

specify that payment shall be made by INTERMEDIARY on behalf of COUNTY.

b. Skilled Nursing Facilities (SNF'S) – COUNTY shall pay INTERMEDIARY the amount necessary to cover reimbursement to SNF's accepting MSI Eligibles referred by COUNTY'S Utilization Management Department. Such amount shall be deducted as follows: one-hundred percent (100%) of the institutional costs from the Hospital Funding and one-hundred percent (100%) of the professional costs from the Physician Funding. ADMINISTRATOR may expand SNF services to include MSI Pendings.

c. Sub-Acute Services – COUNTY shall pay INTERMEDIARY the amount necessary to cover reimbursement for Sub-Acute Services in accordance with implementation and payment procedures agreed to between ADMINISTRATOR and Contracting Hospitals in accordance with the MSI Hospital Agreement. Such amount shall be deducted as follows: one-hundred percent (100%) of the institutional costs from the Hospital Funding and one-hundred percent (100%) of the professional costs from the Physician Funding. ADMINISTRATOR may expand Sub-Acute Services to include MSI Pendings.

d. Special Permit Transfer, Receiving Hospital and Specialized Receiving Hospital Services COUNTY shall pay INTERMEDIARY the amount necessary to cover reimbursement for Special Permit Transfer, Receiving Hospital, and Specialized Receiving Hospital Services in accordance with the MSI Hospital Agreement. Said costs shall be deducted one-hundred percent (100%) from the Hospital Funding.

7. Final Settlement - Prior to Final Settlement, COUNTY shall deposit any Recovery Trust Fund Account monies into the MSI Trust Fund. COUNTY shall pay the balance of the MSI Trust Fund, including all Hospital Funding and Physicians Funding, to INTERMEDIARY. INTERMEDIARY shall use these Funds to make Final Settlement of claims as provided herein, including Exhibit E.

8. Payments to Medical Review Committee Physicians – INTERMEDIARY shall, as directed by ADMINISTRATOR, disburse payments to physicians serving on the MSI Medical Review Committee (MRC Physicians). Funds shall be disbursed from the HCA Recovery Account.

E. INTERMEDIARY and COUNTY acknowledge that the MSI Base Funding contains grant funding. COUNTY reserves the right to reduce the MSI Base Funding, via written notification to INTERMEDIARY, if grant funds are reduced or terminated. Notwithstanding any reductions, all other aspects of the MSI Base Funding will remain in full force and effect.

V. COUNTY OBLIGATIONS

A. COUNTY shall provide oversight of the MSI Program, including appropriate program administration, coordination, planning, evaluation, financial and contract monitoring, public information and referral, standards assurance, and review and analysis of data gathered and reported.

B. COUNTY shall establish, either directly and/or through subcontract(s), a Utilization Management Department (UMD) which shall:

1. Coordinate and make arrangements for the medical needs and care of MSI Patients. The UMD shall not be responsible for the coordination of social services needs of such patients.

2. Perform concurrent and retrospective utilization review of the medical appropriateness, level of care, and utilization of all services provided to MSI Patients by All Providers.

3. Communicate with Contracting Hospitals regarding diversions, admissions, and discharge planning.

4. Assist in coordinating the transitions of MSI Patients to appropriate outpatient care, lower levels of care or needed services through COUNTY-contracted providers for durable medical equipment and pharmacy services and through community-based providers for home health care.

5. Conduct patient, Contracting Hospital, and Other Provider education which shall include, but not be limited to:

a. Availability of MSI Program services at locations other than UCI Medical Center.

b. MSI Program services available through Contracting Clinics.

c. Services for which pre-authorization is recommended and/or required through the UMD.

C. COUNTY'S Utilization Management Department shall work with INTERMEDIARY to develop reporting and information sharing activities to address the following:

1. Deny claims based on recommendations from COUNTY'S Utilization Management Department.

2. Coordinate collection and evaluation of data by INTERMEDIARY and the UMD.

VI. COMMITTEES/GROUPS

A. Medical Review Committee

1. Medical Review Committee (MRC) shall be formed by the parties, and shall perform the duties specified in this Agreement through December 31, 2011.~~February 28, 2012.~~

2. The MRC shall consist of the following members:

a. One physician appointed by ADMINISTRATOR, who shall be chairperson of the committee.

b. One physician appointed by OCMA, and approved by ADMINISTRATOR.

c. One physician representative of a Contracting Hospital appointed by HASC, and approved by ADMINISTRATOR.

3. The MRC shall adopt and follow rules as it determines necessary to carry out its responsibilities.

4. Contracting Hospital, Physicians, Contracting Clinics, and Other Providers, and patients may request MRC review only of claims that were denied based upon scope of services.

5. The MRC shall decide upon appeals no later than thirty (30) calendar days after receipt of the appeal.

6. The MRC shall have final authority to determine whether any medical service for which a claim is submitted is a reimbursable Medical Service under this Agreement.

7. The MRC shall approve and make modifications, deletions, and additions to the list of services for which All Providers will be recommended or required to seek pre-authorization from COUNTY'S Utilization Management Department.

8. As necessary, the MRC may review claims for home health, home IV infusion, and podiatrist services provided to Eligible Persons, and determine whether they are Reimbursable Medical Services, as set forth in Exhibit C to this Agreement, unless otherwise approved by COUNTY'S Utilization Management Department. The MRC shall complete its review and determination of home health, home IV infusion, and podiatrist claims no later than thirty (30) calendar days after their receipt by INTERMEDIARY.

9. As needed, the MRC shall review all diversions, transfers and lengths of stay of Skilled Nursing Facilities and determine whether services were appropriately provided in lieu of acute inpatient hospitalization.

10. Decisions of the MRC shall be final and binding.

11. At ADMINISTRATOR'S request, MRC may be asked to investigate allegations of Inappropriate Patient Referrals as defined in the MSI Hospital Agreement.

12. INTERMEDIARY shall be responsible for ~~hosting~~ attending all meetings of the MRC.

a. Prior to each MRC meeting INTERMEDIARY staff shall submit agenda items ~~research/organize pertinent information~~ relating to the following:

1) Pharmacy Issues.
2) Review of additions and deletions to the MSI pharmacy formulary.
3) Prior-authorization requests presented by UMD.
4) Patient and /or Provider Appeals-Claims initially denied as out of scope.
5) Excessive provider utilization.
6) Pharmacy Review of payment consideration for non-formulary medications.
7) Retrospective review of high dollar surgeries.
8) Evaluation of claims where examiners are unable to render decision.
~~9) Prepare and submit agenda to MRC members.~~

b. During the MRC meeting INTERMEDIARY staff shall be responsible for:

~~1) Calling the meeting to order and determining the sequence of topics.~~

~~2)~~1) Gathering/organizing records according to MRC decisions (disposition of denials vs. approvals);

~~3)~~2) Presenting patient appeals not previously determined by INTERMEDIARY staff;

~~4)~~3) Provide additional information for MRC members on issues as needed;

~~5) Meeting adjournment/Scheduling future meetings.~~

c. After each MRC meeting, INTERMEDIARY staff shall be responsible for follow up and communication of MRC'S decision for denied cases as follows:

1) INTERMEDIARY shall enter the following comment in the "Notes" section of the claim screen "appeal was denied in accordance with MRC".

2) INTERMEDIARY shall send provider(s) a letter informing them of the MRC decision.

3) "Notice of Review Decision" letter is sent to patients.

d. After each MRC meeting, INTERMEDIARY staff shall be responsible for follow up and communication of MRC'S decision for approved cases as follows:

1) Claims are given to examiner and reprocessed.

2) INTERMEDIARY shall enter the following comment in the "Notes" section of the claim screen: "appeal was approved in accordance with MRC".

3) INTERMEDIARY shall send provider(s) a letter informing them of MRC decision.

e. INTERMEDIARY shall prepare and distribute minutes to each MRC member and any other individuals designated by the MSI Program Manager.

VII. RECORDS

A. All Providers submitting claims for reimbursement under this Agreement, shall maintain records that are adequate to substantiate the services for which claims are submitted and the charges thereto. Such records shall include, but not be limited to, individual patient charts and utilization review records.

1. All Providers shall keep and maintain records of each service rendered, the MSI Patient to whom the service was rendered, the date the service was rendered, and such additional information as COUNTY or Department may require.

2. All Providers shall maintain books, records, documents, and other evidence, accounting procedures, and practices sufficient to reflect properly all direct and indirect cost of whatever nature claimed to have been incurred in the performance of this Agreement and in accordance with Medicare principles of reimbursement and generally accepted accounting principles.

3. Other Providers shall ensure the maintenance of medical records required by Sections 70747 through and including 70751 of the California Code of Regulations, as they exist now or may

hereafter be amended, and other records related to a MSI Patients eligibility for services, the service rendered, the medical necessity of the service, and the quality of the care provided. Records shall be maintained in accordance with Section 51476 of Title 22 of the California Code of Regulations, as it exists now or may hereafter be amended.

B. INTERMEDIARY shall maintain adequate records in sufficient detail to permit an evaluation of funds received in relation to claims paid.

C. Records Retention

1. All financial records connected with the performance of this Agreement shall be retained by INTERMEDIARY and All Providers for a period of seven (7) years after termination of this Agreement.

2. All patient records connected with the performance of this Agreement shall be retained by Other Providers for a period of seven (7) years after termination of this Agreement.

3. Records which relate to litigation or settlement of claims arising out of the performance of this Agreement, or costs and expenses of this Agreement as to which exception has been taken by COUNTY or State or Federal governments, shall be retained by INTERMEDIARY and Other Providers until disposition of such appeals, litigation, claims or exceptions is completed.

4. All books of accounts and records shall be made available at the INTERMEDIARY'S main facility, as specified on page 4 of this Agreement, or at a location within the County of Orange. Should INTERMEDIARY move from its main facility, INTERMEDIARY shall advise ADMINISTRATOR and ADMINISTRATOR shall have final discretion as to the location of records maintained in accordance with this Agreement.

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EXHIBIT C
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

GUIDELINES FOR REIMBURSABLE MEDICAL SERVICES

I. REIMBURSABLE MEDICAL SERVICES – STANDARD MSI PROGRAM

A. MSI Medical Services shall be reimbursable through this Agreement if such services are medically necessary to protect life, prevent significant disability, or prevent serious deterioration of health, except as provided for in Paragraph II below of this Exhibit C to the Agreement. Reimbursable and non-reimbursable services include those covered in the MSI Provider Manual, as approved by the Medical Review Committee.

1. The scope of Medical Services may include, but are not limited to, the following:

a. Acute hospital inpatient services, including physician, room and board, diagnostic and therapeutic ancillary services, laboratory, therapy services, anesthesia services, pharmacy services, Administrative Days, and other acute hospital inpatient services necessary for the care of the patient.

b. Home health services.

c. Outpatient services, including physician, clinic services, hospital based surgical center services, emergency room services, diagnostic and therapeutic services, outpatient pharmacy services and physical and occupational therapy services.

d. Acute dental services.

e. Outpatient hemodialysis and home hemodialysis services.

f. Blood and blood derivatives.

g. Durable medical equipment, prosthetic and medical supplies.

h. Initial psychiatric evaluation as required for triage.

i. Emergency medical transportation.

j. Nursing Care Day Level 1 and Nursing Care Day Level 2 services as defined in the MSI Provider Manual. The MRC or COUNTY Utilization Management Department shall review, every fourteen (14) days, any length of stay authorized beyond the initial fourteen (14) day length of stay, for appropriateness and medical necessity.

k. Skilled Nursing Facility (SNF) Services arranged for by COUNTY'S Utilization Management Department in lieu of acute inpatient hospitalization for which the length of stay shall not

exceed fourteen (14) days unless approved by the Medical Review Committee or COUNTY'S Utilization Management Department and subsequently approved by the MRC.

1) The MRC or COUNTY Utilization Management Department shall review, every fourteen (14) days, any length of stay authorized beyond the initial fourteen (14) day length of stay, for appropriateness and medical necessity.

2) A single length of stay may exceed thirty (30) days in those instances in which the MSI Patient has a Medi-Cal application pending. In such instances, the MRC may approve, and ADMINISTRATOR may authorize, INTERMEDIARY to continue to reimburse the SNF until such time the Medi-Cal application is approved. Upon approval of the Medi-Cal application, the SNF shall be required to pay INTERMEDIARY all MSI services subsequently reimbursed by Medi-Cal or shall assign recovery of Medi-Cal reimbursement to INTERMEDIARY'S Third Party Recovery Group.

