AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS
BETWEEN
COUNTY OF ORANGE
AND
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH SEPTEMBER 30, 2014

THIS AGREEMENT is entered into this 10th day of August 2011, 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 low income persons for whom COUNTY is legally responsible pursuant to State of California (State) Law through its Medical Services Initiative (MSI) Program; and,

WHEREAS, COUNTY anticipates receiving Low Income Health Program (LIHP) Funding to expand eligibility requirements for a limited number of additional low income persons and expand scope of service benefits beyond its legal responsibility pursuant to State law; and,

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

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

WHEREAS, COUNTY established the Emergency Medical Services Fund (EMSF) Program in accordance with Health and Safety Code Section 1797.98a; and

WHEREAS, a portion of the EMSF is designated as the Physicians' Allocation; and,

WHEREAS, INTERMEDIARY, is the current fiscal intermediary for the MSI and EMSF Program services specified herein; and,

WHEREAS, the parties wish to provide for equitable reimbursement of those providing MSI and EMSF Program services with a minimum of administrative costs; and,

WHEREAS, the parties desire to state their respective rights and responsibilities related to providing, claiming, and reimbursing MSI and EMSF Program services.

NOW, THEREFORE, IT IS MUTUALLY AGREED AS FOLLOWS:

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REFERENCED CONTRACT PROVISIONS

Term: August 10, 2011 through September 30, 2014

"MSI Period One" means the period August 10, 2011 through December 31, 2012

"MSI Period Two" means the period July 1, 2012 through December 31, 2013

"MSI Period Three" means the period July 1, 2013 through June 30, 2014

"EMSF Period One" means the period August 10, 2011 through September 30, 2012

"EMSF Period Two" means the period July 1, 2012 through September 30, 2013

"EMSF Period Three" means the period July 1, 2013 through September 30, 2014

~~**INTERMEDIARY Maximum Obligation:** **Period One** **Period Two** **Period Three**~~

~~MSI INTERMEDIARY Maximum Obligation: $2,700,000 $2,802,600 $1,949,100~~

~~MSI Ancillary Services Maximum Obligation: 200,000 200,000 200,000~~

~~EMSF INTERMEDIARY Maximum Obligation: 690,740 716,990 744,250~~

~~**INTERMEDIARY Maximum Obligations:** **$3,590,740** **$3,719,590** **$2,893,350**~~

~~MSI Excess Claims Volume Maximum Obligation: $147,923~~

~~**Total INTERMEDIARY Maximum Obligations:** **$10,351,603**~~

INTERMEDIARY Maximum Obligation:	**Period One**	**Period Two**	**Period Three**
MSI INTERMEDIARY Maximum Obligation:	$2,700,000	$2,802,600	$1,949,100
MSI Ancillary Services Maximum Obligation:	$ 200,000	$ 200,000	$ 200,000
EMSF INTERMEDIARY Maximum Obligation:	$ 690,740	$ 716,990	$ 744,250
INTERMEDIARY Maximum Obligations:	$3,590,740	$3,719,590	$2,893,350

MSI Excess Claims Volume Maximum Obligation: $2,132,767

Total INTERMEDIARY Maximum Obligations: $12,336,447

Notices to COUNTY and INTERMEDIARY:

COUNTY: County of Orange
Health Care Agency
Contract Development and Management
405 West 5th Street, Suite 600
Santa Ana, CA 92701

INTERMEDIARY: Advanced Medical Management, Inc.
5000 Airport Plaza Drive, Suite 150

Long Beach, CA 90815-1260
Voice: (562) 766-2000

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
Automobile Liability, including coverage for owned, non-owned and hired vehicles	$1,000,000 per occurrence

I. ALTERATION OF TERMS

This Agreement, together with Exhibits A through F, 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. ASSIGNMENT OF DEBTS

Unless this Agreement is followed without interruption by another Agreement between the parties hereto for the same services and substantially the same scope, at the termination of this Agreement, INTERMEDIARY shall assign to COUNTY any debts owing to INTERMEDIARY by or on behalf of persons receiving services pursuant to this Agreement. INTERMEDIARY shall immediately notify by mail each of these persons, specifying the date of assignment, the County of Orange as assignee, and the address to which payments are to be sent. Payments received by INTERMEDIARY from or on behalf of said persons, shall be immediately given to COUNTY.

III. BUSINESS ASSOCIATE TERMS AND CONDITIONS

A. GENERAL PROVISIONS AND RECITALS

1. The parties agree that the terms used, but not otherwise defined below, shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1966 (HIPAA), as it may exist now or be hereafter amended.

2. It is agreed by both parties that INTERMEDIARY is a Business Associate of COUNTY for the purposes of this Agreement. 3. It is understood by both parties that the HIPAA Security and Privacy Rules apply to the INTERMEDIARY in the same manner as they apply to the covered entity (COUNTY). INTERMEDIARY shall therefore at all times be in compliance with the applicable provisions of both the Privacy and the Security Rules as are described in Subparagraphs B.4. and B.5. below, and is responsible for complying with the issued regulations for said rules, as they

currently exist or are hereafter amended, for purposes of safeguarding any Protected Health Information (PHI) generated by INTERMEDIARY consistent with the terms of this Agreement.

4. It is understood by both parties that the Privacy Rule does not pre-empt any state statutes, rules or regulations that impose more stringent requirements with respect to confidentiality of PHI.

5. COUNTY wishes to disclose certain information to INTERMEDIARY pursuant to the terms of this Agreement, some of which may constitute PHI as defined in Subparagraph B.6. below.

6. COUNTY and INTERMEDIARY intend to protect the privacy and provide for the security of PHI disclosed to the INTERMEDIARY pursuant to this Agreement, in compliance with HIPAA and

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the regulations promulgated thereunder by the U.S. Department of Health and Human Services as they may now exist or be hereafter amended.

B. DEFINITIONS

1. "Breach" means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the Protected Health Information.

a. For purposes of this definition, compromises the security or privacy of the Protected Health Information means poses a significant risk of financial, reputational, or other harm to the Individual.

b. A use or disclosure of Protected Health Information that does not include the identifiers listed at §164.514 (e) (2), date of birth, and zip code does not compromise the security or privacy of protected health information.

c. Breach excludes:

1) Any unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

2) Any inadvertent disclosure by a person who is authorized to access Protected Health Information at a covered entity or business associate to another person authorized to access Protected Health Information at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

3) A disclosure of Protected Health Information where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retains such information.

2. "Designated Record Set" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.501.

3. "Individual" shall have the meaning given to such term under the Privacy Rule, including,

but not limited to, 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.502(g).

4. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

5. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160, Part 162, and Part 164, Subparts A and C."

6. "Protected Health Information" or "PHI" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 160.103, as applied to the information created or received by Business Associate from or on behalf of Covered Entity. 7.

"Required by Law" shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 CFR Section 164.103.

8. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

9. "Unsecured Protected Health Information" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services in the guidance issued on the HHS Web site.

C. OBLIGATIONS AND ACTIVITIES OF INTERMEDIARY AS BUSINESS ASSOCIATE

1. INTERMEDIARY agrees not to use or disclose PHI other than as permitted or required by this Agreement or as required by law.

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

3. 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.

4. INTERMEDIARY agrees to report to COUNTY within five (5) business days any use or disclosure of PHI not provided for by this Agreement of which INTERMEDIARY becomes aware.

5. 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 COUNTY, agrees to the same restrictions and conditions that apply through this Agreement to INTERMEDIARY with respect of such information.

6. 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 in order to meet the requirements under 45 CFR Section 164.524.

7. 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, within thirty (30) calendar days of receipt of said request by COUNTY.

INTERMEDIARY agrees to notify COUNTY in writing no later than ten (10) calendar days after said amendment is completed.

8. 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, 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.

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

10. INTERMEDIARY agrees to provide COUNTY or an Individual, as directed by COUNTY, in a time and manner to be determined by COUNTY, that information collected in accordance with this Agreement, in order to permit COUNTY to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

11. INTERMEDIARY shall work with COUNTY upon notification by INTERMEDIARY to COUNTY of a Breach to properly determine if any Breach exclusions exist as defined in Subparagraph B.1.c. above.

D. SECURITY RULE

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

2. Agents and Subcontractors. INTERMEDIARY shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect the PHI.

3. Security Incidents. INTERMEDIARY shall report any security incident of which it becomes aware to COUNTY. 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.

E. BREACH DISCOVERY AND NOTIFICATION

1. Following the discovery of a Breach of Unsecured Protected Health Information, INTERMEDIARY shall notify COUNTY of such Breach, however both parties agree to a delay in the notification if so advised by a law enforcement official, pursuant to 45 CFR 164.412.

2. A Breach shall be treated as discovered by INTERMEDIARY as of the first day on which the Breach is known to the INTERMEDIARY, or by exercising reasonable diligence, would have been known to INTERMEDIARY.

3. INTERMEDIARY shall be deemed to have knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have known, to any person who is an employee, officer, or other agent of the INTERMEDIARY, as determined by federal common law of agency.

4. INTERMEDIARY shall provide the notification of the Breach without unreasonable delay, and in no case later than five (5) business days after a Breach.

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5. INTERMEDIARY's notification may be oral, but shall be followed by written notification within twenty-four (24) hours of the oral notification. Thereafter, INTERMEDIARY shall provide written notification containing the contents stated below, within five (5) business days. INTERMEDIARY shall be required to provide any other information relevant to the Breach in writing, as soon as discovered, or as soon as the information is available.

6. INTERMEDIARY's notification shall include, to the extent possible:

a. The identification of each Individual whose unsecured protected health information has been, or is reasonably believed by INTERMEDIARY to have been, accessed, acquired, used, or disclosed during the Breach,

b. Any other information that COUNTY is required to include in the notification to Individual it must provide pursuant to 45 CFR §164.404 (c), at the time INTERMEDIARY is required to notify COUNTY, or promptly thereafter as this information becomes available, even after the regulatory sixty (60) day period set forth in 45 CFR § 164.410 (b) has elapsed, including:

1) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

2) A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

3) Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

4) A brief description of what INTERMEDIARY is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any future Breaches; and

5) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

7. COUNTY may require INTERMEDIARY to provide notice to the Individual as required in 45 CFR § 164.404 if it is reasonable to do so under the circumstances, at the sole discretion of the COUNTY.

8. In the event that INTERMEDIARY is responsible for, or suffers a Breach of Unsecured

Protected Health Information, in violation of the Privacy Rule, INTERMEDIARY shall have the burden of demonstrating that INTERMEDIARY made all notifications to COUNTY as required by the Breach Notification regulations, or in the alternative, that the use or disclosure did not constitute a Breach as defined in 45 CFR § 164.402.