2. Long Beach Memorial Medical Center (Medical Center) as a designated Orange County trauma hospital, and its affiliated physicians, shall be obligated only to those terms of this Agreement that apply to Medical Services provided by its trauma center. Medical Center, and its affiliated physicians, may submit claims for only those Eligible Persons who are brought by Orange County paramedics for trauma Medical Services or other services specifically negotiated by ADMINISTRATOR in accordance with the MSI Hospital Agreement.

II. REIMBURSABLE MEDICAL SERVICES – EXPANDED CI SERVICES

The following services are reimbursable through this Agreement as a result of CI Funding. INTERMEDIARY, acting on behalf of COUNTY, may add to this list of CI Reimbursable Services with MRC approval. This list is not exhaustive and may be reviewed on a case by case basis by INTERMEDIARY on behalf of COUNTY. Should CI Funding be terminated, the services specified below shall be considered Non-Reimbursable Services.

A. Commercially available urine "dip-stick" pregnancy testing.

B. Routine physical examinations.

C. Routine dental prophylactic and radiological studies shall be covered for the period September 1, 2008 through July 31, 2009. Additional Dental Services may be added during this period by ADMINISTRATOR upon approval of Medical Review Committee.

D. General Primary Care visits including, but not limited to, treatment of colds, flu, sore throats, and back aches.

E. Office visits which aid in the management of certain chronic diseases such as diabetes.

III. NON-REIMBURSABLE SERVICES

The following services are not reimbursable through this Agreement, except as may be provided for

in the MSI Clinic Agreement. INTERMEDIARY acting on behalf of COUNTY, may add to this list of Non-Reimbursable Services with MRC approval. This list is not exhaustive and may be reviewed on a case by case basis by INTERMEDIARY on behalf of COUNTY.

A. All diagnostic, therapeutic and rehabilitative procedures and services that are considered experimental or of unproved medical efficacy under the State Medi-Cal program.

B. Organ transplants.

C. Pregnancy related services, including complications of pregnancy.

D. Physician services in extended or long-term care facility services.

E. Adult day care health services.

F. Eyeglasses for refraction and eye appliances, hearing aids and radial keratotomy.

G. Acupuncture, chiropractic, optometry, podiatry.

H. Diagnostic and therapeutic services for male and female infertility, voluntary sterilization and birth control.

I. Routine injections of antigen to ameliorate allergic conditions.

J. All cosmetic procedures.

K. Ultrasound, massage and therapeutic thermal packs.

L. Inpatient and outpatient mental health services that are available through County of Orange Behavioral Health Services

M. Any service not included under Title XIX of the Social Security Act.

N. Non-emergency medical transportation, except as otherwise authorized elsewhere in this Agreement.

O. COUNTY shall not reimburse Contracting Hospitals for services provided to Transfer Patients not approved by ADMINISTRATOR; provided, however, COUNTY shall reimburse Contracting Hospitals for services provided to Special Permit Transfers. This Agreement shall not obligate Contracting Hospitals to accept a transfer from, nor to provide compensation to, any other health care facility, subject to requirements of applicable law.

P. Routine dental prophylactic and radiological studies, orthodontia, and fixed prostheses shall be deemed non-reimbursable services during the period August 1, 2009 through ~~August 31~~June 30, 2011.

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EXHIBIT D
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

ELIGIBILITY

I. REIMBURSEMENT

Reimbursement provided through this Agreement is only intended to cover those indigent patients who would not be eligible for medical benefits from the State Medi-Cal Program, or whose medically necessary services would not be covered by other non-COUNTY third party payors.

II. ELIGIBLE PERSON

A. "Eligible Person" or "MSI Eligible" means a person who meets all of the following criteria:

1. Is an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years.

a. Applicants shall meet United States citizenship requirements in accordance with Section 6036 of the Deficit Reduction Act of 2005, entitled 'Improved Enforcement of Documentation Requirements;'

b. ADMINISTRATOR may waive the requirement for residency to be equal to or greater than five (5) years if subparagraph A.7 below applies;

2. Is a legal resident of Orange County;

3. Is not otherwise eligible for medical benefits under a Medi-Cal program, unless eligible as medically indigent, long term care, TB outpatient or as special treatment program - supplement;

4. Has income at or below two hundred percent (200%) of the Federal Poverty Level as updated April of each year, and who lacks sufficient financial resources to pay for Medical Services;

5. Is otherwise eligible based on the application and eligibility determination process as set forth in this Exhibit D and in those sections of the California Code of Regulations, Title 22, applicable to Indigent Adults;

6. Unless otherwise waived by ADMINISTRATOR, must not have had insurance in the three (3) months prior to enrollment except as may otherwise be allowed in the contract between COUNTY and Department;

7. Has an urgent, emergent, or eligible chronic medical condition;

B. CI Eligibility - As a result of CI Funding, COUNTY shall allow a limited number of persons to qualify as an MSI Eligible by meeting all the following criteria:

1. Is an adult legal resident between and including the ages of twenty-one (21) and sixty-four (64) years.

a. Applicants shall meet United States citizenship requirements in accordance with Section 6036 of the Deficit Reduction Act of 2005, entitled 'Improved Enforcement of Documentation Requirements;'

b. Must have been a resident in the United States for a minimum of five (5) years.

2. Is a legal resident of Orange County;

3. Is not otherwise eligible for medical benefits under a Medi-Cal program, unless eligible as medically indigent, long term care, TB outpatient or as special treatment program - supplement;

4. Has income at or below two hundred percent (200%) of the Federal Poverty Level as updated April of each year, and who lacks sufficient financial resources to pay for Medical Services;

5. Is otherwise eligible based on the application and eligibility determination process as set forth in those sections of the California Code of Regulations, Title 22, applicable to Indigent Adults.

6. Must not have had insurance in the three (3) months prior to enrollment except as may otherwise be allowed in the contract between COUNTY and Department.

C. Temporary Eligibility means temporary status as a MSI Eligible and can be granted, with the written approval of the MSI Program Manager, to any person who meets the following criteria:

1. With the approval of the MSI Program Manager, any refugee from a Federal or State declared disaster area.

2. Any person who has completed the MSI application process.

D. Medi-Cal Eligibility

1. Persons who appear to be eligible for Medi-Cal and who refuse or fail to cooperate in the complete Medi-Cal eligibility determination process will be ineligible for benefits from MSI.

2. Persons who are eligible for Medi-Cal who refuse or fail to pay a premium, if applicable, and said requirement is implemented by the State of California, to maintain eligibility, shall be ineligible for benefits from MSI.

3. MSI Patients found to have been terminated from Medi-Cal for non-payment of premiums, if applicable and said requirement is implemented by the State, will be immediately terminated from MSI and COUNTY shall make reasonable efforts to inform HOSPITAL of such patients.

E. A person approved for General Relief shall be an "Eligible Person" or "MSI Eligible."

III. INITIAL SCREENING

A. As part of their usual registration or financial screening process, All Providers submitting

claims for payment of Medical Services through this Agreement shall use their reasonable best efforts to screen whether a patient:

1. Lacks financial resources to pay for Medical Services, and
2. Is currently Medi-Cal or MSI Eligible.

B. Patients who appear to be MSI Eligible shall be referred by a provider to a Contracting Hospital or Qualified Clinic for further eligibility processing.

C. If the patient is unable to provide the information necessary to make the above determination, a provider shall use its reasonable best efforts to obtain this information from any other person with knowledge of the patient.

IV. FINAL SCREENING OF PATIENTS REFERRED TO CONTRACTING HOSPITAL/CLINIC

A. Staff designated by Contracting Hospital or Qualified Clinics shall review the status of patients referred to them for screening, to conclude whether or not a patient is already eligible for Medi-Cal or is an MSI Eligible, lacks sufficient financial resources to pay for Medical Services, and is a legal resident. As appropriate, Contracting Hospital or Qualified Clinics shall:

1. Complete an MSI Program screening form, and refer patients who appear to be Medi-Cal eligible to Orange County Social Services Agency (SSA) Eligibility Technicians.
2. Complete an MSI application for patients who appear to be MSI Eligible. Said applications shall be submitted, in a manner specified by ADMINISTRATOR, to the "Application Processor,"

B. MSI applications shall include:

1. The patient's attestation and signature that under penalty of perjury all information contained in the MSI application is true and correct.
2. Verification of social security number whenever possible.
3. Documentation of legal residency status in accordance with the Deficit Reduction Act of 2005 (DRA).
4. The patient's attestation and signature on the application forms that requirements for spend down of excess resources must be completed by the last day of the month as a condition of eligibility.
5. Any additional information that may be reasonably required in determining eligibility, including a statement of medical need if deemed necessary.

C. Contracting Hospitals and Qualified Clinics shall maintain sufficient staff to expeditiously obtain and screen information, and complete MSI applications as required by this Exhibit D to the Agreement.

D. Contracting Hospitals and Qualified Clinics shall be required to own and maintain the necessary equipment to submit adequate messenger service to ensure timely delivery of applications, referrals and

eligibility information to and from COUNTY.

V. ELIGIBILITY PROCESSING

A. Contracting Hospitals and Qualified Clinics shall electronically submit MSI applications and refer MSI patients to the Application Processor in a timely manner.

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B. Contracting Hospitals and Qualified Clinics shall refer patients who are potentially Medi-Cal eligible to SSA in a timely manner.

C. As a condition of eligibility processing by the Application Processor, MSI applications, and any required documentation, shall be received by the Application Processor no later than the end of the third month following the month during which services were provided. Applications received after this deadline shall be denied.

D. The Application Processor shall be solely responsible for determining whether a person meets the eligibility criteria as set forth in this Agreement.

E. Patients determined to be Eligible Persons by the Application Processor shall be eligible for a twelve month period, commencing the first day of the month in which Medical Services were first rendered.

F. INTERMEDIARY shall:

1. Collect all MSI eligibility data by direct on-line input provided by COUNTY'S Contractor.

2. Print and distribute, daily, the "Notice of Action" forms as to the disposition of claims to both patient and provider.

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EXHIBIT E
AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

CLAIMS AND DISBURSEMENTS

I. SATISFACTION OF COUNTY OBLIGATION

In consideration of payments made by COUNTY through INTERMEDIARY for payment for Medical Services to MSI Eligibles pursuant to this Agreement, COUNTY'S obligation to All Providers, and indigent persons for whom it may have any legal obligation to provide Medical Services, shall be satisfied.

II. HOSPITAL ACCOUNT

A. COUNTY shall require the INTERMEDIARY to maintain an account, herein referred to as the Hospital Account, for the purpose of depositing and disbursing Hospital Funding to Contracting Hospitals, as specified in the MSI Hospital Agreement.

B. Commencing September 15, 2008, and thereafter on the fifteenth (15th) day of each month through and including August 15, 2009 for Period One Program Year; September 15, 2009, and thereafter on the fifteenth (15th) day of each month through and including ~~August~~ October 15, 2010 for Period Two Program Year; and ~~September~~ November 15, 2010, and thereafter on the fifteenth (15th) day of each month through and including ~~August~~ June 15, 2011 for Period Three Program Year, COUNTY shall pay INTERMEDIARY, upon receipt of one or more invoices approved by ADMINISTRATOR an amount equal to eighty percent (80%) of COUNTY'S monthly available Hospital Funding.

C. INTERMEDIARY shall pay Contracting Hospitals, monthly in arrears, the "Periodic Interim Payment" (herein after referred to as PIP Payment) stipulated in Exhibits G-1 through G-3 to this Agreement, which payment and Exhibits may be revised by ADMINISTRATOR if MSI Base Funding is reduced as provided herein, if CI Funding to COUNTY has not been received from Department, or if data received from the INTERMEDIARY supports a revised PIP payment to a Contracting Hospital, provided, however, that the total of all PIP payments shall not exceed:

1. $2,601,454 per month for Period One
2. $2,616,954 per month for Period Two

3. $2,734,787 per month for Period Three.

D. PIP payments shall be disbursed from the Hospital Account, monthly in arrears, commencing October 1, 2008, and thereafter, on or about the first (1st) day of each month through September 1, 2009 for Period One Program Year; October 1, 2009, and thereafter, on or about the first (1st) day of each month through ~~September~~ November 1, 2010 for Period Two Program Year; and ~~October~~ December 1, 2010, and thereafter, on or about the first (1st) day of each month through ~~September~~ July 1, 2011 for Period Three Program Year; provided, however, that the Contracting Hospital has returned a fully executed agreement for the corresponding Period to COUNTY, or its designee.

E. Additionally, COUNTY shall pay INTERMEDIARY, upon receipt of one or more invoices approved by ADMINISTRATOR, $150,000 per month, per Program Year, for the purpose of reimbursing Contracting Hospitals' share of Other Provider expenses as specified in Subparagraph IV.D.6 of Exhibit B to this Agreement. Upon determination by INTERMEDIARY that the Hospital Account requires additional Funds for reimbursement of any claims authorized in accordance with this Agreement and/or the MSI Hospital Agreement, INTERMEDIARY shall submit a request for supplemental payment to COUNTY, together with any documentation that may be required by ADMINISTRATOR so that ADMINISTRATOR may authorize such request for payment.

III. IMPREST ACCOUNT

A. INTERMEDIARY shall maintain an interest-bearing account(s), collectively the "Imprest Account."

1. INTERMEDIARY shall use an Imprest Account to deposit Physician Funding disbursed by COUNTY for the purpose of reimbursing Physician Claims, including, as appropriate, claims submitted by ambulance operators, home health services providers, Skilled Nursing Facilities (SNF), and providers of durable medical equipment and certain pharmaceuticals.

a. Commencing September 1, 2008, and thereafter on the tenth (10^{th}) day of each month through and including August 10, 2009 for Period One Program Year; September 1, 2009, and thereafter on the tenth (10^{th}) day of each month through and including ~~August~~ October 10, 2010 for Period Two Program Year; and ~~September~~ November 1, 2010, and thereafter on the tenth (10^{th}) day of each month through and including ~~August~~ June 10, 2011 for Period Three; INTERMEDIARY shall submit one or more invoices and COUNTY shall pay INTERMEDIARY an amount equal to one-twelfth ($1/12^{th}$) of eighty percent (80%) of the available Physician Funding, as specified in subparagraph IV.C.8.b. of Exhibit B to this Agreement. Additional funds may be requested in accordance with Paragraph III.D. below.

b. Such Funds shall be used by INTERMEDIARY to reimburse Physician Claims.

2. INTERMEDIARY shall use an Imprest Account to deposit Clinic Funding disbursed by

COUNTY for the purpose of reimbursing Contracting Clinics, as specified in the MSI Clinic Agreement.

a. Commencing September 10, 2008 for Period One Program Year, September 10, 2009 for Period Two Program Year, and ~~September~~ November 10, 2010 for Period Three Program Year, COUNTY shall pay INTERMEDIARY an amount equal to one-twelfth ($1/12^{th}$) of eighty percent (80%) of the Clinic Funding, as specified in subparagraph IV.C.8.c of Exhibit B to this Agreement. Additional payments thereafter shall be as determined by ADMINISTRATOR based on demonstrated need by INTERMEDIARY and may be requested in accordance with Paragraph III.D. below.

b. Such Funds shall be used by INTERMEDIARY to reimburse Clinic Claims.

3. INTERMEDIARY shall use an Imprest Account to deposit Outpatient Funding disbursed by COUNTY for the purpose of reimbursing non-hospital based outpatient service providers as specified in Paragraph IV.D.4 of Exhibit B to the Agreement.

a. Commencing September 10, 2008 for Period One Program Year, September 10, 2009 for Period Two Program Year and ~~September~~ November 10, 2010 for Period Three Program Year, COUNTY shall pay INTERMEDIARY an amount equal to one-twelfth ($1/12^{th}$) of eighty percent (80%) of the Outpatient Funding, as specified in subparagraph IV.C.8.d. of Exhibit B to this Agreement. Additional payments thereafter shall be as determined by ADMINISTRATOR based on demonstrated need by INTERMEDIARY and may be requested in accordance with Paragraph III.D. below.

b. Such Funds shall be used by INTERMEDIARY to reimburse claims for non-hospital based outpatient services.

4. INTERMEDIARY shall use an Imprest Account to deposit Dental Funding disbursed by COUNTY for the purpose of reimbursing Dental Services provided by Contracting Clinics or other providers as specified in Paragraph IV.D.5 of Exhibit B to this Agreement.

a. Commencing September 10, 2008 for Period One Program Year, September 10, 2009 for Period Two Program Year, and ~~September~~ November 10, 2010 for Period Three Program Year, COUNTY shall pay INTERMEDIARY an amount equal to one-twelfth ($1/12^{th}$) of eighty percent (80%) of the Dental Funding, as specified in subparagraph IV.C.8.e. of Exhibit B to this Agreement. Additional payments thereafter shall be as determined by ADMINISTRATOR based on demonstrated need by INTERMEDIARY and may be requested in accordance with Paragraph III.D. below.

b. Such Funds shall be used by INTERMEDIARY to reimburse claims for Dental Services.

5. If INTERMEDIARY determines that the fees to maintain an interest-bearing Imprest Account are more than projected interest to be earned, INTERMEDIARY shall recommended to ADMINISTRATOR that such funds be maintained in a non-interest-bearing Imprest Account. Approval of the recommendation shall be at the sole discretion of ADMINISTRATOR.

B. Except as otherwise provided herein, the Imprest Account shall not exceed a maximum of $4,000,000, exclusive of Hospital PIP payments, and shall be managed so as to maximize the interest earned upon Funds in the Account.

C. INTERMEDIARY shall invoice COUNTY as needed to reimburse claims submitted by ambulance operators, home health services providers, pharmaceuticals, SNF's, and durable medical equipment providers. INTERMEDIARY may, if there are sufficient funds in the Imprest Account, pay said claims prior to invoicing COUNTY and replenish the Imprest Account upon receipt of funds from COUNTY.

D. Upon determination by INTERMEDIARY that the Imprest Account requires additional Funds for reimbursement of any claims authorized in accordance with this Agreement, INTERMEDIARY shall submit a request for supplemental payment to COUNTY, together with any documentation that may be required by ADMINISTRATOR.

E. Monthly, beginning October 20, 2008 for Period One Program Year, October 20, 2009 for Period Two Program Year, and ~~October~~ December 20, 2010 for Period Three Program Year, unless otherwise agreed to by ADMINISTRATOR, INTERMEDIARY shall provide ADMINISTRATOR a copy of the prior month's bank statement(s) and reconciliation with respect to all monies disbursed pursuant to this Agreement.

F. In the event INTERMEDIARY anticipates expenditures pursuant to this Agreement in excess of the Imprest Account maximum, INTERMEDIARY may request an appropriate advance, in writing from COUNTY. Upon approval by ADMINISTRATOR, COUNTY will disburse to INTERMEDIARY the requested Funds. INTERMEDIARY shall disburse Funds advanced in such manner to Other Providers and Physicians. Such disbursement shall be made immediately upon receipt of the advance, unless otherwise approved, in writing, by ADMINISTRATOR.

G. INTERMEDIARY shall maintain a separate accounting of funds commingled in the Imprest Account for each service for which specific funding has been identified by COUNTY, which services are: Physician, Non-Hospital Outpatient, Pharmacy, Ambulance, Clinic and Dental Services.

IV. REVIEW OF CLAIMS

A. INTERMEDIARY shall review all claims to determine whether the services for which reimbursement is sought are Medical Services, reimbursable pursuant to Exhibit C to this Agreement, and whether such services were rendered to an MSI Eligible.

B. INTERMEDIARY shall review claims, and provide a medical utilization review, in accordance with its Operations Manual.

C. INTERMEDIARY shall deny all claims that do not meet the conditions and requirements of this Agreement for claim submission, processing, and reimbursement, including, but not limited to

obligations pursuant to Paragraph VII., Third Party, Primary, or Other Insurance Covered Claims, as specified in this Exhibit E to the Agreement.

D. INTERMEDIARY shall use its best efforts to collect any monies paid, in any form, for non-reimbursable services, for services to persons who are not Eligible Person, or for payment to any provider or other entity not entitled under this Agreement to such payment if the result of inaccurate or inappropriate billing by any provider or other entity. INTERMEDIARY shall not be subject to disallowances for said payments.

E. INTERMEDIARY shall use its best efforts to collect any monies paid, in any form, for non-reimbursable services, for services to persons who are not Eligible Person, or for payment to any provider or other entity not entitled under this Agreement to such payment if the result of inaccurate or inappropriate processing by INTERMEDIARY. Upon becoming aware of such uncollectible payments, INTERMEDIARY shall submit to ADMINISTRATOR a plan of corrective action. Upon review by ADMINISTRATOR, INTERMEDIARY may be subject to disallowances for said payments.

F. INTERMEDIARY shall process claims submitted by Long Beach Memorial Medical Center (Medical Center), and affiliated physicians, for only those MSI Eligibles brought by Orange County Paramedics to Medical Center for trauma services or other services specifically negotiated by ADMINISTRATOR in accordance with the MSI Hospital Agreement.

V. CONDITIONS OF REIMBURSEMENT

A. As a condition of reimbursement through this Agreement, all claims for reimbursement of Medical Services provided to Eligible Persons shall be:

1. Claims for Medical Services provided during the period September 1, 2008 through August 31, 2009 for Period One; September 1, 2009 through ~~August~~ October 31, 2010 for Period Two; and ~~September~~ November 1, 2010 through ~~August 31~~ June 30, 2011 for Period Three;, except for:

   a. Claims covered by a court order.

   b. Claims for services if eligibility for a person is established by SSA after the claims submission deadline for the applicable contract period.

2. Submitted and completed in accordance with this Agreement.

3. Initially received by INTERMEDIARY no later than ninety (90) calendar days following the date of service or the date of the Notice of Action that establishes MSI eligibility, whichever is later; provided, however that claims to be considered in Final Settlement shall be received no later than November 30, 2009 for Period One, ~~November 30, 2010~~ January 31, 2011 for Period Two, and ~~November~~ September 30, 2011 for Period Three.

B. INTERMEDIARY shall initially approve or deny all claims no later than December 31, 2009 for Period One, ~~December 31, 2010~~ February 28, 2011 for Period Two, and ~~December~~ October 31, 2011

for Period Three.

C. Upon approval, by either INTERMEDIARY or the MRC, INTERMEDIARY shall reimburse all claims as soon as possible, and in no event later than thirty (30) calendar days following the end of the month in which the claim was approved.

D. Except as otherwise specified in this paragraph, any unapproved claims for Medical Services provided during the period September 1, 2008 through August 31, 2009 shall be null and void after January 31, 2010; any unapproved claims for Medical Services provided during the period September 1, 2009 through ~~August~~ October 31, 2010 shall be null and void after ~~January~~ March 31, 2011 and any unapproved claims for Medical Services provided during the period ~~September~~ November 1, 2010 through ~~August 31~~June 30, 2011 shall be null and void after ~~January 31, 2012~~November 30, 2011.

E. COUNTY, at its sole discretion, may direct INTERMEDIARY to pay certain claims received outside the timeframes specified in this paragraph. When directed, INTERMEDIARY shall pay claims from an available funding source designated by COUNTY.

VI. CLAIM DENIAL/APPEAL

A. INTERMEDIARY shall notify, in writing, All Providers and their respective patients shall be notified of the reason for any denial of a claim(s).

B. Notice shall be deemed effective:

1. Three (3) calendar days from the date written notice is deposited in the United States mail, first class postage prepaid; or

2. When faxed, transmission confirmed; or

3. When accepted by U.S. Postal Service Express Mail, Federal Express, United Parcel Service, or other expedited delivery service.

C. All Providers may resubmit denied claims to INTERMEDIARY; provided, however, All Providers shall complete any necessary corrective action, and resubmit the claim no later than thirty (30) calendar days after notification of the denial.

D. All Providers or their respective MSI Eligible patients may appeal to the MRC only those claims denied by INTERMEDIARY for which the service claimed was determined to be outside the scope of reimbursable services. Such appeal shall be made, in writing, to the MRC, no later than thirty (30) calendar days after notification of denial. The MRC shall decide upon the appeal within thirty (30) calendar days.

E. If a denied claim is not resubmitted and/or appealed in writing to the MRC, within thirty (30) calendar days after notification of denial, INTERMEDIARY'S determination shall be final, and the affected provider or its patient shall have no right to review of the claim.

VII. THIRD PARTY, PRIMARY, OR OTHER INSURANCE COVERED CLAIMS

A. Reimbursement provided through this Agreement shall be payment of last resort. Prior to submitting any claim to INTERMEDIARY for reimbursement of Medical Services provided to an Eligible Person, All Providers shall:

1. Use their reasonable best efforts to determine whether the claim is a third-party or primary other insurance covered claim.

2. Bill and use their reasonable best efforts to collect third-party or primary other insurance covered claims to the full extent of such coverage.

B. All Providers shall determine that a claim is not covered, in whole or in part, under any other State or Federal medical care program or under any other contractual or legal entitlement including, but not limited to, coverage defined in W&I Section 10020.

C. With submission of a claim, All Providers shall give proof of denial to INTERMEDIARY, if a third-party or primary other insurance denies coverage of the claim.

D. All Providers shall report to INTERMEDIARY any payments received from third-party or primary other insurance covered claims.

E. This Agreement shall not reimburse deductibles and co-payments required by an Eligible Person's primary other insurance coverage.