9. INTERMEDIARY shall maintain documentation of all required notifications required pursuant to this Agreement in the event of an impermissible use or disclosure of Unsecured Protected Health Information, or its risk assessment of the application of an exception to demonstrate that the notification was not required.

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10. INTERMEDIARY shall provide to COUNTY all specific and pertinent information about the Breach to permit COUNTY to meet its notification obligations under the HITECH Act, as soon as practicable, but in no event later than fifteen (15) calendar days after reporting the initial Breach to the COUNTY.

11. INTERMEDIARY shall continue to provide all additional pertinent information about the Breach to COUNTY as it may become available, in reporting increments of fifteen (15) calendar days after the last report to COUNTY. INTERMEDIARY shall also respond in good faith to any reasonable requests for further information, or follow-up information after report to COUNTY, when such request is made by COUNTY.

12. INTERMEDIARY shall bear all expense or other costs associated with the Breach, and shall reimburse COUNTY for all expenses COUNTY incurs in addressing the Breach and consequences thereof, including costs of investigation, notification, remediation, documentation or other costs associated with addressing the Breach.

F. PERMITTED USES AND DISCLOSURES BY INTERMEDIARY

1. 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.

2. INTERMEDIARY is permitted to use PHI as necessary for the proper management and administration of INTERMEDIARY or to carry out legal responsibilities of INTERMEDIARY. (ref. 45 C.F.R. 164.504(e)(4)(i)(A-B)).

3. INTERMEDIARY is permitted to disclose PHI received from COUNTY for the proper management and administration of INTERMEDIARY or to carry out legal responsibilities of INTERMEDIARY, provided:

a. The disclosure is required by law; or

b. INTERMEDIARY obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to

prevent unauthorized use or disclosure of the PHI, and the person immediately notifies INTERMEDIARY of any instance of which it is aware in which the confidentiality of the Information has been Breached. (ref. 45 C.F.R. 164.504(e)(4)(ii)).

4. INTERMEDIARY is also permitted to use or disclose PHI to provide data aggregation services, as that term is defined by 45 C.F.R. 164.501, relating to the health care operations of COUNTY.

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G. OBLIGATIONS OF COUNTY

1. 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.

2. COUNTY shall notify INTERMEDIARY of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect INTERMEDIARY's use or disclosure of PHI.

3. 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 extent that such restriction may affect INTERMEDIARY's use or disclosure of PHI.

4. 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.

H. BUSINESS ASSOCIATE TERMINATION

1. Notwithstanding the Termination provisions set forth in this Agreement, the Agreement shall only terminate when all of the PHI provided by COUNTY to INTERMEDIARY, or created or received by INTERMEDIARY on behalf of COUNTY, is destroyed or returned to COUNTY, or if infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Subparagraph.

2. 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 Paragraph, COUNTY shall either:

a. 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

b. Immediately terminate this Agreement if INTERMEDIARY has breached a material term of this Paragraph and cure is not possible; or

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

3. 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.

a. This provision shall apply to PHI that is in the possession of subcontractors or agents of INTERMEDIARY.

b. INTERMEDIARY shall retain no copies of the PHI.

C. IN THE EVENT THAT INTERMEDIARY DETERMINES THAT RETURNING OR DESTROYING THE PHI IS INFEASIBLE, INTERMEDIARY SHALL PROVIDE TO COUNTY NOTIFICATION OF THE CONDITIONS THAT MAKE RETURN OR DESTRUCTION INFEASIBLE. UPON DETERMINATION BY COUNTY THAT RETURN OR DESTRUCTION OF PHI IS INFEASIBLE, 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.

IV. COMPLIANCE

A. COMPLIANCE PROGRAM – ADMINISTRATOR 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 ensure that INTERMEDIARY is made aware of the relevant policies and procedures relating to ADMINISTRATOR's Compliance Program.

2. INTERMEDIARY 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 ADMINISTRATOR's Compliance Program and related policies and procedures.

3. INTERMEDIARY has the option to adhere to ADMINISTRATOR's Compliance Program or establish its own.

4. If INTERMEDIARY elects to have its own Compliance Program then it shall submit a copy of its Compliance Program and relevant policies and procedures to ADMINISTRATOR within thirty (30) calendar days of award of this Agreement.

5. ADMINISTRATOR's Compliance Officer shall determine if INTERMEDIARY's Compliance Program is accepted. INTERMEDIARY shall take necessary action to meet said standards or shall be asked to acknowledge and agree to the ADMINISTRATOR's Compliance Program.

6. Upon approval of INTERMEDIARY's Compliance Program by ADMINISTRATOR's Compliance Officer, INTERMEDIARY shall ensure that its Covered Individuals relative to this Agreement are made aware of INTERMEDIARY's Compliance Program and related policies and procedures.

7. Failure of INTERMEDIARY to submit its Compliance Program and relevant policies and procedures shall constitute a material breach of this Agreement. 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.

B. CODE OF CONDUCT -ADMINISTRATOR has developed a Code of Conduct for adherence by ADMINISTRATOR's employees and contract providers.

1. ADMINISTRATOR shall ensure that INTERMEDIARY is made aware of ADMINISTRATOR's Code of Conduct.

2. INTERMEDIARY shall ensure that its Covered Individuals relative to this Agreement are made aware of ADMINISTRATOR's Code of Conduct.

3. INTERMEDIARY has the option to adhere to ADMINISTRATOR's Code of Conduct or establish its own.

4. If INTERMEDIARY elects have its own Code of Conduct, then it shall submit a copy of its Code of Conduct to ADMINISTRATOR within thirty (30) calendar days of award of this Agreement.

5. ADMINISTRATOR's Compliance Officer shall determine if INTERMEDIARY's Code of Conduct is accepted. INTERMEDIARY shall take necessary action to meet said standards or shall be asked to acknowledge and agree to ADMINISTRATOR's Code of Conduct.

6. Upon approval of INTERMEDIARY's Code of Conduct by ADMINISTRATOR, INTERMEDIARY shall ensure that its Covered Individuals relative to this Agreement are made aware of INTERMEDIARY's Code of Conduct.

7. If INTERMEDIARY elects to adhere to ADMINISTRATOR's Code of Conduct then INTERMEDIARY shall submit to ADMINISTRATOR a signed acknowledgement and agreement that INTERMEDIARY shall comply with ADMINISTRATOR's Code of Conduct.

8. Failure of INTERMEDIARY to timely submit the acknowledgement of ADMINISTRATOR's 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. COVERED INDIVIDUALS – INTERMEDIARY 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. INTERMEDIARY shall screen prospective Covered Individuals prior to hire or engagement. INTERMEDIARY shall not hire or engage any Ineligible Person to provide services relative to this Agreement.

3. INTERMEDIARY shall screen all current Covered Individuals semi-annually (January and July) to ensure that they have not become Ineligible Persons. INTERMEDIARY shall also request that its subcontractors use their best efforts to verify that they are eligible to participate in all federal and State of California health programs and have not been excluded or debarred from participation in any federal or state health care programs, and to further represent to INTERMEDIARY that they do not have any Ineligible Person in their employ or under contract.

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

5. INTERMEDIARY 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 INTERMEDIARY becomes aware that a Covered Individual has become an Ineligible Person, INTERMEDIARY shall remove such individual from responsibility for, or involvement with, COUNTY business operations related to this Agreement.

6. INTERMEDIARY shall notify ADMINISTRATOR immediately if a Covered Individual or entity is currently excluded, suspended or debarred, or is identified as such after being sanction screened. Such individual or entity shall be immediately removed from participating in any activity associated with this Agreement. ADMINISTRATOR will determine if any repayment is necessary from INTERMEDIARY for services provided by ineligible person or individual.

D. REIMBURSEMENT STANDARDS

1. INTERMEDIARY shall take reasonable precaution to ensure that the coding of health care claims, billings and/or invoices 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. INTERMEDIARY shall submit no false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.

3. INTERMEDIARY shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, INTERMEDIARY shall use only correct billing codes that accurately describe the services provided and to ensure compliance with all billing and documentation requirements.

4. INTERMEDIARY 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. INTERMEDIARY shall use its best efforts to encourage completion by Covered Individuals; provided, however, that at a minimum INTERMEDIARY 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. INTERMEDIARY shall retain the certifications. Upon written request by ADMINISTRATOR, INTERMEDIARY shall provide copies of the certifications.

V. 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, federal and county 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 members of the Board of Directors or its designee or authorized agent, employees, consultants, Subcontractors, volunteers and interns 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 members of the Board of Directors or its designee or authorized agent, employees, consultants, Subcontractors, volunteers and interns.

VI. DELEGATION, ASSIGNMENT AND SUBCONTRACTS

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.

1. After approval of a subcontract, ADMINISTRATOR may revoke the approval of a subcontract upon five (5) calendar days written notice to INTERMEDIARY if the subcontract

subsequently fails to meet the requirements of this Agreement or any provisions that ADMINISTRATOR has required.

2. No subcontract shall terminate or alter the responsibilities of INTERMEDIARY to COUNTY pursuant to this Agreement.

3. ADMINISTRATOR may disallow, from payments otherwise due INTERMEDIARY, amounts claimed for subcontracts not approved in accordance with this paragraph.

4. 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.

B. For INTERMEDIARY, which is a for-profit organization, any change in the business 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.

VII. EMPLOYEE ELIGIBILITY VERIFICATION

INTERMEDIARY 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 statutes and regulations. INTERMEDIARY 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. INTERMEDIARY shall retain all such documentation for all covered employees for the period prescribed by the law.

VIII. FACILITIES, PAYMENTS AND SERVICES

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

IX. INDEMNIFICATION AND INSURANCE

A. INTERMEDIARY agrees to indemnify, defend and hold COUNTY, its elected and appointed officials, officers, employees, agents and those special districts and agencies for which COUNTY's Board of Supervisors acts as the governing Board ("COUNTY INDEMNITEES") harmless from any

claims, demands, including defense costs, or liability of any kind or nature, including but not limited to personal injury or property damage, arising from or related to the services, products or other performance provided by INTERMEDIARY pursuant to this Agreement. If judgment is entered against INTERMEDIARY and COUNTY by a court of competent jurisdiction because of the concurrent active negligence of COUNTY or COUNTY INDEMNITEES, INTERMEDIARY and COUNTY agree that liability will be apportioned as determined by the court. Neither party shall request a jury apportionment.