F. All Providers shall provide INTERMEDIARY such records and other documentation as INTERMEDIARY may reasonably require to maintain centralized data collection and referral services in support of third-party revenue recovery activities.

G. Provider Refunds of Claims Reimbursed By Other Payments

1. Refunds received from Contracting Hospitals shall be as specified in the MSI Hospital Agreement and for the purposes of this Paragraph shall not be included in the definition of "Provider".

2. If any Provider receives Medi-Cal reimbursement for services reimbursed through this Agreement, such provider(s) shall reimburse INTERMEDIARY an amount equal to the MSI Payment ~~or the Medi-Cal payment, whichever is less~~.

3. If any Provider receives reimbursement from a primary other insurance claim for services reimbursed through this Agreement, such provider shall reimburse INTERMEDIARY an amount equal to the MSI payment ~~or the primary other insurance payment, whichever is less~~.

4. If any Provider receives reimbursement from a third-party settlement for services reimbursed through this Agreement, such provider shall reimburse INTERMEDIARY an amount equal to the MSI payment ~~or the third-party settlement, whichever is less~~. Third-party settlement payments may be directed by any Provider to be paid directly to COUNTY if the date(s) of service related to the claim are such that the Provider has already written off the patient account.

5. If it is determined that a patient whose care was previously reimbursed with MSI funding

was eligible for third party reimbursement or primary other insurance, retroactively or otherwise, and Provider could have sought such reimbursement and failed to do so, Provider shall reimburse INTERMEDIARY the amount of the MSI payment within thirty (30) calendar days notification of said fact.

6. ADMINISTRATOR may authorize INTERMEDIARY to act as a Third-Party Recovery Group (Recovery Group), or to subcontract with a Recovery Group for the purpose of actively pursuing reimbursement of claims paid for MSI Eligibles later determined to be eligible for Medi-Cal or other primary insurance. INTERMEDIARY and All Providers shall cooperate with the Recovery Group in recovering these costs. Except as provided for above, monies recovered due to the efforts of the Recovery Group shall be reimbursed to the Recovery Group. The Recovery Group, after deduction of appropriate administrative fees, shall remit the balance to INTERMEDIARY for deposit as follows: ten percent (10%) into the HCA Recovery Account and the remainder into the appropriate Recovery Account.

VIII. RECOVERY ACCOUNTS

A. INTERMEDIARY shall collect and deposit refunds and any third-party payments related to any Medical Service rendered by any Provider as follows:

1. Payments or refunds for hospital services shall be deposited in the Hospital Recovery Account.

2. Payments or refunds for physician services shall be deposited in the Physicians Recovery Account.

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3. Refunds and payments from ambulance operators, home health services providers, and providers of medical goods shall be deposited seventy percent (70%) to the Hospital Recovery Account, and thirty percent (30%) to the Physicians Recovery Account; provided, however, refunds and payments of any claims reimbursed through Outpatient Trust Fund Account shall be deposited in accordance with subparagraph VIII.A.5 below.

4. Refunds and payments from Skilled Nursing Facilities, including but not limited to reimbursement following approval of Medi-Cal applications in accordance with subparagraph I.A.1.k.2 of Exhibit C to this Agreement, shall be deposited as follows: 100% of institutional charges to the Hospital Recovery Account and 100% of professional charges to the Physicians Recovery Account.

5. Refunds and payments from non-hospital outpatient providers shall be deposited as follows: ninety percent (90%) to the Outpatient Trust Fund Account and ten percent (10%) to the HCA Recovery Account.

6. Refunds and payments relating to Dental Services shall be deposited 100% into the Dental

Services Recovery Account.

B. At Final Settlement

1. Funds in the Hospital and Physician Recovery Accounts shall be deposited in the Hospital and Physicians Accounts and paid to providers in the same manner as are other Funds in these Accounts.

2. Any funds in the Dental Services Recovery Account shall be either used to pay outstanding Dental Services Claims or deposited, at ADMINISTRATOR'S sole discretion, into one of the Imprest Accounts.

3. Any funds in the HCA Recovery Account shall be, at ADMINISTRATOR'S sole discretion, either returned to COUNTY upon Final Settlement, used for reimbursement of other MSI Program costs through INTERMEDIARY, or retained by INTERMEDIARY for use in a subsequent Agreement between COUNTY and INTERMEDIARY.

IX. INTERIM PAYMENTS TO PHYSICIANS AND CLINICS

A. "Medical Fee Schedule" means the Medicare Resource-Based Relative Value Scale (RBRVS) listed in the Federal Register on November 22, 1996 or the version in effect September 1 for each Period.

B. "RVU" means the value set forth in the Medical Fee Schedule for a service, which when multiplied by the conversion factor specified below equals one hundred percent (100%) of the payment for that RVU under this Agreement.

C. Upon approval of Physician Claims, INTERMEDIARY shall make interim reimbursements for Physician Claims at the specified percentage of the applicable rate established below for medicine, x-ray, lab services and surgical services (collectively "Medical") and at the specified percentage of the applicable rate for anesthesia established below.

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1. The conversion factors per RVU are as follows, which factor shall be modified by INTERMEDIARY as the Medical Fee Schedule is modified by Law or regulation and in effect upon execution of this Agreement. INTERMEDIARY shall notify ADMINISTRATOR prior to making any modifications.

a. For Medical Services provided during the period September 1, 2008 through August 31, 2009:

SERVICE	100% of Conversion Factor per RVU		Interim Payment per RVU
Medical	$38.0870	x 70%	$26.66

Anesthesia	$17.82	x 100%	$17.82

b. For Medical Services provided during the period September 1, 2009 through August 31, 2010:

SERVICE	100% of Conversion Factor per RVU		Interim Payment per RVU
Medical	$36.0666	x 60%	$21.64
Anesthesia	$20.92	x 100%	$20.92

c. For Medical Services provided during the period September 1, 2010 through June 30~~August 31~~, 2011:

SERVICE	100% of Conversion Factor per RVU		Interim Payment per RVU
Medical	~~$36.0846~~ $36.8729	x 60%	~~$21.65~~ $22.12374
Non-Medical Home	$36.8729	X 50%	$18.43645
Anesthesia	$21.114	x 100%	$21.114

2. INTERMEDIARY shall reimburse certain physician groups as authorized in writing by ADMINISTRATOR, at rates negotiated by ADMINISTRATOR. Such agreements with COUNTY shall be limited to types of specialties and/or geographic areas for which said provider services are not otherwise available. The rates negotiated shall constitute payment in full and are not subject to Final Settlement. ADMINISTRATOR shall provide copies of all said agreements to INTERMEDIARY and ADMINISTRATOR and INTERMEDIARY shall mutually agree on how claims for said agreements shall be processed.

3. Commencing with claims for services provided September 1, 2009, INTERMEDIARY shall subtract a co-payment in the amount of five ($5.00) dollars from each approved Physician claim paid, including those agreements as authorized in accordance with subparagraph IX.C.2 above unless otherwise specified, in writing, by ADMINISTRATOR.

D. If, at any time, the interim payments for Physicians Claims are projected to equal the total monies allocated to the Physician Funding, less the $1,250,000 Reserve required by this Agreement, prior to November 30, 2009 for Period One, ~~November 30, 2010~~ January 31, 2011 for Period Two, and ~~November~~ September 30, 2011 for Period Three, ADMINISTRATOR may, at its sole discretion, reduce the percentage of the interim reimbursement to physicians specified in Subparagraph C.1. above or authorize the temporary use of any funds remaining in the Physician Account or any other provider

accounts from a Prior Year; provided however, said funds are returned, in their entirety to the Prior Year's account prior to Final Settlement for that Program Year.

1. At Final Settlement, ~~$250,000~~ the following portions of the Reserve shall be used for the MSI Physician Pay-for-Performance Program.

a. $250,000 for Period One Program Year

b. $291,667 for Period Two Program Year

c. $166,667 for Period Three Program Year

2. Prior to Final Settlement, COUNTY shall instruct INTERMEDIARY on the distribution methodology for the Pay-for-Performance funds to those physicians who provide Medical Home/Primary Care Physician services to MSI Patients. Distribution of funds shall be proportional determined by a formula set by the MSI Program Manager; and shall be based on objective performance based criteria which may include, but not be limited to, the following:

d. Number of Medical Home Patients

b. Number of Medical Home Visits

E. If interim payments for Physician Claims equal the total monies allocated to the Physicians Trust Fund Account, less the $1,250,000 Reserve required by this Agreement, no further reimbursement of Physicians Claims shall be made, until INTERMEDIARY determines through Final Settlement whether any Physician Funding remain for distribution.

X. INTERIM PAYMENTS TO CONTRACTING CLINICS

A. Upon approval of Clinic Claims, the INTERMEDIARY shall make interim reimbursements for Clinic Claims, except Dental Services, at the specified percentage of the applicable rate established below for medicine, x-ray, lab services and surgical services (collectively "Medical") and at the specified percentage of the applicable rate for anesthesia. The conversion factor per RVU is as follows, which factor shall be modified by the INTERMEDIARY as the Medical Fee Schedule is modified by Law or regulation and in effect upon execution of this Agreement.

1. For Clinic Services provided during the Period September 1, 2008 through August 31, 2009:

SERVICE	100% of Conversion Factor per RVU		Interim Payment per RVU
Medical	$38.0870	x 85%	$32.37
Anesthesia	$17.82	100%	$17.82

2. For Clinic Services provided during the Period September 1, 2009 through August 31, 2010:

SERVICE	100% of Conversion Factor per RVU		Interim Payment per RVU
Medical	$36.0666	x70%	$25.25
Anesthesia	$20.92	100%	$20.92

3. For Clinic Services provided during the Period September 1, 2010 through June 30~~August 31~~, 2011:

SERVICE	100% of Conversion Factor per RVU		Interim Payment per RVU
Medical	~~$36.0846~~$36.8729	60%	$22.12374
Anesthesia	$21.114	100%	$21.114

4. Commencing with claims for services provided September 1, 2009, INTERMEDIARY shall subtract a co-payment in the amount of five ($5.00) dollars from each approved CLINIC claim, unless otherwise specified in writing by ADMINISTRATOR.

B. Claims experience during the first six (6) months of the term of this Agreement shall be reviewed by ADMINISTRATOR and the percentage of the interim reimbursement to Contracting Clinics may be adjusted based on availability of funding.

1. If, at any time, the interim payments for Clinic Claims are projected to equal the total monies allocated to the Clinic Funding, less the Reserve required by the MSI Clinic Agreement, prior to September 30, 2009 for Period One, September 30, 2010 for Period Two and September 30, 2011 for Period Three, ADMINISTRATOR may, at its sole discretion, reduce the percentage of the interim reimbursement to Contracting Clinics specified in Subparagraph A. above or authorize the temporary use of any funds remaining in the Clinic Account or any other provider accounts from a Prior Year; provided however, said funds are returned, in their entirety to the Prior Year's account prior to Final Settlement for that Program Year.

a. Commencing with Period Two, at Final Settlement for Period Two Program Year and Period Three Program Year, ~~$250,000~~ $333,333 of the Reserve shall be used for the MSI Clinic Pay-for-Performance Program.

b. Prior to Period Two Final Settlement, ADMINISTRATOR shall instruct INTERMEDIARY on the distribution methodology for the Pay-for-Performance funds to those Contracting Clinics who provide Medical Home/Primary Care services to MSI Patients. Distribution of funds shall be proportional as determined by a formula set by the MSI Program Manager, and shall be based on objective performance criteria which may include, but not be limited to, the following:

1) Number Medical Home Patients

2) Number of Medical Home Visits

2. If interim payments for Clinic Claims equal the total monies allocated to the Clinic Funding, less the Reserve required by the MSI Clinic Agreement, no further reimbursement of Clinic Claims shall be made, until INTERMEDIARY determines through Final Settlement whether any Funds remain for distribution.

C. Claims for Dental Services shall be reimbursed at State Medi-Cal (Denti-Cal) rates, in accordance with the current MSI dental fee matrix, from the available Dental Funding, shall be limited to $1,000 per MSI Eligible per Program Year, and shall not be subject to Final Settlement. In the event that the total of all payments for Dental Services exceeds the amount available in Dental Funding for the Program Year, any additional payments for Dental Services shall be made from available Clinic Funding; provided, however, at ADMINISTRATOR'S sole discretion, the scope of allowable Dental Services may be reduced to ensure adequate funds are available to satisfy any obligation of the Clinic Trust Fund Account.

XI. PAYMENTS TO OTHER PROVIDERS

A. Ambulance operators, home health services providers, and providers of durable medical equipment, shall be reimbursed at the Contract Rates specified in subparagraph I.M.2 of Exhibit B to this Agreement.~~one hundred percent (100%) of the lesser of prevailing Medicare or Medi-Cal rates for similar services and goods; provided, however, that in no instance shall a payment be equal to zero dollars ($0).~~ These payments are not subject to Final Settlement as defined for all Other Providers.

1. INTERMEDIARY shall reimburse certain Other Providers authorized in writing by ADMINISTRATOR, at rates negotiated by ADMINISTRATOR. Such agreements with COUNTY shall be limited to types of services and/or geographic areas for which these Other Provider services are not otherwise available. The rates negotiated shall constitute payment in full and are not subject to Final Settlement. ADMINISTRATOR shall provide copies of all said agreements to INTERMEDIARY and ADMINISTRATOR and INTERMEDIARY shall mutually agree on how claims for said agreements shall be processed.

2. Prior to Final Settlement, at ADMINISTRATOR'S sole discretion, ADMINISTRATOR shall direct INTERMEDIARY to reconcile any or all reimbursement in either one of the following manners:

~~1.~~a. The cost of such reimbursement shall be charged by INTERMEDIARY seventy percent (70%) to the Hospital Trust Fund Account, and thirty percent (30%) to the Physicians Trust Fund Account, except for ambulance costs as specified in subparagraph IV.D.4.b. of Exhibit B to this Agreement; or,

~~2.~~b. The cost of such reimbursement for any or all of said providers should be charged

to by INTERMEDIARY 100% to the Outpatient Trust Fund Account.

B. Skilled Nursing Facility (SNF) Payments – For SNF services arranged for by COUNTY'S Utilization Management Department, INTERMEDIARY shall make payment to such facilities at rates negotiated by COUNTY. The costs of such reimbursements shall be charged one hundred percent (100%) of the institutional costs to the Hospital Trust Fund Account and one hundred percent (100%) of the professional costs to the Physicians Trust Fund Account. Such SNF facilities shall not be considered eligible for Points as calculated for Final Settlement in accordance the MSI Hospital Agreement.

C. Non-hospital based outpatient service provider payments shall be reimbursed at rates negotiated by ADMINISTRATOR and reimbursed from the Outpatient Trust Fund Account and are not subject to Final Settlement as defined for all Other Providers.

XII. FINAL SETTLEMENT

A. INTERMEDIARY shall complete final reimbursement to All Providers, as specified below (Final Settlement) for each Program Year. Final Settlement shall be accomplished no later than February 28, 2010 for Period One, ~~February 28~~April 30, 2011 for Period Two and ~~February 29, 2012~~ December 31, 2011 for Period Three unless otherwise authorized in writing by ADMINISTRATOR. If ADMINISTRATOR authorizes a change in the date for completion of Final Settlement, ADMINISTRATOR shall also be deemed authorized to change any corresponding dates specified in this Final Settlement Paragraph.

B. Prior to Final Settlement, but not later than January 15, 2010 for Period One, ~~January~~ March 15, 2011 for Period Two, and November 15, 2011 ~~January 15, 2012~~ for Period Three, INTERMEDIARY shall complete an estimated preliminary reimbursement to All Providers to determine redistribution of funds in order to maximize CI Funding and meet COUNTY MOE requirements (Preliminary Final Settlement) as specified in this Subparagraph B. It is understood by the parties that all adjustments are for the sole purpose of maximizing CI Funding and shall not result in a reduction in allocation amounts to any Provider below that would otherwise have been available; provided, however, that total Allowable Costs for each Trust Fund Account exceed each allocation amount.

1. ~~The total of all CI Funding allocated by Department to COUNTY for each Program Year is $16,871,577~~. The Department has allocated a certain amount of CI Funding to COUNTY for each Program Year. CI Funding must be matched with an equal amount of MSI Funds; therefore, the total of all CI Claimable Services which must be provided to allow COUNTY to receive CI Funding must be equal to or greater than ~~$33,743,154~~ twice the CI Funding allocation which may include any or all of the CI Claimable services provided through this Agreement, the MSI Hospital Agreement, the MSI Clinic Agreement, and COUNTY'S Agreement with its Pharmacy Benefits Manager.

a. If the total of COUNTY'S CI Claimable Services is less than ~~$33,743,154 or~~ twice the

CI Funding Allocation for any Program Year and the CI Funding or allocation is reduced by Department, the resulting reduction in CI Funding shall be deducted as follows; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply:

1) 39% from Hospital Funding
2) 45% from Physician Funding
3) 16% from Clinic Funding

b. For the period September 1, 2007 through August 31, 2008. COUNTY'S CI Claimable Services exceeded ~~$33,743,154~~ the required amount and Department is anticipated to allocate additional CI Funding to COUNTY. The additional CI Funding shall be allocated 100% towards Hospital Funding; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply. If Department allocates additional CI Funding after February 28, 2009, COUNTY shall request INTERMEDIARY to complete a Supplemental Final Settlement Process prior to February 28, 2010.

c. If the total of COUNTY'S CI Claimable Services for the Period September 1, 2008 through August 31, 2009 is greater than ~~$33,743,154~~ the amount required and Department allocates additional CI Funding to COUNTY, the CI Funding shall be allocated as follows; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply. If Department allocates additional CI Funding after February 28, 2010, COUNTY shall request Intermediary to complete a Supplemental Final Settlement Process.

1) 39% towards Hospital Funding
2) 45% towards Physician Funding
3) 16% towards Clinic Funding

2. The COUNTY has a required MOE for each Program Year which includes the MSI funds required to match CI Funding in accordance with Subparagraph B.1 above and which represents the actual COUNTY expenditures for the MSI Program provided through this Agreement, the MSI Hospital Agreement, the MSI Clinic Agreement, and COUNTY'S Agreement with its Pharmacy Benefits Manager.

a. There is no financial impact to COUNTY or any Provider if the MOE is exceeded.

b. If the MOE is not met for any Program Year, Department may reduce COUNTY'S CI Funding by an amount no less than the difference between the amount of funds expended for the Program Year and COUNTY'S MOE. Any reduction in CI Funding shall be allocated in accordance with subparagraph B.l.a. above; provided, however, reallocations in accordance with Preliminary Final Settlement as detailed herein still apply.

3. Step 1: Pharmacy claims paid through COUNTY'S Pharmacy Benefits Manager shall be reconciled by ADMINISTRATOR no later than October 1, preceding Final Settlement date for each

Period.

a. ADMINISTRATOR shall obtain from its Pharmacy Benefits Manager, a report of all Pharmacy Claims separately detailing those pharmacy claims that are CI Claimable from those that are not CI Claimable. Administrative fees charged by the Pharmacy Benefits Manager may not be CI Claimable.

b. If the total of all Pharmacy claims, when added to the MSI Funding provided through this Agreement, the COUNTY'S Agreement with Intermediary, and the MSI Clinic Agreement, are less than the required MOE, ADMINISTRATOR shall allocate MSI Funds and CI Funds exactly as detailed by the Pharmacy Benefits Manager and shall make adjustments within the MSI Base Funding as appropriate; provided, it is understood by the parties that all adjustments are for the sole purpose of maximizing CI Funding and shall not result in a reduction in allocation amounts to any Provider below that would otherwise have been available; provided, however, that total Allowable Costs for each Trust Fund Account exceed each allocation amount.

1) The adjustments to the MSI Base Funding and the difference between the actual Pharmacy claims and the amount needed to meet MOE shall be reported by ADMINISTRATOR to INTERMEDIARY.

2) COUNTY shall deposit this amount into the MSI Trust Fund and prior to Preliminary Final Settlement, INTERMEDIARY shall invoice COUNTY for these amounts, which amounts COUNTY shall pay, and INTERMEDIARY shall deposit into an interest-bearing account ('Holding Account') pending continued calculation of the Preliminary Final Settlement.

a) Step 1A: After deduction of Physician Claims not subject to Final Settlement, if Intermediary determines that the total of all Physician Claims, paid at seventy percent (70%) of RBRVS, national rate, is estimated to exceed the total amount of Physician Funding available, the Intermediary shall first allocate an amount up to one hundred percent (100%) of the Holding Account until a minimum of seventy percent (70%) of RBRVS, national rate is achieved.

b) Step 1B: If Intermediary determines that the total of all Clinic Claims, paid at eighty-five percent (85%) of RBRVS, national rate, is estimated to exceed the total amount of Clinic Funding available, the Intermediary shall allocate an amount up to one hundred percent (100%) of the remaining balance of the Holding Account until a minimum of eighty-five percent (85%) of RBRVS, national rate is achieved.

c. If the total of all Pharmacy claims, when added to the MSI Funding provided through this Agreement, the COUNTY'S Agreement with Intermediary, and the MSI Clinic Agreement, is greater than the required MOE, ADMINISTRATOR shall allocate MSI Funds and CI Funds exactly as detailed by the Pharmacy Benefits Manager and shall make adjustments to the MSI Base Funding as appropriate.

d. If funds were transferred to COUNTY'S and/or INTERMEDIARY'S Holding Accounts based on ADMINISTRATOR'S projections to meet MOE, and all or part of said funds are determined not to be required for MOE, the excess funds shall be allocated at ADMINISTRATOR'S sole discretion, including but not limited to, return of funds to COUNTY.

4. Step 2: ADMINISTRATOR shall report to INTERMEDIARY the estimated MSI Trust Fund balances to be used in calculating the Preliminary Final Settlement which shall be completed in the following order: Dental Trust Fund, Clinic Trust Fund, Outpatient Trust Fund, Physician Trust Fund and Hospital Trust Fund.

a. All calculations are subject to adjustment to maximize CI Funding, meet MOE requirements, and ensure rates of payment for CI Claimable Services and non-CI Claimable services are consistent for each specific Provider Funding allocation subject to final settlement. All calculations are understood to be estimates only, subject to additional minor adjustments during Final Settlement.

b. Each preliminary adjustment shall be detailed and reported by ADMINISTRATOR to HASC, OCMA, and COCCC. ADMINISTRATOR, with INTERMEDIARY as necessary, will be available at the request of HASC, OCMA and COCCC to discuss the Preliminary Final Settlement calculations before INTERMEDIARY proceeds with Final Settlement; provided, however that such meetings shall be held no later than January 31, 2010 for Period One, ~~January~~ March 31, 2011 for Period Two and ~~January 31, 2012~~ November 30, 2011 for Period Three.

c. ADMINISTRATOR and INTERMEDIARY shall agree on timelines to begin and complete each step of the Preliminary Final Settlement Process to meet the final completion deadline of January 15, 2010 for Period One, ~~January~~ March 15, 2011 for Period Two and November 15, 2011~~January 15, 2012~~ for Period Three in order to allow HASC, OCMA and COCCC opportunity for review and questions.

5. Step 3: Dental Claims are not subject to a Final Settlement adjustment and Dental Funding shall not be augmented by funds in the Holding Account, if any except as may be allowed in subparagraph XIIB.9.b.3 below

a. If the total of all Dental Claims is estimated to exceed available funding for the applicable Period as specified in Exhibit B to this Agreement funding for additional Dental Claims shall be secured from Clinic Funding in accordance with subparagraph IV.D.5.c of Exhibit B to this Agreement. INTERMEDIARY shall report the total of all Dental Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

1) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) INTERMEDIARY shall report the balance of Clinic Funding remaining after

funding for additional Dental Claims has been made and proceed to Step 4 of Preliminary Final Settlement.

b. If the total of all Dental Claims is estimated to be less than available funding for the applicable Period as specified in Exhibit B to this Agreement INTERMEDIARY shall report the total of all Dental Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds.

1) INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) The difference between the estimated Dental Claims to be paid and the amount of available funding for the applicable period as specified in Exhibit B to this Agreement shall be added to the Clinic Funding and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

6. Step 4: INTERMEDIARY shall utilize the procedures specified in the MSI Clinic Agreement to determine and compute amounts due to Contracting Clinics through Final Settlement; provided, however, that the procedure set forth herein for Preliminary Final Settlement shall be included for the purpose of determining the ratio of MSI Funds, CI Funds, and amounts, if any, allowed for retention in the Clinic Trust Fund Account and/or to be transferred to or from the Holding Account.

a. Case Management Clinic Expenditures: Of the total allocated for Clinic Claims for each applicable Period as specified in Exhibit B to this Agreement, the following amount shall be set aside for Case Management Services for each Period. These amounts shall not be subject to Final Settlement, funded with CI Funds, or included in COUNTY'S MOE calculation for Program Year 2008-09, Program Year 2009-10 or Program Year 2010-11 as appropriate and applicable.