B. COUNTY agrees to indemnify, and hold INTERMEDIARY, its officers, agents and employees, directors, members, shareholders and/or affiliates harmless from any claims, demands, including defense costs or liability of any kind or nature, including but not limited to personal injury or property damage, arising from or related to the services, products or other performance provided by COUNTY pursuant to this Agreement. If judgment is entered against COUNTY and INTERMEDIARY by a court of competent jurisdiction because of the concurrent active negligence of INTERMEIDARY, COUNTY and INTERMEDIARY agree that liability will be apportioned as determined by the court. Neither party shall request a jury apportionment.

C. Each party agrees to provide the indemnifying party with written notification of any claim related to services provided by either party pursuant to this Agreement within thirty (30) calendar days of notice thereof, and in the event the indemnifying party is subsequently named party to the litigation, each party shall cooperate with the indemnifying party in its defense.

D. Without limiting INTERMEDIARY's indemnification, INTERMEDIARY warrants that it is self-insured or shall maintain in force at all times during the term of this Agreement, the policy or policies of insurance covering its operations placed with reputable insurance companies in amounts as specified in the Reference Contract Provisions. Upon request by ADMINISTRATOR, INTERMEDIARY shall provide evidence of such insurance.

E. All insurance policies except Workers' Compensation and Employer's Liability shall contain the following clauses:

1. "The County of Orange is included as an additional insured with respect to the operations of the named insured performed under contract with the County of Orange."

2. "It is agreed that any insurance maintained by the County of Orange shall apply in excess of, and not contribute with, insurance provided by this policy."

3. "This insurance shall not be cancelled, limited or non-renewed until after thirty (30) calendar days written notice has been given to Orange County HCA/Contract Development and Management, 405 West 5th Street, Suite 600, Santa Ana, CA 92701-4637."

F. 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 and EMSF Programs. 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."

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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/Contract Development and Management , 405 West 5th Street, Suite 600, Santa Ana, California 92701."

3. In the event the size of the Accounts specified in Exhibit A 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.

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

H. 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.

X. 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 Management and Maintenance paragraph of 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.

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.

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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.

XI. LICENSES AND LAWS

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 Low Income Health Program 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 a contractor 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.

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.

XII. MAXIMUM OBLIGATION

A. The Maximum Obligation of COUNTY for services provided by INTERMEDIARY in accordance with this Agreement for each Period are as specified in the Reference Contract Provisions of this Agreement.

B. The MSI Program Maximum Obligation for each Period, as specified in the Reference Contract Provisions, 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 Exhibit A to this Agreement.

C. ADMINISTRATOR may amend the Aggregate Maximum Obligation by an amount not to exceed ten percent (10%) for Period One of funding for this Agreement.

XIII. 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 orientation, 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 orientation, 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.

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 orientation, medical condition, or physical or mental disability in accordance with Title IX of the Education Amendments of 1972; Title VI of the Civil Rights Act of 1964, 42 U.S.C.A. §2000d the Age Discrimination Act of 1975 (42 U.S.C.A. §6101); and Title 9, Division 4, Chapter 6, Article 1 (§10800, et seq.) of the California Code of Regulations, 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.

1. For the purpose of this subparagraph B., "discrimination" includes, but is not limited to the following based on one or more of the factors identified above:

a. Denying a client or potential client any service, benefit, or accommodation.

b. Providing any service or benefit to a client which is different or is provided in a different manner or at a different time from that provided to other clients.

c. Restricting a client in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit.

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d. Treating a client differently from others in satisfying any admission requirement or condition, or eligibility requirement or condition, which individuals must meet in order to be provided any service or benefit.

e. Assignment of times or places for the provision of services.

2. Complaint Process - INTERMEDIARY shall establish procedures for advising all clients through a written statement that INTERMEDIARY's clients may file all complaints alleging discrimination in the delivery of services with INTERMEDIARY, ADMINISTRATOR, or the U.S. Department of Health and Human Services' Office for Civil Rights. INTERMEDIARY's statement shall advise clients of the following:

a. In those cases where the client's complaint is filed initially with the Office for Civil Rights (Office), the Office may proceed to investigate the client's complaint, or the Office may request COUNTY to conduct the investigation.

b. Within the time limits procedurally imposed, the complainant shall be notified in writing as to the findings regarding the alleged complaint and, if not satisfied with the decision, may file an appeal with the Office for Civil Rights.

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.

E. In the event of noncompliance with this paragraph or as otherwise provided by federal or state law, this Agreement may be canceled, terminated, or suspended, in whole or in part, and

INTERMEDIARY may be declared ineligible for future contracts involving federal, state, or county funds.

XIV. 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 in the Reference Contract Provisions 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 in the Reference Contract Provisions 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. INTERMEDIARY shall notify ADMINISTRATOR, in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature, which may expose COUNTY to liability. Such occurrences shall include, but not be limited to, accidents, injuries, or acts of negligence, or loss or damage to any COUNTY property in possession of INTERMEDIARY.

D. 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.

XV. RECORDS MANAGEMENT AND MAINTENANCE

A. INTERMEDIARY, its officers, agents, employees and subcontractors shall, throughout the term of this Agreement, prepare, maintain and manage records appropriate to the services provided and in accordance with this Agreement and all applicable requirements.

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

C. INTERMEDIARY shall implement and maintain administrative, technical and physical safeguards to ensure the privacy of protected health information (PHI) and prevent the intentional or unintentional use or disclosure of PHI in violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), federal and state regulations and/or COUNTY HIPAA Policies (see COUNTY HIPAA P&P 1-2). INTERMEDIARY shall mitigate to the extent practicable, the known harmful effect of any use or disclosure of protected health information made in violation of federal or

state regulations and/or COUNTY policies.

D. Patient records provided to INTERMEDIARY in support of services as specified herein shall be maintained in a secure manner. INTERMEDIARY shall maintain patient records and must establish and implement written record management procedures.

E. INTERMEDIARY may retain participant, client, and/or patient documentation electronically in accordance with the terms of this Agreement and common business practices. If documentation is retained electronically, INTERMEDIARY shall, in the event of an audit or site visit:

1. Have documents readily available within twenty-four (24) hour notice of a scheduled audit or site visit.

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2. Provide auditor or other authorized individuals access to documents via a computer terminal.

3. Provide auditor or other authorized individuals a hardcopy printout of documents, if requested.

F. INTERMEDIARY shall ensure appropriate financial records related to cost reporting, expenditure, revenue, billings, etc., are prepared and maintained accurately and appropriately.

G. INTERMEDIARY shall ensure all appropriate state and federal standards of documentation, preparation, and confidentiality of records related to participant, client and/or patient records are met at all times.

H. INTERMEDIARY shall be informed through this Agreement that HIPAA has broadened the definition of medical records and identified this new record set as a Designated Record Set (DRS). INTERMEDIARY shall ensure all HIPAA DRS requirements are met. HIPAA requires that clients, participants and patients be provided the right to access or receive a copy of their DRS and/or request addendum to their records. 45 CFR §164.501, defines DRS as a group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered health care Provider;

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

I. INTERMEDIARY shall ensure compliance with requirements pertaining to the privacy and security of personally identifiable information (hereinafter "PII") and/or protected health information (hereinafter "PHI"). INTERMEDIARY shall, immediately upon discovery of a breach of privacy and/or security of PII and/or PHI by INTERMEDIARY, notify ADMINISTRATOR of such breach by telephone and email or facsimile.

J. INTERMEDIARY may be required to pay any costs associated with a breach of privacy and/or security of PII and/or PHI, including but not limited to the costs of notification. INTERMEDIARY

shall pay any and all such costs arising out of a breach of privacy and/or security of PII and/or PHI.

K. INTERMEDIARY shall retain all participant, client and/or patient medical records for seven (7) years following discharge of the participant, client and/or patient, with the exception of non-emancipated minors for whom records must be kept for at least one (1) year after such minors have reached the age of eighteen (18) years, or for seven (7) years after the last date of service, whichever is longer.

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

M. INTERMEDIARY shall make records pertaining to the costs of services, participant fees, charges, billings, and revenues available at one (1) location within the limits of the County of Orange.

N. If INTERMEDIARY is unable to meet the record location criteria above, ADMINISTRATOR may provide written approval to INTERMEDIARY to maintain records in a single location, identified by INTERMEDIARY.

O. INTERMEDIARY may be required to retain all records involving litigation proceedings and settlement of claims for a longer term which will be directed by the ADMINISTRATOR.

P. INTERMEDIARY shall direct all requests which are determined by INTERMEDIARY to be Public Record Act (PRA) requests to ADMINISTRATOR. INTERMEDIARY shall comply with ADMINISTRATOR instructions in providing information that is requested by the PRA request.

XVI. 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.

XVII. 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.

XVIII. TERM

The term of this Agreement shall commence and terminate as specified in the Referenced Contract Provisions of this Agreement; provided, however, the parties shall continue to be obligated to comply with the requirements and perform the duties specified in this Agreement including, but not limited to, obligations with respect to claims processing, reimbursement, reporting, indemnification, audits, and accounting.

XIX. TERMINATION

A. Either party may terminate this entire Agreement without cause upon one-hundred eighty (180) calendar days written notice given the other party.

B. ADMINISTRATOR, at its sole discretion, may terminate any program or specific service funded through this Agreement without cause upon one-hundred eighty (180) calendar days written notice.

C. Unless otherwise specified in this Agreement, either party may terminate this Agreement or those provisions specific to either the MSI Program or the EMSF Program, 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 and/or the terminated program services of the Agreement.

D. 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.

E. 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, or the provisions relating to the MSI or EMSF Program as applicable, 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.

F. CONTINGENT FUNDING

1. Any obligation of COUNTY under this Agreement shall be contingent upon the following:
    a. The continued availability of sufficient federal, 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. For the MSI Program,

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

2) COUNTY may reduce Low Income Health Program Funding and its obligations to make payments for services funded through the Low Income Health Program under this Agreement upon thirty (30) calendar days written notice to INTERMEDIARY.

b. For the EMSF Program, COUNTY may reduce its obligations to make payments under this Agreement upon thirty (30) calendar days written notice to INTERMEDIARY.

G. In the event that this Agreement, or portion thereof, is terminated prior to the completion of the term as specified in the Referenced Contract Provisions of this Agreement, ADMINISTRATOR may, at its sole discretion, reduce the Maximum Obligations of this Agreement in an amount consistent with the reduced term or services of the Agreement.

H. 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.

I. 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 Business Associate Terms and Conditions of this Agreement and are in addition to the rights and remedies of COUNTY provided in this Termination paragraph.

J. 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.

XX. 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.

XXI. WAIVER OF DEFAULT OR BREACH

Waiver by COUNTY of any default by INTERMEDIARY shall not be considered a waiver of any subsequent default. Waiver by COUNTY of any breach by INTERMEDIARY of any provision of this Agreement shall not be considered a waiver of any subsequent breach. Waiver by COUNTY of any default or any breach by INTERMEDIARY 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.

BY: _____ DATED: _____

TITLE: _____

BY: _____ DATED: _____

TITLE: _____

COUNTY OF ORANGE

BY: _____ DATED: _____

HEALTH CARE AGENCY

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL

ORANGE COUNTY, CALIFORNIA

BY: _____ DATED: _____

DEPUTY

If the contracting party is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, 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 contract 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 by HCA.

EXHIBIT A
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH JUNE 30, 2014

MEDICAL SERVICES INITIATIVE PROGRAM

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 the Agreement.

A. "Administrative Days" means those days of inpatient care where the MSI Eligible no longer requires acute care Hospital Services.

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

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

1. For non-FQHC Clinics, the following listed below in 1a. through 1c. are estimated percentages from the average reimbursement rate(s) used by Orange County's Medi-Cal Program for the most utilized billing codes by Contracting Clinics for charges that are determined by INTERMEDIARY to be attributable to reimbursable services to Eligible Persons in accordance with the Agreement.

a. For services provided July 1, 2011 through June 30, 2012, a maximum of one hundred twenty six percent (126%).

b. For services provided July 1, 2012 through June 30, 2013, a maximum of one hundred thirteen percent (113%).

c. For services provided July 1, 2013 through December 31, 2013, a maximum of one hundred percent (100%).

d. The above percentages may be modified by ADMINISTRATOR based on the amounts negotiated in the MSI Clinic Agreement for Period Two and Period Three.

2. For FQHC Clinics, an amount or amounts equivalent to CLINIC's Prospective Payment System (PPS) Rate(s), in effect for each period of the Agreement, and in accordance with the STCs and the LIHP Agreement. The PPS rate is the per visit rate negotiated between CLINIC and Department, which rate may vary by location if CLINIC has more than one site designated as an FQHC Clinic.

~~3. For Physicians who are also Medical Home Providers means an estimated percentage of the average reimbursement rate(s) used by Orange County's Medi-Cal Program for the most utilized billing codes by Medical Home Physicians 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.~~

~~a. For services provided July 1, 2011 through June 30, 2012, maximum of one hundred fifteen percent (115%).~~

~~b. For services provided July 1, 2012 through June 30, 2013, a maximum of one hundred eight percent (108%).~~

~~c. For services provided July 1, 2013 through December 31, 2013, a maximum of one hundred percent (100%).~~

~~d. The above percentages may be modified by ADMINISTRATOR.~~

3. For Physicians who are Medical Home Providers

a. Except as specified in subparagraph I.C.3.b below, means an estimated percentage of the average reimbursement rate(s) used by Orange County's Medi-Cal Program for the most utilized billing codes by Medical Home Physicians 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.

1) For services provided July 1, 2011 through June 30, 2012, a maximum of one hundred fifteen percent (115%).

2) For services provided July 1, 2012 through June 30, 2013, a maximum of one hundred eight percent (108%).

3) For services provided July 1, 2013 through December 31, 2013, a maximum of one hundred percent (100%).

4) The above percentages may be modified by ADMINISTRATOR.

b. For Services as specified in 42 CFR Part 438, 441, and 447 and provided January 1, 2013 through December 31, 2013, means one hundred percent (100%) of the Medicare Resource Based Relative Value Scale (RBRVS), Area 26.

~~4. For Physicians who are not Medical Home Providers means an estimated maximum of one hundred percent (100%) of the average reimbursement rate(s) used by Orange County's Medi-Cal Program for the most utilized billing codes by non-Medical Home Physicians 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.~~

4. For Physicians who are not Medical Home Providers

a. Except as specified in subparagraph I.C.4.b. below, means an estimated maximum of one hundred percent (100%) of the average reimbursement rate(s) used by Orange County's Medi-Cal Program for the most utilized billing codes by non-Medical Home Physicians 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.

b. If Physicians also have a specialty designation of family medicine, general internal

medicine, or pediatric medicine, for Services as specified in 42 CFR Part 438, 441, and 447 and provided January 1, 2013 through December 31, 2013, means one hundred percent (100%) of the Medicare Resource Based Relative Value Scale (RBRVS), Area 26.

5. 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. "Claimable Services" means Medical Services provided to all persons meeting MSI Eligibility as specified in the STCs and the LIHP Agreement.

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

F. "Clinic Funding" means the amount of all funding identified for reimbursement of Medical Services provided by Contracting Clinics.

G. "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.

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

I. "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 means:

a. 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 the Agreement, for services provided by Physicians and Contracting Clinics, except FQHC Clinics.

b. The applicable National Medicare Rate for services claimed by Providers of durable medical equipment.

c. 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 the Agreement for home health services.

e. For pharmacy charges claimed through INTERMEDIARY:

1) For services provided during Period One: Average Sales Price (ASP) plus six

percent (6%). Claims containing pharmaceutical codes that do not have ASP pricing will be paid at the Average Wholesale Price (AWP) less sixteen percent (16%) (brand) and AWP less sixty percent (60%) (generic).

2) For services provided during Period One: Pharmaceuticals related to home health services claims shall be paid at AWP less sixteen percent (16%) (brand) and AWP less sixty percent (60%) (generic).

3) For services provided during Period Two and Period Three: One hundred percent (100%) of the prevailing Medicare rate. Claims containing pharmaceutical codes that do not have Medicare pricing will be paid at rates detailed in the existing agreement with COUNTY's Pharmacy Benefits Manager, for brand name pharmaceuticals or generic name pharmaceuticals, or one hundred percent (100%) of the prevailing Medicare rate whichever is lower.

4) For services provided during Period Two and Period Three: Pharmaceuticals related to home health services claims shall be paid at rates detailed in the existing agreement with COUNTY's Pharmacy Benefits Manager, for brand name pharmaceuticals or generic name pharmaceuticals, or one hundred percent (100%) of the prevailing Medicare rate whichever is lower.

f. One hundred percent (100%) of State Medi-Cal (Denti-Cal) rates for Providers of Dental Services, except FQHC Clinics.

g. For FQHC Clinics means one hundred percent (100%) of the FQHC Clinic's Prospective Payment System (PPS) Rate(s) for Medical and Dental Services.

h. Where applicable, By Report, Unlisted procedures will be reimbursed at thirty-five percent (35%) of billed charges.

J. "Contracting Clinic" means a community clinic that has executed a Clinic and Dental Services for the Medical Services Initiative Program Agreement with COUNTY for specific services provided by community clinics.

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

L. "Dental Funding" means the amount of all funding identified specifically for the reimbursement of Dental Services.

M. "Dental Services" means Medical Services relating to or used on the teeth necessary to prevent serious deterioration of health, as well as preventive and early intervention services as may be allowed in accordance with the STCs and the Agreement.

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

O. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of Emergency Services and/or Care to result in placing the health of the MSI Eligible in serious jeopardy, the serious impairment to bodily functions, or the serious dysfunction of any bodily organ or part.

P. "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.

Q. "Federally Qualified Health Center" or "FQHC Clinic" means a Contracting Clinic that has also executed an agreement with the Centers for Medicare & Medicaid Services (CMS) and is receiving a federal grant under §330 of the Public Health Services Act (§330 grant). For the purposes of the Agreement, FQHC Clinics shall also include a Contracting Clinic designated as an FQHC Look-Alike, which has been determined by CMS to meet the requirements for receiving a §330 grant, but not actually receiving such a grant.

R. "Final Settlement" means the final reimbursement to All Providers, as specified in Paragraph X. of Exhibit B to the Agreement.

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

T. "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 the Agreement.

U. "Hospital Funding" means the amount all funding identified for reimbursement of Medical Services provided by Contracting Hospitals.

V. "Low Income Health Program" or "LIHP" 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 preventive services and early intervention. As of the execution of the Agreement, COUNTY anticipates executing an LIHP Agreement with Department effective for services provided November 1, 2010 and after.

W. "Low Income Health Program Agreement" or "LIHP Agreement" means the agreement for California Department of Health Care Services for participation in the Low Income Health Program effective for services provided November 1, 2010 and after.

X. "Maintenance of Effort" or "MOE" means the minimum amount of non-federal MSI funding required during each Fiscal Year, in accordance with the LIHP Agreement, to maintain the same level of MSI Funding that was actually expended for the MSI Program during FY 2006-07.

Y. "Medical Home" 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 medical Providers as needed.

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 LIHP Funding, Medical Services may also include preventive services and early intervention in accordance with the STCs.

AA. "MSI" means Medical Services Initiative Program.

AB. "MSI Base Funding" means the amount of funds identified by COUNTY for reimbursement of all Medical Services.

AC. "MSI Clinic Agreement" means the Agreement between the COUNTY and Contracting Clinics for Clinic Services for the Medical Services Initiative Program dated July 1, 2011, as it exists now or may hereafter be amended.

AD. "MSI Eligible"or "Eligible Person," means a person, enrolled in the MSI Program, meeting the eligibility requirements set forth in the STCs or criteria set by ADMINISTRATOR in order to meet its obligations under Welfare & Institutions Code (W&I) 17000.

AE. "MSI Hospital Agreement" means the Agreement between COUNTY and Contracting Hospitals for Hospital Services for the Medical Services Initiative Program dated July 1, 2011, as it exists now or may hereafter be amended.

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

AG. "MSI Pending" means a person believed to meet the eligibility requirements set forth in the STCs for enrollment into the MSI Program whose MSI Program application has been submitted and not yet approved.

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

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

AJ. "Out-of-Network Provider" means any non-Contracting Hospital, and/or Physician with a practice outside of Orange County, which has provided Emergency Services and/or Care, and/or required Post-Stabilization Care to an MSI Eligible presenting with an Emergency Medical Condition at a non-Contracting Hospital.

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AK. "Outpatient Funding" the amount of all funding identified for reimbursement of Medical Services provided by Other Providers.

AL. "Physician(s)" means any licensed medical doctor with a practice located in Orange County and registered with the MSI Program.

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

AN. "Physician Funding" means the amount of all funding identified for reimbursement of Medical Services provided by Physicians.

AO. "Points" means numeric values assigned to various categories of Medical Services provided by Contracting Hospitals for the purposes of standardizing the measurement of the quantity of the services provided by all Contracting Hospitals. Points shall be used to distribute Hospital Funding to

Contracting Hospitals in a manner proportionate to the amount of services provided by all Contracting Hospitals, in accordance with Exhibit B to the Agreement.

AP. "Post-Stabilization Care" means the inpatient days following the inpatient day on which an Out-of-Network Provider determines that the MSI Eligible is stable enough to be safely transferred to a Contracting Hospital.