1) $905,146 for Period One. If the total of all Case Management Clinic Claims is estimated to be less than $905,146, the difference between the estimated expenditure and $905,146 shall be added to Clinic Funding for Preliminary Final Settlement Calculations, if required for the COUNTY to meet MOE; otherwise, the difference between the estimated expenditure and $905,146 shall be transferred to the Holding Account for use at COUNTY'S sole discretion.

2) ~~$250,000~~ $333,333 for Period Two Program Year

3) ~~$250,000~~ $333,333 for Period Three Program Year

b. Contracting Clinic Claims – INTERMEDIARY shall estimate the total amount of funds available to reimburse Contracting Clinic Claims including the Clinic Fund allocation for Program Year 2008-09, any Dental Funding that may have been reallocated to Clinic Funding, any Clinic Funds retained following Final Settlement in accordance with the Prior Agreement and Prior Clinic Agreement, and any Case Management Clinic allocation that may have been reallocated to Clinic Funding.

1) If the total of all Contracting Clinic Claims, paid at one hundred percent (100%) of Allowable Charges, is estimated to exceed the total amount of Clinic Funding available, INTERMEDIARY shall allocate an amount up to, but not exceeding, ten percent (10%) of the funds available in the Holding Account, if any, to the Clinic Funding to achieve the highest possible reimbursement without exceeding Allowable Charges.

a) INTERMEDIARY shall report the total of all Contracting Clinic Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

b) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) If the total of all Contracting Clinic Claims, paid at one hundred percent (100%) of Allowable Charges, is estimated to be less than the total amount of Clinic Funding available, INTERMEDIARY shall report the total of all Contracting Clinic Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

a) At ADMINISTRATOR'S sole discretion, ADMINISTRATOR may authorize not more than the actual amount remaining at Final Settlement for the Prior Agreement and Prior Clinic Agreement to be retained in the 'Clinic Trust Fund' provided such action is determined to be consistent with actual MOE reported for FY 2006-07.

b) Any remaining balance, after deduction of any amount allowed to be retained, shall be deposited into the Holding Account.

c) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

7. Step 5: Outpatient Claims are not subject to a Final Settlement adjustment and Outpatient Funding shall not be augmented by funds in the Holding Account, if any, except as may be allowed in subparagraph XI.B.9.b.3 below.

a. If the total of all Outpatient Claims is estimated to exceed the available Outpatient Funding, funding for additional Outpatient Claims shall be secured from either Hospital Funding or Physician Funding in accordance with subparagraph IV.D.4.e. of Exhibit B to this Agreement except as may be allowed in subparagraph XII.B.8.b.3. INTERMEDIARY shall report the total of all Outpatient Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

1) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

2) INTERMEDIARY shall report the balance of Hospital Funding and Physician

Funding remaining after funding for additional Outpatient Claims has been made and proceed to Steps 6 and 7 of Preliminary Final Settlement.

b. If the total of all Outpatient Claims is estimated to be less than the available Outpatient Funding, INTERMEDIARY shall report the total of all Outpatient Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds.

1) At ADMINISTRATOR'S sole discretion, ADMINISTRATOR may authorize not more than the actual amount remaining at Final Settlement for the Prior Agreement to be retained in the "Outpatient Trust Fund" provided such action is determined to be consistent with actual MOE reported for FY 2006-07.

2) Any remaining balance, after deduction of any amount allowed to be retained, shall be deposited into the Holding Account.

3) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

8. Step 6: The total allocated for Physician Claims through this Agreement is as specified in Exhibit B to this Agreement, less any amounts deducted for Outpatient Claims or other MSI Funding Obligations as specified in this Agreement. A portion of this amount, to be estimated by INTERMEDIARY, represent negotiated rates with certain providers and shall not be subject to Final Settlement, but may be eligible to be funded with CI Funds and included in COUNTY'S MOE calculation for Program Year 2008-09, Program Year 2009-10 and/or Program Year 2010-11 as applicable and appropriate. Final Settlement for physicians shall be calculated in accordance with subparagraph XII.D.3 of this Exhibit E to the Agreement; provided, however, that the procedure set forth herein for Preliminary Final Settlement shall be included for the purpose of determining the ratio of MSI Funds, CI Funds, and amounts, if any, to be transferred to or from the Holding Account

a. After deduction of Physician Claims not subject to Final Settlement, if the total of all Physician Claims, paid at one hundred percent (100%) of Allowable Charges, is estimated to exceed the total amount of Physician Funding available, INTERMEDIARY shall allocate an amount up to, but not exceeding, thirty percent (30%) of the amount remaining in the Holding Account, if any, to the Physician Funding to achieve the highest possible reimbursement without exceeding Allowable Charges.

1) INTERMEDIARY shall report the total of all Physician Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

2) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

3) If the total of all Physician Claims, paid at one hundred percent (100%) of

Allowable Charges, is estimated to be less than the total amount of Physician Funding available, INTERMEDIARY shall report the total of all Physician Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

a) Any remaining balance after Physician Claims have been paid at one hundred percent (100%) of Allowable Charges shall be deposited into the Holding Account.

b) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

9. Step 7: INTERMEDIARY shall utilize the procedures specified in the MSI Hospital Agreement to determine and compute amounts due to Contracting Hospitals through Final Settlement; provided, however, that the procedure set forth herein for Preliminary Final Settlement shall be included for the purpose of determining the ratio of MSI Funds, CI Funds, and amounts, if any, to be transferred to or from the Holding Account. The total allocated for Hospital Claims through this Agreement is ~~$39,326,582~~ as specified in Exhibit B to this Agreement, less any amounts deducted for Outpatient Claims or other MSI Funding Obligations as specified in this Agreement. CHIP funding shall not be used to match CI Funds for CI Claimable Services and is not included in COUNTY'S MOE calculation.

a. After deduction of any Hospital Claims not subject to Final Settlement, if the total of all Hospitals Claims, paid at one hundred percent (100%) of Allowable Charges, is estimated to exceed the total amount of Hospital Funding available, INTERMEDIARY shall allocate all available funding remaining in the Holding Account, if any, to the Hospital Funding to achieve the highest possible reimbursement without exceeding Allowable Charges.

1) INTERMEDIARY shall report the total of all Hospital Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

2) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

b. If the total of all Hospital Claims, paid at one hundred percent (100%) of Allowable Charges, is estimated to be less than the total amount of Hospital Funding available, INTERMEDIARY shall report the total of all Hospital Claims and shall detail the portion of which may be offset with MSI Funds and the portion of which may be offset with CI Funds, pending further adjustments as appropriate.

1) Any remaining balance remaining after Hospital Claims have been paid at one hundred percent (100%) of Allowable Charges shall be deposited into the Holding Account.

2) ADMINISTRATOR and INTERMEDIARY shall make adjustments to the Holding Account and/or the MSI Base Funding as appropriate.

3) If funds remaining in the Holding Account after completion of Step 7, INTERMEDIARY and ADMINISTRATOR may make one or more of the following adjustments:

a) Reverse adjustments to the Clinic Funding as a result of Dental Claims exceeding available Dental Funding

b) Reverse adjustments to the Physician Funding as a result of certain Outpatient Claims exceeding available Outpatient Funding

c) Reverse adjustments to the Hospital Funding as a result of certain Outpatient Claims exceeding available Outpatient Funding

d) Reduce and reallocate CHIP funding to one or more Contracting Hospitals in a manner to be determined by ADMINISTRATOR.

e) Increase the rate of Allowable Charges for any or all Providers, as determined by ADMINISTRATOR.

C. Immediately prior to Final Settlement, INTERMEDIARY shall deposit any Hospital Recovery Trust Fund Account balance into its Hospital Account and any Physicians Recovery Trust Fund Account balance into its Imprest Account and shall advise ADMINISTRATOR of any funds in the HCA Recovery Account. For Period One, INTERMEDIARY shall transfer $2,500,000 from the Hospital Funding to the Physician Funding prior to Final Settlement.

D. After Preliminary Final Settlement, and in preparation for Final Settlement, ADMINISTRATOR shall report to INTERMEDIARY the MSI Trust Fund Account balances to be distributed through Final Settlement. INTERMEDIARY shall invoice COUNTY for this amount, which amount COUNTY shall pay, and INTERMEDIARY shall deposit in the appropriate Hospital or Imprest account. INTERMEDIARY shall disburse such Funds, the balance of all other monies in the Physicians Account and any other accounts maintained for the purposes of this Agreement, and any earned interest, to All Providers in the manner specified below.

1. Settlement to Contracting Hospitals – INTERMEDIARY shall utilize the procedures specified in the MSI Hospital Agreement to determine and compute amounts due to Contracting Hospitals through Final Settlement.

2. Settlement to Contracting Clinics - INTERMEDIARY shall utilize the procedures specified in the MSI Clinic Agreement to determine and compute amounts due to Contracting Clinics through Final Settlement.

3. Settlement to Physicians and Clinics - INTERMEDIARY shall distribute all monies remaining in INTERMEDIARY'S Physician Account after all approved Physician Claims have been paid pursuant to this Agreement. INTERMEDIARY shall distribute these monies as follows:

a. Step 1: Payments to all physician groups as specified in Subparagraph IX. of this Exhibit E shall be made at percentages or amounts specified in this Agreement.

b. Step 2: If additional monies remain in the Physicians Account, INTERMEDIARY shall distribute to each Physician and applicable clinic, except those specified in subparagraph IX.C.2. of this Exhibit E to the Agreement, a proportionate share of monies remaining in the Physicians Account based on the formula below:

Individual Physician Share	=	Total Agreement Term interim payments to individual physician / Total Agreement Term interim payments for all Physicians Claims	x	Funds Remaining in INTERMEDIARY Physicians Account

c. At ADMINISTRATOR'S sole discretion, ADMINISTRATOR may direct INTERMEDIARY to modify Step 2 such that the monies remaining in the Physicians Account are first allocated, as determined by ADMINISTRATOR, between those physicians who provide medical home/primary physician care services to MSI Patients and all other physicians. The separate allocations shall then be distributed proportionately to each Physician as specified in Step 2.

4. Settlement Limitation - Total interim payments shall be adjusted for other insurance, voided claims and refunds.

a. No provider shall be reimbursed more than one hundred percent (100%) of Allowable Charges.

b. INTERMEDIARY shall only disburse those Final Settlement payments that total greater than fifty-dollars ($50.00) to Physicians and Clinics. Physicians and Clinics due Final Settlement payments totaling less than fifty dollars ($50.00) shall not receive said Final Settlement payment. INTERMEDIARY shall proportionally reallocate the total of the non-disbursed funds to Physicians and Clinics receiving Final Settlement payments.

5. All Funds provided during the term of the Agreement and placed in accounts maintained by INTERMEDIARY, which funds are remaining after one hundred percent (100%) of Allowable Charges have been reimbursed through Final Settlement, and all other payments required by this Agreement have been made, shall, at ADMINISTRATOR'S sole discretion, be either returned to COUNTY by INTERMEDIARY or retained by INTERMEDIARY for inclusion in the Final Settlement process is a subsequent agreement between COUNTY and INTERMEDIARY.

E. Supplemental Final Settlement

1. PY 2007-08 –The total of COUNTY'S CI Claimable Services for PY 2007-08 was greater than $33,743,154 and COUNTY understands that Department intends to allocate additional CI Funding to COUNTY after February 28, 2009 for PY 2007-08. INTERMEDIARY shall complete a Supplemental Final Settlement process. Supplemental Final Settlement shall be calculated in the following order:

a. Step 1: Contracting Hospitals - The total of all Contracting Hospital Claims, paid at

one hundred percent (100%) of Allowable Charges, exceeded the total amount of Hospital Funding available after completion of Final Settlement for PY 2007-08. INTERMEDIARY shall allocate 100% of the additional CI Funding received from Department to the Hospital Funding to achieve the highest possible reimbursement without exceeding Allowable Charges. Any balance of funds remaining shall then be applied to Physicians in accordance with subparagraphs E.1.b. below.

b. Step 2: Physicians

1) If additional CI Funding is available after Intermediary completes its calculations in accordance with subparagraph E.1.a above, and if the total of all Physician Claims, paid at one hundred percent (100%) of Allowable Charges, still exceed the total amount of Physician Funding available, INTERMEDIARY shall allocate an amount of the additional CI Funding received from Department to the Physician Funding to achieve the highest possible reimbursement without exceeding Allowable Charges.

2) Any remaining CI Funding shall be returned to COUNTY by INTERMEDIARY and COUNTY shall return such funds to Department."