AQ. "Qualified Clinic(s)" means a fully licensed community clinic or FQHC that has provided services to MSI Eligibles for twelve consecutive months, and has received eligibility identification training approved by ADMINISTRATOR.

AR. "Quarter" means a three (3) month period of a Fiscal Year.

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

AT. "Recovery Accounts" means separate hospital, physician, clinic, dental, outpatient services, and administrative accounts for monies recovered from All Providers or third party payers.

AU. "Recuperative Care" or "Recuperative Care Day" means post-hospital room and board provided by a community-based Provider to MSI Patients transitioning out of HOSPITAL's acute care facility. Additional health care services may be arranged/provided by a home health care and/or durable medical equipment Provider.

AV. "Referring Hospital" means a Contracting Hospital authorized by ADMINISTRATOR to request transfers or diversions of MSI Patients to a Receiving Hospital.

AW. "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.

AX. "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.

AY. "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.

AZ. "Specialized Receiving Hospital" means any hospital that has identified specific services it can provide; is willing to accept additional MSI Eligibles requiring these specific services from Contracting Hospitals, and; has entered into a separate agreement with COUNTY 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.

BA. "Special Terms and Conditions" or "STCs" means the document (Number 11-W-00193/9), issued by CMS to the California Health and Human Services Agency (State), setting forth the conditions and limitations on the State's 1115(a) Medicaid Demonstration Waiver. The document describes in detail the nature, character and extent of CMS involvement in the Waiver and the State's obligations to CMS. The parties acknowledge that requirements in the STCs, including any official amendments or clarifications thereto, relating to the LIHP shall be deemed as COUNTY's obligation to the State.

BB. "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 payer.

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

BD. "Utilization Management Department" or "UMD" means appropriately licensed COUNTY staff and/or 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.

II. PHYSICIAN, CLINIC AND OTHER PROVIDER OBLIGATIONS

A. Physicians and Other Providers billing for Medical Services for which reimbursement is provided through the Agreement shall provide Medical Services to all MSI Patients covered by the Agreement presenting for treatment.

1. As a condition of receiving reimbursement, Physicians and Other Providers shall be required to register with INTERMEDIARY for the MSI Program and provide all requested information by logging on to https://ochca.amm.cc/register.aspx .

2. By registering as a Provider for the MSI Program, Physicians and Other Providers shall assure that they meet all applicable licensing requirements to provide Medical Services to Eligible Persons under the Agreement. However, Physicians and Other Providers may be required to provide information necessary to verify credentials as required by the STCs. Such information shall be provided to ADMINISTRATOR or its contracted Provider for credentialing services. Information requested may include, but may not be limited to, documentation to verify state licensure; education, training, and board certifications; Drug Enforcement Administration (DEA)/Controlled Dangerous Substance (CDS) certification; Office of Inspector General (OIG) sanctions; malpractice claims history; work history; medical board sanctions, and meeting of Joint Commission or National Committee for Quality Assurance (NCQA) standards.

3. In accordance with the STCs, Physicians and Other Providers shall provide Medical Services in the same manner to MSI Patients as it provides to all other patients with the same medical need or condition and shall not discriminate against said MSI Patients in any manner, including: admission practices, place of residency within the County, and timely access to care and services considering the urgency of the service needed.

a. ADMINISTRATOR shall notify Physicians and/or Other Providers of and investigate allegations of discrimination in the provision of services on the basis of the patient's status as an MSI Patient, including but not limited to denial of care. ADMINISTRATOR may request that the Medical Policy Committee (MPC) assist with the investigation of service denials for discrimination.

b. In the event that Physician and/or Other Provider is determined by ADMINISTRATOR to have discriminated in the provision of Medical Services on the basis of the patient's status as an MSI Patient, ADMINISTRATOR shall advise INTERMEDIARY to levy appropriate financial penalties for each occurrence against Physician and/or Other Provider, in the period the discrimination is deemed to have occurred, which may include, but not be limited to, the following:

1) A reduction in payment related to the episode of care from any payment due Physician and/or Other Provider, including Final Settlement.

2) Withholding of any payment due Physician and/or Other Provider pending satisfactory compliance.

4. Reimbursable services shall include all services allowable under Section 1905(a) of the Social Security Act or the State Medi-Cal Program, plus those additional services waived in accordance with the STCs. As of the execution of the Agreement, additional services waived, and therefore allowed in accordance with the STCs which are not normally allowable under Section 1905(a) of the Social Security Act or State Medi-Cal Program include: podiatry.

5. The following services are not reimbursable through the Agreement and are not required to be provided to any MSI Patient. This list is not exhaustive and may be amended in accordance with STCs or LIHP Agreement, or a case by case review by ADMINISTRATOR.

a. All diagnostic, therapeutic and rehabilitative procedures and services which are considered experimental or of unproved medical efficacy under the State Medi-Cal Program.

b. Pregnancy related services, including complications of pregnancy.

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

d. Acupuncture and chiropractic procedures.

e. Adult day care health services.

f. Routine dental prophylactic, orthodontia, and fixed prostheses.

g. Routine eye examinations; eyeglasses for refraction and eye appliances, hearing aids, radial keratotomy, and other corrective laser eye procedures, except for diabetics.

h. Routine injections of antigen to ameliorate allergic conditions.

i. All medication available over the counter and medication not on the MSI Program formulary.

j. Massage and therapeutic thermal packs.

k. Bariatric surgery.

l. Unless otherwise waived through the STCs, all services not allowable under Section 1905(a) of the Social Security Act or the State Medi-Cal Program.

6. Upon approval of ADMINISTRATOR, at ADMINISTRATOR's sole discretion, INTERMEDIARY shall reimburse certain Physicians and/or Other Providers specified by ADMINISTRATOR at rates negotiated by ADMINISTRATOR, which rates may be the same as those specified in the 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 the Agreement.

7. As a condition of negotiating any additional agreement for certain services, ADMINISTRATOR may require Physician or Other Provider to meet additional requirements that may not be otherwise specified in the Agreement or the MSI Provider Manual. For example: the ability to electronically transmit patient specific test results to COUNTY's contracted Provider of its patient registration system.

8. During the registration process, Physician may express interest in becoming a Medical Home. In addition, Physician shall submit to ADMINISTRATOR a written request, on Physician's letterhead, to become a Medical Home and shall include their geographic location, contact information, and any experience in providing medical care to low income and/or underserved populations.

a. Physician may inform ADMINISTRATOR, in writing, of its request to institute limitations to assigning MSI Patients to Physician as a Medical Home. This may include limiting the number of assigned MSI Patients Physician is willing or capable of accepting. Physician shall provide ADMINISTRATOR thirty (30) calendar days to review the assignment and attempt to reassign patient(s) to a new medical home if reassignment is determined to be necessary by ADMINISTRATOR. Physician shall continue to provide services during the thirty (30)-day review period or until a final resolution is adopted.

b. Physician shall provide the following services to each MSI Patient who selects them as their medical home:

1). Evidenced-based care as indicated by MSI's Quality and Outcomes Framework that has been approved by MSI's Quality Improvement Committee.

2) An initial face-to-face orientation and education session within one hundred twenty (120) days of assignment to Physician. The orientation session may include establishing treatment goals.

3) Facilitating expedited care as necessary, via case management services with MSI Connect or other systems, including providing same-or next-day appointments when medically necessary.

4). Entering MSI Patient clinical data, such as height, weight, HbA1c, blood pressure, and other data agreed upon, in writing, by Physician and ADMINISTRATOR, through the MSI Connect

application as it becomes available. ADMINISTRATOR agrees to collaborate with Physician regarding all changes made to the MSI Connect application, prior to deployment.

5). Facilitating referrals to specialists and coordinate forwarding of referral information to the specialist for follow–up care through UMD.

6) Meeting the access requirements as specified in the STCs, specifically, providing Primary care appointments within thirty (30) business days of the request for Period One and within twenty (20) business days of the request for Period Two and Period Three.

c. ADMINISTRATOR shall monitor utilization of Medical Services provided by Physician to evaluate if assigned MSI Eligibles are receiving the level of services as specified in the Agreement and appropriate to their medical needs and/or conditions. If ADMINISTRATOR determines that the level of services provided by Physician are below or in excess of the level of care required, based on the MSI Eligible's medical need and/or condition, Physician shall be required to implement a corrective action plan as directed by ADMINISTRATOR. Failure of Physician to appropriately implement a corrective action plan may result, at ADMINISTRATOR's discretion, in the level of MSI Eligibles assigned to Physician as a Medical Home being reduced or with the elimination of Physician as a Medical Home Provider.

d. Physicians electing to be a Medical Home shall be eligible for a Quality and Outcomes Framework incentive which shall be calculated based on Physician's performance as a Medical Home Provider as compared to all other Physician's acting as a Medical Home including, but not limited to, the following areas:

1) Number of MSI Patients assigned to Physician as a Medical Home;

2) Meeting the access requirements as specified in the STCs specifically, providing Primary care appointments within thirty (30) business days of the request for Period One and within twenty (20) business days of the request for Period Two and Period Three;

3) Chronic Disease Management;

4) Preventive Measures; and

5) MSI Connect adoption and usage.

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

B. As a condition of reimbursement for Medical Services provided by Physicians and Other Providers to MSI Eligibles, Physicians and Other Providers shall comply with the Agreement, including Exhibit B hereto. ADMINISTRATOR may direct INTERMEDIARY to withhold or delay payment due any Physician, Clinic or Other Provider for failure to comply with the terms of the Agreement.

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

2. Acceptance by Physician and Other Providers of reimbursement made by INTERMEDIARY for services provided in accordance with the 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, include those received by or on behalf of an MSI Patient. Physicians 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 payers.

b. If Physician or Other Provider 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 or Other Provider from pursuing reimbursement from these sources; provided, however, that Physician or Other Provider shall comply with Paragraph VI.G. of Exhibit B to the Agreement. Nothing in this paragraph shall prohibit Physician or Other Provider from applying any unreimbursed portion of Physician's or Other Provider's charges toward its respective charity and write-off policy.

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

D. All Providers shall make their best efforts to provide services pursuant to the 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.

E. 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 the 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.

F. 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 MSI Patient records, of Physician or Other Providers which such persons deem reasonably pertinent to the Agreement, for the purpose of responding to a MSI Patient complaint or, conducting an audit, review, evaluation, or examination, or making transcripts during the periods of retention set forth in Paragraph II.H. below of this Exhibit A to the Agreement. The above mentioned persons, may at all reasonable times, inspect or otherwise evaluate the services provided pursuant to the 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 or Other Provider with at least fifteen (15) calendar 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 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 the LIHP, 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 the Agreement and to allow interviews of any employees who might reasonably have information related to such records.

a. If the Agreement is terminated prior to the termination of the contract between COUNTY and the California Department of Health Care Services, Physician 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 the 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.

G. Physician and Other Provider shall actively participate and cooperate with any person specified in subparagraph F. above in any evaluation of the services provided pursuant to the 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.

H. Physician and Other Provider shall maintain records that are adequate to substantiate the

services for which claims are submitted for reimbursement under the Agreement and the charges thereto. Such records shall include, but not be limited to, individual patient charts and utilization review records.

1. Physician 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 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 the Agreement and in accordance with Medicare principles of reimbursement and generally accepted accounting principles.

3. Physician 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 the Agreement shall be retained by the parties, at a location in the County of Orange, or other location approved in advance and in writing by ADMINISTATOR, for a period of seven (7) years after termination of the Agreement.

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

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

I. 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.

J. 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.

K. 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.

III. INTERMEDIARY OBLIGATIONS

A. INTERMEDIARY shall perform as fiscal intermediary on behalf of All Providers, Out-of-Network Providers, and COUNTY. INTERMEDIARY shall reimburse All Providers and Out-of-Network Providers in accordance with the 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 the Agreement, and for such time thereafter as required by the 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 by direct on-line input provided by ADMINISTRATOR's eligibility system provider, performing utilization review, and processing, denying, approving all claims submitted in accordance with Exhibit B.

3. Providing a process for All Provider and patient appeals of denied services.

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

5. Reimbursing claims and making other required payments.

6. Sanction screening All Providers for the MSI Program to ensure that they are not designated as Ineligible Persons.

C. MSI Provider Appeals – INTERMEDIARY shall provide a formal opportunity for MSI Providers to appeal denial of services or payment (Appeals System). The Appeals System shall meet the requirements, if any, established by the STCs, any court with jurisdiction and the following submission requirements:

1. Print and distribute the "Explanation of Benefits" or "EOB" forms as to the disposition of claims to MSI Providers.

2. INTERMEDIARY shall advise MSI Provider on all EOBs that if the MSI Provider wishes to appeal a service or payment denied by INTERMEDIARY, the MSI Provider must submit the request for appeal within thirty (30) days of the date of the EOB.

3. All appeals must include an Appeal Form, provided on the back of the EOB, from the MSI Provider requesting the appeal and must be accompanied by the corresponding medical records. The MSI Provider 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. Provider 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 Provider sends the Appeal Form, but does not also send the medical records.

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

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

c. Nothing herein shall prevent INTERMEDIARY from contacting any MSI Provider regarding an incomplete appeal and requesting the required information be submitted within the original thirty (30) day timeframe.

D. Sanction Screening

1. INTERMEDIARY shall screen All Providers registered to provide Medical Services for the MSI Program, as well as Contracting Hospitals, to ensure that they are not designated as Ineligible Persons as defined in the Compliance Paragraph of the Agreement. Screening shall be conducted against the following lists;

a. General Services Administration's List of Parties Excluded from Federal Programs;

b. Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities;

c. State of California Medi-Cal Suspended and Ineligible Provider List; and

d. Any other lists regarding exclusion or debarment from participation in federal or state health care programs as may be requested by ADMINISTRATOR.

2. INTERMEDIARY shall screen All Providers monthly to ensure that they have not become Ineligible Persons.

3. INTERMEDIARY shall submit a monthly report to ADMINISTRATOR detailing if a Provider of Medical Services has been found to be currently excluded, suspended or debarred, or is identified as such after a prior sanction screening.

a. INTERMEDIARY shall notify such individual or entity and immediately remove them from being able to be reimbursed for Medical Services in accordance with this or any other Agreement for MSI Services.

b. INTERMEDIARY shall note the date the Provider became an Ineligible Person, or the date INTERMEDIARY became aware that the Provider became an Ineligible Person and shall provide ADMINISTRATOR with a report of the claims received and paid to said Ineligible Person. ADMINISTRATOR will determine if any repayment is necessary from the Ineligible Person for services provided.

E. 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.

F. INTERMEDIARY shall attend MPC meetings as requested by ADMINISTRATOR and shall provide additional information to Committee members as may be requested by ADMINISTRATOR.

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.

H. INTERMEDIARY shall refer requests for patient information requested in accordance with the Public Records Act to ADMINISTRATOR's Custodian of Records.

I. 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.

J. Credentialing Services

1. ADMINISTRATOR may require, and INTERMEDIARY has agreed, if requested by ADMINISTRATOR, to provide at an additional cost to COUNTY, verification of credentials or "credentialing" of All Providers of Medical Services for the MSI Program.

2. Credentialing of all current and new Providers, if required, shall be done at a frequency required by Department, in accordance with the STCs. ADMINISTRATOR anticipates credentialing shall be completed at least once during the term of the Agreement for all current and new Providers determined to not already be credentialed by another entity as approved by ADMINISTRATOR.

3. Credentials to be verified shall be as required by the STCs and/or Department, and may include, but not necessarily be limited to:

a. State licensure
b. Education, training, and board certifications
c. DEA/CDS certification
d. National Practitioner Data Bank
e. OIG sanctions
f. Malpractice claims history
g. Work history
h. Medical board sanctions
i. Meeting of Joint Commission or NCQA standards

K. INTERMEDIARY shall make its best efforts to provide services pursuant to the 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:

a. Records of participation in COUNTY-sponsored or other applicable training;
b. Recruitment and hiring policies and procedures;

c. Copies of literature in multiple languages and formats, as appropriate; and

d. Descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged.

L. 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 the 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 the Agreement and all other agreements for the MSI Program, COUNTY shall reimburse INTERMEDIARY monthly in arrears, as follows; provided, however the total of all payments to INTERMEDIARY does not exceed COUNTY's Maximum Obligation for INTERMEDIARY for each Period as specified in the Referenced Contract Provisions section of the Agreement:

a. Period One – One-hundred fifty-eight thousand eight-hundred twenty-four dollars ($158,824) per month for August 2011 through and including November 2012, and One-hundred fifty-eight thousand eight-hundred sixteen ($158,816) dollars for December 2012, up to a total maximum of two million seven-hundred thousand dollars ($2,700,000).

b. Period Two – One-hundred fifty-five thousand seven-hundred dollars ($155,700) per month up to a total maximum of two million eight-hundred two thousand six-hundred dollars ($2,802,600).

c. Period Three – One-hundred sixty-two thousand four-hundred twenty-five dollars ($162,425) per month up to a total maximum of one million nine-hundred forty-nine thousand one-hundred dollars ($1,949,100).

~~2. Should claims processed by INTERMEDIARY, in accordance with the Agreement for the MSI Program, exceed six-hundred fifty thousand (650,000) claims for Period One, or seven-hundred thousand (700,000) claims for Period Two, or three-hundred seventy-five thousand (375,000) claims for Period Three, INTERMEDIARY may submit an invoice for an additional fiscal intermediary services fee of five dollars ($5.00) per claim for each claim processed in excess of the stated amount above for each Period. The additional intermediary services fee shall not exceed the Maximum Obligation as specified in the Referenced Contract Provisions section of the Agreement.~~

2. Should claims processed by INTERMEDIARY, in accordance with this Agreement for the MSI Program, exceed six-hundred fifty thousand (650,000) claims for Period One, or seven-hundred thousand (700,000) claims for Period Two, or three-hundred seventy-five thousand (375,000) claims for Period Three, INTERMEDIARY may submit an invoice for an additional fiscal intermediary services

fee of five dollars ($5.00) per claim for each claim processed in excess of the stated amount above for each Period.

3. For ancillary services, approved in advance by ADMINISTRATOR and provided in accordance with the Agreement for the MSI Program, COUNTY shall reimburse INTERMEDIARY monthly in arrears, for the actual cost of providing said services; provided, however the total of all payments to INTERMEDIARY for ancillary services do not exceed COUNTY's Maximum Obligation for INTERMEDIARY for each Period as specified in the Referenced Contract Provisions of the Agreement.

4. 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 the Agreement.

5. INTERMEDIARY's invoice shall be on a form approved or supplied by ADMINISTRATOR and provide such information as is required by ADMINISTRATOR. INTERMEDIARY shall use its best efforts to submit invoices to ADMINISTRATOR no later than two (2) business days following INTERMEDIARY's check run, unless otherwise agreed to by ADMINISTRATOR and INTERMEDIARY, and payments to INTERMEDIARY should be released by COUNTY no later than twenty-one (21) days after receipt of the correctly completed invoice form.

6. If requested by ADMINISTRATOR, INTERMEDIARY has agreed to provide credentialing services as specified in subparagraph III.J. of this Exhibit A to the Agreement. Reimbursement of credentialing services shall be in addition to reimbursement provided for in subparagraph A.1 above.

a. Credentialing services shall be reimbursed to INTERMEDIARY at one-hundred fifty dollars ($150.00) per Provider file.

b. Nothing in this paragraph shall prevent ADMINISTRATOR from releasing a separate solicitation for credentialing services and entering into a separate contract with INTERMEDIARY or a separate Provider who is not INTERMEDIARY. Should ADMINISTRATOR release a solicitation for credentialing services, nothing in this paragraph shall prevent INTERMEDIARY from submitting a separate bid for credentialing services which may vary from the costs provided herein.

7. Upon determination by INTERMEDIARY that the Account requires additional funds for reimbursement of claims authorized in accordance with the Agreement, INTERMEDIARY shall submit a supplemental invoice to COUNTY, together with any documentation that may be required by ADMINISTRATOR.

8. All billings to COUNTY shall be supported, at INTERMEDIARY's facility, by source documentation including, but not limited to, ledgers, books, and records of services provided.

9. COUNTY may withhold or delay any payment if INTERMEDIARY fails to comply with any provision of the Agreement.

10. COUNTY shall not reimburse INTERMEDIARY for direct services provided beyond the

expiration and/or termination of the Agreement, except as may otherwise be provided under the Agreement, or specifically agreed upon in a subsequent Agreement.

B. "MSI Base Funding" – means the MSI Program pass through funding for reimbursement of all MSI Program services for each Period, except those provided by INTERMEDIARY, which shall be as specified in the Referenced Contract Provisions of the Agreement. The parties agree that the funds may be deposited into a Holding Account in accordance with Paragraph II of Exhibit B to the Agreement and may be added to the MSI Base Funding as specified herein.