2. PY 2008-09, PY 2009-10, and PY 2010-11, if applicable – If the total of COUNTY'S CI Claimable Services for PY 2008-09 is greater than $33,743,154 and Department allocates additional CI Funding to COUNTY after Final Settlement for the applicable Program Year, INTERMEDIARY shall to complete a Supplemental Final Settlement process. Supplemental Final Settlement shall be calculated in the following order:

a. Step 1: Contracting Clinics:

1) If the total of all Contracting Clinic Claims, paid at one hundred percent (100%) of Allowable Charges, exceed the total amount of Clinic Funding available after completion of Final Settlement for the applicable Program Year, INTERMEDIARY shall allocate an amount up to, but not exceeding, sixteen percent (16%) of the additional CI Funding to the Clinic Funding to achieve the highest possible reimbursement without exceeding Allowable Charges. Any balance of funds remaining shall be allocated thirty percent (30%) to the Physician Funding and seventy percent (70%) to the Hospital Funding.

2) If Final Settlement for the applicable Program Year resulted in all Contracting Clinic Claims being paid at one hundred percent (100%) of Allowable Charges, there will be no Supplemental Final Settlement for Contracting Clinics and the additional CI Funding which would have been apportioned to Contracting Clinics shall instead be allocated thirty percent (30%) to the Physician Funding and seventy percent (70%) to the Hospital Funding.

3. Step 2: Physicians *[note – paragraph numbering was changed in 1st amend, but difficult to show in this document]*

a. If the total of all Physician Claims, paid at one hundred percent (100%) of Allowable Charges, exceed the total amount of Physician Funding available after completion of Final Settlement

for the applicable Program Year, INTERMEDIARY shall first apply the Physician allocation of any Clinic Funding reallocated to Physician Funding in accordance with subparagraph H.1. above. Any balance of funds remaining shall be allocated one hundred percent (100%) to the Hospital Funding.

b. If the total of all Physician Claims, paid at one hundred percent (100%) of Allowable Charges, still exceed the total amount of Physician Funding available after application of subparagraph 2.a. above, INTERMEDIARY shall allocate an amount up to, but not exceeding, forty-five percent (45%) of the additional CI Funding received from Department to the Physician Funding to achieve the highest possible reimbursement without exceeding Allowable Charges. Any balance of funds remaining shall be allocated one hundred percent (100%) to the Hospital Funding.

c. If Final Settlement for PY 2007-08 resulted in all Physician Claims being paid at one hundred percent (100%) of Allowable Charges, there will be no Supplemental Final Settlement for Physicians and any additional CI Funding which would have been apportioned to Physicians shall instead be allocated one hundred percent (100%) to the Hospital Funding.

4. Step 3: Contracting Hospitals

a. If the total of all Contracting Hospital Claims, paid at one hundred percent (100%) of Allowable Charges, exceed the total amount of Hospital Funding available after completion of Final Settlement for the applicable Program Year, INTERMEDIARY shall first apply the Hospital allocation of any Clinic Funding reallocated to Hospital Funding in accordance with subparagraph H.1. above. Any balance of funds remaining shall be returned to COUNTY by the Intermediary.

b. If the total of all Contracting Hospital Claims, paid at one hundred percent (100%) of Allowable Charges, still exceed the total amount of Hospital Funding available after application of subparagraph 3.a. above, INTERMEDIARY shall then apply the Hospital allocation of any Physician Funding reallocated to Hospital Funding in accordance with subparagraph E.2. above. Any balance of funds remaining shall be returned to COUNTY by INTERMEDIARY.

c. If the total of all Contracting Hospital Claims, paid at one hundred percent (100%) of Allowable Charges, still exceed the total amount of Hospital Funding available after application of subparagraphs c.1) and c.2) above, INTERMEDIARY shall allocate the balance of the additional CI Funding received from Department to the Hospital Funding to achieve the highest possible reimbursement without exceeding Allowable Charges. Any balance of funds remaining shall be returned to COUNTY by INTERMEDIARY.

d. If Final Settlement for the applicable Program Year resulted in all Contracting Hospital Claims being paid at one hundred percent (100%) of Allowable Charges, there will be no Supplemental Final Settlement for Hospitals and any additional CI Funding which would have been apportioned to Hospital shall instead be returned to COUNTY by INTERMEDIARY.

e. Any CI Funding returned to COUNTY by INTERMEDIARY shall be returned to

Department.

XIII. SATISFACTION OF CLAIMS

Acceptance by All Providers of payments made by INTERMEDIARY in accordance with this Agreement shall be deemed satisfaction in full of any obligation to All Providers, and no provider shall seek additional reimbursement from an MSI Eligible patient, with respect to those claims for Medical Services for which payment has been made by the MSI Program, notwithstanding a provider's right to appeal any denied claim, as provided for in subparagraph II.A.2 of Exhibit B to the Agreement and in subparagraph VII. of this Exhibit E.

XIV. CLAIMS PROCESSING STANDARDS AND SANCTIONS

A. INTERMEDIARY shall take action upon ninety percent (90%) of all claims within thirty (30) calendar days after their receipt. Such action shall include, but not be limited to, claim suspension, approval, or denial.

B. INTERMEDIARY shall submit a monthly Processing Timeliness Report, as required by Exhibit F to this Agreement.

C. At ADMINISTRATOR'S sole discretion, ADMINISTRATOR may assess a penalty (Penalty Assessment) if INTERMEDIARY fails to process and reimburse claims in accordance with the standards set forth herein, as evidenced by the above monthly Processing Timeliness Report.

1. The Penalty Assessment, if any, shall be equal to $100 for every percentage point below ninety percent (90%), and shall be deducted from the monthly payment otherwise due INTERMEDIARY for services provided pursuant to this Agreement.

2. Penalty Assessments, if any, shall be deposited as directed by ADMINISTRATOR and in consideration of, and consistent with, those claims not meeting processing standards as set forth herein.

3. If claims received any month, exceed the previous three (3)-month average by at least twenty-five (25%), INTERMEDIARY shall be provided an additional ten (10) calendar days to process such claims.

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EXHIBIT F
AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012
INTERMEDIARY DATA REPORTING REQUIREMENTS

I. GENERAL REQUIREMENTS

A. INTERMEDIARY shall provide the reports and data specified herein to COUNTY, in the manner and at the times indicated.

B. INTERMEDIARY'S obligation to compile and preserve data is limited to that data or information that is made available to INTERMEDIARY by SSA'S eligibility process, from claims submitted by All Providers, and from inquiries and reports pertaining to, or arising from, third-party payment recovery activities.

C. INTERMEDIARY shall advise COUNTY of any problems experienced in obtaining data or information necessary to meet its obligations pursuant to this Agreement, including data from eligibility documents or Medical Services claims.

D. At no additional cost to COUNTY, INTERMEDIARY may compile other data, as it deems necessary; provided, however such information shall be the property of COUNTY.

E. INTERMEDIARY shall provide online access to its internal data reporting system to persons designated by ADMINISTRATOR for the purposes of creating ad-hoc reports.

F. INTERMEDIARY shall advise ADMINISTRATOR of reports or information requested by HASC, OCMA, or COCCC or outside parties and shall direct these requests to ADMINISTRATOR. INTERMEDIARY shall not provide any such requests for information to HASC, OCMA or COCCC or outside parties unless specifically approved by ADMINISTRATOR.

II. ADDITIONAL REPORTS

A. INTERMEDIARY shall provide to COUNTY additional reports and data that may be required, in writing, by ADMINISTRATOR, such as:

1. Information and data required by this Exhibit at intervals more frequent than those specified.

2. Additional cross tabulations of the characteristics of Eligible Persons, Contracting Hospitals, and Other Providers by assessment and treatment descriptors as may be requested, in writing, by ADMINISTRATOR, if such cross tabulations are capable of computation from the data collected and

processed by INTERMEDIARY pursuant to this Agreement.

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3. A machine readable copy of the data accumulated on those items specified in this Exhibit, upon five (5) calendar days prior written notice by ADMINISTRATOR.

B. INTERMEDIARY shall maintain a remote machine readable copy of all information and data compiled in accordance with the requirements of this Exhibit, for purposes of reducing the risk of loss or destruction of such information and data. INTERMEDIARY shall consult with, and receive written approval from, COUNTY regarding the manner in which it intends to meet its obligations under this subparagraph.

C. At the discretion of ADMINISTRATOR, failure by INTERMEDIARY to provide any reports required by this Agreement, within thirty (30) calendar days of their due date, may result in a temporary withholding of $150 per delayed report. If such reports are more than sixty (60) calendar days late, a penalty assessment of $150 per report may be assessed.

D. INTERMEDIARY shall collect, compile, preserve and report the following information and data. Unless otherwise specified, reports shall be run each month and consist of data for the prior three (3) months running. A final annual report for services provided for the period of September 1, 2008 through August 31, 2009; September 1, 2009 through August 31, 2010; and September 1, 2010 through August 31, 2011 shall be completed no later than the Final Settlement for each Program Year. INTERMEDIARY shall ensure the internal consistency of all reports. Some reports, or databases used to generate such reports, may be requested in machine readable format at a later date. Format of all reports shall be determined by COUNTY in accordance with State and COUNTY requirements as they currently exist or may be amended. Unless otherwise specified, all reports shall be sent to ADMINISTRATOR'S MSI Program Manager as specified on Page 4 of this Agreement.

1. Data for Medically Indigent Care Reporting System (MICRS) from all sources (clinics, hospitals, physicians, etc.) based on claims submitted to INTERMEDIARY shall be processed and forwarded to COUNTY in State specified format. ADMINISTRATOR, at its sole discretion, may waive this report requirement.

2. Monthly data transfer updating COUNTY eligibility file and identifying potential Medi-Cal eligibles receiving MSI.

3. Financial monitoring reports to include:

a. Open Pending Report: Claims status (pending, approved, denied) by individual Contracting Hospital showing key action dates for all logged claims. (Quarterly)

b. Provider Pool Status Reports: For each of the following provider pools, detail dollars by month of service, the pool allocation, total billed charges, allowed charges by service category appropriate to the pool, disallowed charges by reason, Contract Rate, share of cost, points and/or interim

payments, unduplicated users, and encounters.

1) Hospital Pool by Contracting Hospital.

2) Physician Pool by individual provider.

3) Ambulance, Home Health, and Durable Medical Equipment providers.

4) Clinic Pool by Individual Provider.

5) Pharmaceuticals.

6) Ambulance claims relating to Receiving Hospital transfers.

7) Non-Hospital Outpatient Service Providers.

8) Dental Pool by individual provider.

c. The following reports shall be submitted to ADMINISTRATOR'S Strategic Projects Administration Manager as specified on Page 4 of this Agreement:

1) Processing Timeliness Report: Month's numbers of claims received, processed, pending action-to-date; current week's claims being worked and current processing time from receipt to final action. (Monthly)

2) Recovery Account Status Report: Hospital, Physician, and HCA Recovery Account balances, listing refunding hospitals and individual providers and origin of reimbursement resulting in refund. (Quarterly)

3) MSI Fund Reconciliation Report: INTERMEDIARY and ADMINISTRATOR shall mutually agree on a format and content of this report which shall be designated to aid in the reconciliation of Funds provided by COUNTY to INTERMEDIARY.