C. MSI Trust Fund and Other Funding

1. COUNTY shall establish an interest-bearing trust fund (MSI Trust Fund) into which it shall transfer, one-sixth of the following amounts of the MSI Base Funding, herein referred to as the "Monthly Trust Fund Transfer" ten (10) business days after approval of the Agreement and one-twelfth (1/12th) of the following amounts of the MSI Base Funding thereafter by the tenth (10th) day of each month from September through and including June 10th for Period One and one-twelfth (1/12th) of the following amounts of the MSI Base Funding, herein referred to as the "Monthly Trust Fund Transfer for Period Two and one-sixth (1/6th) of the following amounts of the MSI Base Funding, herein referred to as the "Monthly Trust Fund Transfer for Period Three." The amount of MSI Base Funding may be modified by ADMINISTRATOR consistent with the budget for the MSI Program, as may be adjusted. The total amount of all such Transfers for each Period shall be as follows, which amounts may be modified by ADMINISTRATOR during Preliminary Final Settlement in accordance with Exhibit B of the Agreement to maximize LIHP Funding available to COUNTY each Fiscal Year and ability of COUNTY to meet its MOE requirement:

a. Period One

1) "Hospital Trust Fund Account" – thirty-three million six hundred forty-four thousand five hundred sixty-eight dollars ($33,644,568)

2) "Physicians Trust Fund Account" – twelve million eight hundred eighty-six thousand six hundred ninety-three dollars ($12,886,693)

3) "Clinic Trust Fund Account" – one million five hundred twenty thousand dollars ($1,520,000)

4) "Dental Trust Fund Account" – three hundred thousand dollars ($300,000)

5) "Outpatient Fund Account" – two million dollars ($2,000,000)

b. Period Two – which amounts may be modified by ADMINISTRATOR based on the amounts negotiated in the MSI Hospital Agreement and/or MSI Clinic Agreement for Period Two

1) "Hospital Trust Fund Account" – thirty-three million six hundred forty-four thousand five hundred sixty-eight dollars ($33,644,568)

~~2) "Physicians Trust Fund Account" – twelve million eight hundred eighty-six thousand six hundred ninety-three dollars ($12,886,693)~~

2) Physicians Trust Fund Account' – twelve million eight hundred eighty-six

thousand six hundred ninety-three dollars ($12,886,693) and up to an additional estimated two million dollars ($2,000,000) for reimbursement in accordance with subparagraphs I.C.3.b and I.C.4.b of this Exhibit A to the Agreement.

3) "Clinic Trust Fund Account" – one million five hundred twenty thousand dollars ($1,520,000)

4) "Dental Trust Fund Account" – three hundred thousand dollars ($300,000)

5) "Outpatient Fund Account" – two million dollars ($2,000,000)

c. Period Three – which amounts may be modified by ADMINISTRATOR based on the amounts negotiated in the MSI Hospital Agreement and/or MSI Clinic Agreement for Period Three

1) "Hospital Trust Fund Account" – sixteen million eight hundred twenty-two thousand two hundred eighty-four dollars ($16,822,284)

~~2) "Physicians Trust Fund Account" – six million four hundred forty-three thousand three hundred forty-seven dollars ($6,443,347)~~

2) 'Physicians Trust Fund Account' – six million four hundred forty-three thousand three hundred forty-seven dollars ($6,443,347) and, at ADMINISTRATOR'S sole discretion, up to an additional estimated two million dollars ($2,000,000) for reimbursement in accordance with subparagraphs I.C.3.b and I.C.4.b of this Exhibit A to the Agreement. The parties agree that this additional funding is not guaranteed.

3) "Clinic Trust Fund Account" – seven hundred sixty thousand dollars ($760,000)

4) "Dental Trust Fund Account" – one hundred fifty thousand dollars ($150,000)

5) "Outpatient Fund Account" – one million dollars ($1,000,000)

d. Additional MSI Base Funding – As provided for in Paragraph X.E.2 of Exhibit B to this Agreement, COUNTY, at its sole discretion, may allocate additional MSI Base funding to any Period specified herein. At ADMINISTRATOR's sole discretion, said additional MSI Base Funding may be allocated in whole or in part, at the sole discretion of ADMINISTRATOR, to the Hospital, Physician and/or Clinic Trust Funds for distribution through a supplemental Final Settlement.

2. Unless otherwise directed by ADMINISTRATOR, Monthly Trust Fund Deposits shall commence by July 10th for Period Two and Period Three, and continue thereafter by the tenth (10th) day of each month through and including June 10th for Period Two and December 10th for Period Three.

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 be allocated proportionately to each Account based on the balance of all other funds in the MSI Trust Fund pending transfer to INTERMEDIARY. The interest earned and apportioned to funds pending transfer to INTERMEDIARY may be, in whole or part and at ADMINISTRATOR's sole discretion, transferred to the Holding

Account with any transferred principal and retained by COUNTY to offset any portion of its administrative expenses, or applied by COUNTY towards the MOE requirement for any Fiscal Year.

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

4. COUNTY shall allocate the LIHP Funding as follows, which amounts are estimates only for the purposes of providing funding to INTERMEDIARY and may be modified by ADMINISTRATOR based on actual LIHP funding received for the applicable Period and during Preliminary Final Settlement in accordance with Paragraph X of Exhibit B to the Agreement to maximize the amount of LIHP Funding to be received by COUNTY each Fiscal Year and ability of COUNTY to meet its MOE requirement.

a. Period One

1) Hospital Funding – twenty-nine million four hundred forty-one thousand three hundred fifty-eight dollars ($29,441,358)

2) Physician Funding – sixteen million two hundred thirty-six thousand one hundred forty-eight dollars ($16,236,148)

3) Clinic Funding – four million five hundred one thousand five hundred sixty-five dollars ($4,501,565)

4) Dental Funding – zero dollars ($0)

5) Outpatient Funding – seven million thirty-eight thousand two hundred ninety-eight dollars ($7,038,298)

b. Period Two – which amounts may also be modified by ADMINISTRATOR based on the amounts negotiated in the MSI Hospital Agreement and/or MSI Clinic Agreement for Period Two

1) Hospital Funding – twenty-nine million four hundred forty-one thousand three hundred fifty-eight dollars ($29,441,358)

2) Physician Funding – sixteen million two hundred thirty-six thousand one hundred forty-eight dollars ($16,236,148)

3) Clinic Funding – four million five hundred one thousand five hundred sixty-five dollars ($4,501,565)

4) Dental Funding – zero dollars ($0)

5) Outpatient Funding – seven million thirty-eight thousand two hundred ninety-eight dollars ($7,038,298)

c. Period Three – which amounts may also be modified by ADMINISTRATOR based on the amounts negotiated in the MSI Hospital Agreement and/or MSI Clinic Agreement for Period Three

1) Hospital Funding – sixteen million eight hundred twenty-two thousand two hundred eighty-four dollars ($16,822,284)

2) Physician Funding – six million four hundred forty-three thousand three hundred

forty-seven dollars ($6,443,347)

3) Clinic Funding – seven hundred sixty thousand dollars ($760,000)

4) Dental Funding – zero dollars ($0)

5) Outpatient Funding – three million five hundred nineteen thousand one hundred forty-nine dollars ($3,519,149)

5. The total of LIHP Funding for each Fiscal Year shall not be greater than the actual amount received by COUNTY from Department for services provided during each Fiscal Year. LIHP funding shall be made available to INTERMEDIARY to reimburse Medical Services as follows, at the discretion of ADMINISTRATOR:

a. Advanced by COUNTY to INTERMEDIARY in anticipation of LIHP funding to be received for services provided during the Fiscal Year.

b. Reimbursed from LIHP funding actually received by COUNTY.

c. The parties understand that at the execution of the Agreement, COUNTY has received approval to implement its LIHP, but has not executed a contract with Department for LIHP Funding for claiming reimbursement for Medical Services commencing July 1, 2011.

D. MSI Funding Disbursements

1. Hospital Funding – In accordance with Exhibit B to the Agreement, COUNTY shall pay amounts from COUNTY's available Hospital Funding to INTERMEDIARY, which funds shall be used by INTERMEDIARY to reimburse Hospital claims for Eligible Persons. INTERMEDIARY shall make disbursements to Contracting Hospitals in accordance with the MSI Hospital Agreement.

2. Physician Funding

a. In accordance with Exhibit B to the 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.

3. Clinic Funding – In accordance with Exhibit B to the Agreement, COUNTY shall pay amounts from COUNTY's available Clinic and Dental Funding to INTERMEDIARY, which funds shall be used by INTERMEDIARY to reimburse Clinic and Dental claims services provided to Eligible Persons at Contracting Clinics. INTERMEDIARY shall make disbursements to Contracting Clinics shall be in accordance with the MSI Clinic Agreement.

4. Outpatient Funding

a. In accordance with Exhibit B to the 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 and other ancillary Providers not otherwise specified in the Agreement and approved in writing by ADMINISTRATOR, including, but not limited to, ambulance, home health Providers, durable medical equipment, laboratories, imaging, surgery centers, and urgent care centers which may include professional services; as negotiated by

ADMINISTRATOR.

b. In the event that the total of all claims for Outpatient Funding exceeds the amount of Outpatient Funding available for the Fiscal 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.

c. 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 specified, 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 Providers may be paid by INTERMEDIARY.

5. Dental Funding

a. In accordance with Exhibit B to the 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 the 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 as specified by ADMINISTRATOR.

a. 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. These services may include, but are not limited to, Sub-Acute and Skilled Nursing Facility Services. ADMINISTRATOR may expand Sub-Acute Services to include MSI Pendings.

b. 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.

c. Implantable Devices – Upon written authorization from ADMINISTRATOR, INTERMEDIARY shall, during Period Two and/or Period Three of the Agreement, reimburse Hospital for one-hundred percent (100%) of Hospital's actual cost of Implantable Devices. Said reimbursement shall be deducted one-hundred percent (100%) from Hospital Funding and shall not be subject to Final Settlement.

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 LIHP Funding in accordance with the Agreement, to INTERMEDIARY. INTERMEDIARY shall use these Funds to make Final Settlement of claims as provided herein, including Exhibit B.

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.

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

G. CATALOG OF FEDERAL DOMESTIC ASSISTANCE (CFDA) INFORMATION

1. The Agreement includes federal funds paid to INTERMEDIARY for reimbursement of Providers for the MSI Program. The CFDA number and associated information for federal funds paid through the Agreement are specified below:

CFDA Term:	November 1, 2010 through October 31, 2015
CFDA No.:	93.778
Program Title:	California Bridge to Reform Demonstration
Federal Agency:	Centers for Medicare & Medicaid Services (CMS)
Award Name:	Low Income Health Program
Annual Amounts:	Will vary depending on actual services provided/claimed

2. INTERMEDIARY may be required to have an audit conducted in accordance with federal OMB Circular Number A-133. INTERMEDIARY shall be responsible for complying with any federal audit requirements within the reporting period specified by OMB Circular Number A-133.

3. If the CFDA information listed above is revised, ADMINISTRATOR shall notify INTERMEDIARY in writing of said revisions.