4. Utilization Review Reports to include:

a. All Trauma Patients Sorted By Charges: Listing each trauma patient by name, case number, inpatient days and charges, points, Contract Rate, primary discharge diagnosis, facility, admission and discharge dates, disposition.

b. 25 Most Costly Surgical, 25 Most Costly Non-Surgical, and 25 Patients With The Greatest Number of Emergency Room Encounters: Listing each selected patient by name, case number, encounters and charges by type, Contract Rate, primary discharge diagnosis, ICD9 Code, facility, service dates, disposition.

c. 50 Most Costly Patients: Listing each selected patient by name, case number, Contract Rates, primary diagnosis, ICD9 Code, initial service data, disposition.

d. Inpatients With Length of Stay Exceeding 15 Days: Listing each selected patient by name, case number, total days, case type, primary diagnosis, ICD9 Code, admission and discharge date, hospital, Contract Rate.

e. Summary of Trauma Cases by Facility: For each trauma center, a summary line of number of discharges, allowed charges, trauma days charges, ancillary charges, Contract Rate, total

days, points, unit ratios.

f. Listing of Current Confirmed Eligibles and Users by Characteristics: Based on eligibility data input by COUNTY; alphabetical listing by name, case number, SSN, birth date, eligibility approval dates, termination date, Medi-Cal effective date, statistical data, eligibility status for each of prior twelve (12) months. (Annually)

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g. Listing of Patients Diagnosed with AIDS: Including patient name, MSI number, date of birth, provider, name, date of service, total billed, total allowed, and amount paid. (As Requested)

5. Utilization Monitoring Reports to include:

a. Encounters, Charges, and Payments by Service Category: For each provider pool and hospital providers, table of unduplicated users, discharges, encounters, allowed charges, billed charges, points, Contract Rate, and ratios of charges, points, encounters to users, encounters to discharges, charges and base rate to encounters by service categories appropriate to pool; totals and subtotals independently unduplicated for users. (Quarterly and Annually)

b. Inpatient Characteristics and Charges by Length Of Stay: For hospital claims a table of total inpatient days, average length of stay, specified length of stay intervals by number of unduplicated users, discharges, age, sex, ethnicity, disposition and case type (trauma, surgical, other), ICD9 major disease groups, ranges of allowed charges per discharge, and average dollars per discharge. (As Requested)

c. Inpatient Experience by ICD9: For hospital inpatient claims overall a table of unduplicated users, discharges, inpatient days, points, allowed charges, ancillary charges, per discharge ratios, charges per day, case type by specific disease groupings and/or individual diseases/conditions; by ICD9 major disease groups; by hospital by ICD9 major disease groups, by hospital by charges. (As Requested)

d. User Experience by CPT4: For physician provider pool claims a table of unduplicated users, encounters, allowed charges, Contract Rate, charges/Contract Rate per encounter by CPT4 major procedure code groups. (As Requested)

6. Program Monitoring Reports to Include:

a. MSI Profile of All Patients: Based on eligibility data tapes provided by COUNTY, table of number of eligibles in each twelve (12) months, total eligibles in past twelve (12) months, average monthly eligibles for past twelve (12) months by transaction (total, additions, discontinued, changes), sex, age group, ethnicity, employment status, monthly income group, household configuration, IRCA alien status. (Bi-Annual)

b. Encounters by ICD9 and Services Rendered by Patient Characteristics: For all pools combined and each pool and service type combination, a table of encounters by ICD9 major disease

groups and median age of patients, sex, age group, ethnicity, IRCA alien status. (As Requested)

c. Unduplicated Users by Disposition: A table of unduplicated users' dispositions (follow-up, referral, death, release, continuing care, unknown) by month of service; by patient characteristics (age, sex, ethnicity, employment status, monthly income, household configuration, IRCA alien status) ; by diagnosis (ICD9 major disease groups). (As Requested)

7. Denial Reports to Include:

a. Reason for Disallowed Charges by Service Category: By facility, show total billed charges, total disallowed charges, percentage of disallowed charges, the reasons for denial of charges: Timeliness, Eligibility, Scope of Service, Utilization Review or Other Reason for the following service categories:

1. Inpatient with subcategories: Acute, Inpatient and Step-Down
2. Emergency Room Admission
3. Emergency Room with subcategories: Minor, Minor w/ Ancillary, Surgical
4. Outpatient with subcategories: Minor, Minor w/ Ancillary, Surgical (Bi-Monthly)

b. Utilization Review Denial Reason: By facility, including remark code, description, inpatient disallowed charges, inpatient disallowed admits, SNF disallowed charges, and SNF disallowed admits. (Monthly)

8. Annual/Periodic Reports:

a. Alphabetic listing of all claims by patient name in both hardcopy and electronically, including name, case number, provider name, service dates, bill type, total billed, total allowed, denial code, Contract Rate, share of cost, date paid, check number, total paid. (Annually)

b. Cumulative, quarterly, alphabetic listing of physician providers to include provider name, tax I.D. number, total billed, total allowed, and total paid; to be provided in hardcopy and machine readable format by February 28, 2010 for Period One, February 28, 2011 for Period Two. And February 29, 2012 for Period Three (As Requested)

c. The following reports shall be submitted to both ADMINSTRATOR'S MSI Program Manager and Strategic Projects Manager as specified on Page 4 of this Agreement.

1) Reports of final payout results, settlements, and adjustments including listings of payments for each provider pool and provider. Semi-monthly preliminary final payout reports commencing in January 2010 for Period One, January 2011 for Period Two, and January 2012 for Period Three.

2) Quarterly and annual estimated/actual data (reflecting final settlements) in report formats as specified by the State in both hardcopy and required electronic medium (e.g., ASCII text file on floppy diskette).

3) Quarterly and annual estimated/actual data (reflecting final settlements) of

unduplicated users by specified identifiers (SSN, DOB, Name) which merge medical services and other indigent services data for State reporting, in both hardcopy and floppy diskette as required by the Medically Indigent Care Reporting System (MICRS).

4) Quarterly and annual estimated/actual uncompensated care listings, including charges by medical providers, and payment by ICD9 codes, as required to meet California Healthcare Initiative Program and Emergency Medical Services Fund reporting requirements, in both hard copy and magnetic medium.

E. ADMINISTRATOR and INTERMEDIARY agree that the reporting periods specified in this Paragraph II shall be correspondingly modified to reflect any changes in the term for any Period and/or Program Year.

III. SYSTEM MAINTENANCE AND DOCUMENTATION REQUIREMENTS

INTERMEDIARY shall maintain written documentation of the following, which documentation shall be provided to ADMINISTRATOR upon request.

A. System Maintenance

1. Description of computer system hardware; software, and overall system flowchart and procedures.

2. Specification of provision for routine production backup of all system hardware and software used in connection with this contract.

3. Provision for modifying items specified in I. and II. above as required for State reporting purposes, including retrieval of report data on a defined subpopulation(s).

4. Specification of new procedures effective dates.

5. Specification for transfer of historical files.

6. Updates for system modifications.

B. Report Production

1. Documentation for all reports specified in I. and II. above to include:

   a. Production schedule

   b. Report summary (job code, report number, description, program names, file inputs required)

   c. Report production procedures

   d. Flow charts showing file inputs, processing and outputs

   e. Sample outputs for each report

2. Updates for report modifications.

IV. DATA ELEMENTS

INTERMEDIARY shall maintain the following data elements to generate the reports required by this Agreement.

A. Demographic Characteristics of MSI Eligibles and Users:
   1. Full name
   2. MSI Case Number
   3. Social Security Number
   4. Full mailing address, including zip code
   5. Date of birth
   6. Sex
   7. Ethnicity
   8. Employment
   9. Monthly income
   10. Household configuration
   11. Other insurance coverage
   12. Medi-Cal status and effective date
   13. Accident case, if applicable
   14. Eligibility certification date
   15. Eligibility effective date(s)
   16. Eligibility termination date(s)
   17. Eligibility status for each of prior eighteen (18) months
   18. Income Source
   19. Type of Employment
   20. Family Size
   21. Employment Status

B. Characteristics of Providers:
   1. Current name
   2. Previous name, if applicable
   3. Current identifier (tax ID)
   4. Previous identifier (tax ID), if applicable
   5. Professional/billing address(es), including zip code
   6. Type of provider
   7. Physician/facility specialty

C. Characteristics of Service Delivery:
   1. Date(s) of service (encounter, inpatient admission and discharge)
   2. Primary and secondary admitting diagnosis
   3. Primary and secondary discharge diagnosis
   4. Major procedures codes

5. Disposition (follow-up, referral, release, death, continuing care)

6. Location of service delivery (hospital, ambulance, outpatient clinic, physician office, emergency room, other facility)

7. Services rendered (users, encounters) - ambulance provider

a. Pickup and delivery

b. Oxygen usage

c. Mileage

d. Night call

8. Services rendered (users, encounters) - hospital provider

a. Inpatient room; acute, step-down, critical care

b. Trauma admission

c. Inpatient pharmacy

d. Inpatient ancillary: laboratory/pathology, radiology, anesthesia, operating room/recovery, other/miscellaneous

e. Emergency room: minor, minor with ancillary, major, surgery

f. Outpatient department: minor, minor with ancillary, major, surgery

g. Outpatient pharmacy

h. Detoxification, Physician Specialty

i. Ambulatory Surgery

9. Services rendered (users, encounters) - physician provider

a. Office visit

b. Hospital outpatient service; surgery, anesthesia, radiology, laboratory/pathology, medical visit

c. Hospital inpatient service; surgery, anesthesia, radiology, laboratory/pathology, medical visit

d. Dental services

e. Pharmacy

f. Medical Supplies

g. Physician Specialty

h. Ambulatory Surgery

10. Services rendered (users, encounters) - home health provider

a. Nursing services

b. Durable medical equipment provided

D. <u>Billing/Claims Processing:</u>

1. Date of claim

2. Date claim received
3. Date claim processed
4. Date claim paid
5. Itemized billed charges for services rendered
6. Allowable charges for services rendered
7. Data Source
8. Disallowed charges for services rendered by reason for denial
9. Contract Rate for services rendered
10. Points computed for services rendered
11. Weekly check registers of claims processed
12. Adjustments to claims; Medi-Cal, retractions, voids, refunds
13. Bill type: ambulance, hospital, physician, Home health, Durable Medical Equipment
14. Cumulative numbers of claims; received, processed, paid, denied
15. Claim disposition: pending, approved, denied
16. Processing time: mean, median, standard deviation

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EXHIBIT G-1
AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

I. HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services provided during the period September 1, 2008 through August 31, 2009, which payment may be revised pursuant to Paragraph II. of Exhibit E to this Agreement.

HOSPITAL	PIP PAYMENTS
Anaheim General Hospital	$38,886
Anaheim Memorial Medical Center	$187,429
Chapman Medical Center, Inc., dba Chapman Medical Center	$26,138
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$68,282
Fountain Valley Regional Hospital	$250,384
Garden Grove Hospital & Medical Center	$68,282
Hoag Memorial Hospital Presbyterian	$172,080
Irvine Medical Center	$28,220
Kaiser Foundation Hospitals, Inc.-Anaheim	$4,559
Kaiser Foundation Hospitals, Inc.-Irvine	$0
Los Alamitos Medical Center	$38,683
Mission Hospital	$212.923
Orange Coast Memorial Medical Center	$68,022
Placentia Linda Community Hospital	$29,520
Prime Healthcare Anaheim	$64,900
Prime Healthcare Huntington Beach	$86,752
Prime Healthcare La Palma	$12,091
Regents of the University of California	$519,894
Saddleback Memorial Medical Center (SMMC) (includes Laguna Hills Campus and San Clemente Campus)	$117,710
Saint Joseph Hospital - Orange	$124,473
Saint Jude Medical Center	$159,853
South Coast Medical Center	$14,172
WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	$61,258
WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	$251,945
Total PIP Payments	$2,601,454

EXHIBIT G-2
AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

II. HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services provided during the period September 1, 2009 through August 31, 2010, which payment may be revised pursuant to Paragraph II. of Exhibit E to this Agreement.

HOSPITAL	PIP PAYMENTS
Chapman Medical Center, Inc., dba Chapman Medical Center	$15,792
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$80,567
Fountain Valley Regional Hospital	$309,955
Hoag Memorial Hospital Presbyterian	$56,477
Kaiser Foundation Hospitals,	$10,443
Los Alamitos Medical Center	$27,569
Mission Hospital	$295,501
Orange Coast Memorial Medical Center	$61,027
Placentia Linda Community Hospital	$35,599
Prime Healthcare Anaheim	$78,158
Prime Healthcare Garden Grove	$67,451
Prime Healthcare Huntington Beach	$67,184
Prime Healthcare La Palma	$21,681
Regents of the University of California	$506,688
Saddleback Memorial Medical Center (SMMC)	$77,890
Saint Joseph Hospital - Orange	$135,973
Saint Jude Medical Center	$207,440
South Coast Medical Center	$13,383
WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	$31,317
WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	$287,471
Total PIP Payments	$2,616,954

EXHIBIT G-3
AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR THE
MEDICAL SERVICES INITIATIVE PROGRAM
SEPTEMBER 1, 2008 THROUGH FEBRUARY 29, 2012

III. HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services provided during the period September 1, 2010 through August 31, 2011, which payment may be revised pursuant to Paragraph II. of Exhibit E to this Agreement.

HOSPITAL	PIP PAYMENTS
Anaheim General Hospital	$0
Anaheim Memorial Medical Center	$0
Chapman Medical Center, Inc., dba Chapman Medical Center	$0
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$0
Fountain Valley Regional Hospital	$0
Garden Grove Hospital & Medical Center	$0
Hoag Memorial Hospital Presbyterian	$0
Irvine Medical Center	$0
Kaiser Foundation Hospitals, Inc.-Anaheim	$0
Kaiser Foundation Hospitals, Inc.-Irvine	$0
Los Alamitos Medical Center	$0
Mission Hospital	$0
Orange Coast Memorial Medical Center	$0
Placentia Linda Community Hospital	$0
Prime Healthcare Anaheim	$0
Prime Healthcare Huntington Beach	$0
Prime Healthcare La Palma	$0
Regents of the University of California	$0
Saddleback Memorial Medical Center (SMMC) (includes Laguna Hills Campus and San Clemente Campus)	$0
Saint Joseph Hospital - Orange	$0
Saint Jude Medical Center	$0
South Coast Medical Center	$0
WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	$0
WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	$0
Total PIP Payments	