V. COUNTY OBLIGATIONS

A. ADMINISTRATOR 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.

1. ADMINISTRATOR shall notify INTERMEDIARY, Physicians and Other Providers, upon becoming aware of any amendments, modifications, changes, or updates to the STCs or the LIHP Agreement. When available, ADMINISTRATOR shall provide INTERMEDIARY with a copy of the STCs and the LIHP Agreement, including any written amendments, modifications, changes or updates.

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

B. ADMINISTRATOR shall establish, either directly and/or through subcontract(s), a UMD which shall:

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

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

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

4. Assist in coordinating the transitions of MSI Eligibles 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 through the UMD.

C. COUNTY's UMD shall work with INTERMEDIARY to develop reporting and information sharing activities to address the following:

1. Deny claims based on recommendations from COUNTY's UMD.

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

VI. COMMITTEES/GROUPS

A. A Medical Policy Committee (MPC) shall be formed by the parties, and shall perform the duties specified in the Agreement through June 30, 2014.

B. The MPC shall consist of the following members:

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

2. One physician from the MSI Physician Community;

3. One representative from the MSI Hospital Community;

4. One representative from the MSI Clinic Community; and

5. Two representatives from the MSI Program.

C. The MPC shall adopt and follow rules as it deems necessary to carry out its responsibilities.

1. Prospective and retrospective review of services rendered and their medical appropriateness.

2. Review of procedures, treatments, and therapies, consistent with MSI Program benefits, for inclusion in the MSI Program's scope of covered services.

3. Review of medical policy as it relates to patient treatment and community standards of care.

4. The MPC shall approve and make modifications, deletions, and additions to the list of services for which All Providers will be recommended to seek pre-authorization from COUNTY's UMD.

D. Decisions of the MPC shall be final and binding.

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EXHIBIT B
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH JUNE 30, 2014

MEDICAL SERVICES INITIATIVE PROGRAM

CLAIMS AND DISBURSEMENTS

I. SATISFACTION OF COUNTY OBLIGATION

Reimbursement provided through the Agreement is only intended to cover those low income persons who would not be eligible for medical benefits from the State Medi-Cal Program, or whose medical care would not be covered by other non-COUNTY third party payers. In consideration of payments made by COUNTY through INTERMEDIARY for payment for Medical Services to MSI Eligibles pursuant to the Agreement, COUNTY's obligation to All Providers and low income persons for whom it may have any legal obligation to provide Medical Services, shall be satisfied.

II. IMPREST ACCOUNT

A. INTERMEDIARY shall maintain an interest-bearing account for the MSI Program called the "Imprest Account." A separate Imprest Account shall be maintained for each Period.

1. 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 in Paragraph IV of Exhibit A to the Agreement, which services are: Hospital, Physician, Clinic, Dental and Outpatient Services. The separate accounting of Funds within the Imprest Account for these services shall be referred to respectively as the Hospital Account, Physician Account, Clinic Account, Dental Account, and Outpatient Account. Within the Imprest Account, INTERMEDIARY shall also maintain a separate accounting of funds for the HCA Recovery, HCA Exception, and HCA Holding service accounts.

2. The separate accounting of Funds by service shall include, but may not be limited to: deposits/funding, interest, recovery, transfers, claims and other payments, and bank charges.

3. INTERMEDIARY shall use the Imprest Account to deposit MSI Base Funding disbursed by COUNTY for each service for the purpose of reimbursing corresponding claims from Providers of those services as specified herein.

4. Except as otherwise provided herein, the Imprest Account shall not exceed a maximum of four million dollars ($4,000,000) during any forty-five (45) day period, exclusive of Hospital Periodic

Interim Payments, and shall be managed so as to maximize the interest earned upon Funds in the Account. Upon written request of INTERMEDIARY, and at ADMINISTRATOR's sole discretion, the maximum may be modified.

5. If INTERMEDIARY determines that the fees to maintain an interest-bearing Imprest Account are more than projected interest to be earned, INTERMEDIARY shall recommend 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. Funding of the Imprest Account – INTERMEDIARY shall use its best efforts to submit invoices to ADMINISTRATOR no later than two (2) business days following INTERMEDIARY's check run, unless otherwise agreed to by ADMINISTRATOR and INTERMEDIARY, and payments to INTERMEDIARY should be released by COUNTY no later than twenty-one (21) days after receipt of the correctly completed invoice form.

1. COUNTY shall pay INTERMEDIARY, upon receipt of an appropriate invoice, an initial provisional payment for each service account for each Period as follows:

a. Hospital Account (Non-PIP) – one-hundred fifty thousand dollars ($150,000)

b. Physician Account – one-million five-hundred thousand dollars ($1,500,000)

c. Clinic Account – one-hundred fifty thousand dollars ($150,000)

d. Dental Account – thirty thousand dollars ($30,000)

e. Outpatient Account – four-hundred fifty thousand dollars ($450,000)

2. Following the initial payment, for each Period, in accordance with subparagraph B.1. above, INTERMEDIARY shall submit separate and appropriate invoices for each service account for payment of MSI Hospital, Physician, Clinic, Dental, and Outpatient claims on a regular basis, which frequency shall be no less often than bi-weekly without mutual consent of ADMINISTRATOR and INTERMEDIARY. Each individual invoice may be in an amount up to the COUNTY's initial provisional payment as specified in subsection B.1. above, which amount may be modified by mutual consent of INTERMEDIARY and ADMINISTRATOR. Payments to INTERMEDIARY should be released by COUNTY no later than twenty-one (21) calendar days after receipt of the correctly completed invoice form; provided, however that the aggregate of all payments for claims for each service account shall not exceed the available funding, as specified in Exhibit A of the Agreement, for each Period.

C. Claims and Other Payments from the Imprest Account – INTERMEDIARY shall deposit Funds received from COUNTY into the appropriate service account for reimbursement of Providers as follows:

1. From the Hospital Account, INTERMEDIARY shall pay Contracting Hospitals, monthly in arrears, the "Periodic Interim Payment" (herein after referred to as PIP Payment) specified in Exhibits D-1 through D-3 to the Agreement.

a. Exhibits D-1, D-2 and/or D-3 may be revised by ADMINISTRATOR based on

amendments or reductions to MSI Base Funding or estimated LIHP Funding, LIHP Funding has not been received by COUNTY from Department, or if data received from the INTERMEDIARY supports a revised PIP payment to one or more Contracting Hospitals.

b. PIP payments shall be disbursed from the Hospital Account, monthly in arrears, commencing on or about September 1st for Period One and on or about August 1st for Period Two, Period Three, and thereafter; on or about the first (1st) day of each month through July 1st for Period One and Period Two, and through January 1, 2014 for Period Three; provided, however, that the Contracting Hospital has returned a fully executed agreement for the corresponding Period to COUNTY.

c. COUNTY may have the ability, for each period of the Agreement, to use each Contracting Hospital's proportional share of Tobacco Settlement Revenue (TSR) funding, as established in the Agreement for the Provision of Indigent and Trauma Care between COUNTY and HOSPITAL, dated July 1, 2011, and as may hereafter be amended, as match to receive additional federal dollars through the COUNTY's Medical Services Initiative (MSI) Program. If Contracting Hospital has approved the use of TSR funding for the MSI Program, in writing, and returned it's fully executed agreement, or any subsequent amendments, COUNTY shall authorize INTERMEDIARY, in writing, to submit to ADMINISTRATOR an invoice for the aforementioned TSR funding, and upon receipt of said funds proceed with a Supplemental PIP payment to each Contracting Hospital in an amount equivalent to its proportional share of TSR funding, on or around the first working day of June for each period.

2. From the Physician Account, INTERMEDIARY shall reimburse the follow expenses:

a. Claims received from Physicians.

b. Claims received from non-Physician practitioners which may include, but not be limited, to Nurse Practitioners and Physicians' Assistants.

c. Claims for the professional component of Sub-Acute Services as specified in Exhibit A Subsection IV.D.6.a. in the Agreement.

d. Letters of Agreement for specialty Physician and capitated physician services as may be negotiated by ADMINISTRATOR.

e. Quality and Outcomes Framework incentive for physicians also designated as a Medical Home.

f. Other expenses as authorized by ADMINISTRATOR in accordance with the Agreement or other Agreements for the MSI Program.

3. From the Clinic Account, INTERMEDIARY shall reimburse claims received from Contracting Clinics and the Quality and Outcomes Framework incentive for non-FQHC Contracting Clinics providing Medical Home Services.

4. From the Dental Account, INTERMEDIARY shall reimburse claims received from Contracting Clinics or from other Providers of Dental Services as authorized by ADMINISTRATOR in accordance with the Agreement and the MSI Clinic Agreement.

5. From the Outpatient Account, reimbursing non-hospital based outpatient service Providers as specified in Paragraph IV.D.4 of Exhibit A to the Agreement.

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

E. INTERMEDIARY shall provide ADMINISTRATOR by the tenth (10^{th}) day of each month access to an electronic copy of the prior month's bank statement(s) and reconciliation with respect to all monies disbursed through the Imprest Account pursuant to the Agreement.

F. In the event INTERMEDIARY anticipates expenditures pursuant to the Agreement in excess of the Imprest Account maximum, INTERMEDIARY shall advise ADMINISTRATOR, in writing of the circumstances. Upon approval by ADMINISTRATOR, COUNTY will disburse to INTERMEDIARY the requested Funds and INTERMEDIARY shall disburse Funds immediately upon receipt to Providers of Medical Services, unless otherwise approved, in writing, by ADMINISTRATOR.

III. 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 the STCs, the LIHP Agreement and the 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 the Agreement for claim submission, processing, and reimbursement, including, but not limited to obligations pursuant to Paragraph VI., Third Party, Primary, or Other Insurance Covered Claims, as specified in this Exhibit B 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 the 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 the 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 corrective action plan (CAP). 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. For the purposes of the Agreement, Long Beach Memorial Medical Center and its affiliated physicians shall not be considered Out-of-Network Providers.

IV. CONDITIONS OF REIMBURSEMENT

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

1. Claims for Medical Services provided during the period July 1, 2011 through June 30, 2012 for Period One; July 1, 2012 through June 30, 2013 for Period Two; and July 1, 2013 through December 31, 2013 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 the Agreement.

3. Claims 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 September 30th for Period One and for Period Two, and March 31, 2014 for Period Three.

B. INTERMEDIARY shall initially approve or deny all claims no later than October 31st for Period One and Period Two, and April 30, 2014 for Period Three.

C. Upon approval, by either INTERMEDIARY or the MSI Medical Director, 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 July 1, 2011 through June 30, 2012 shall be null and void after November 30, 2012; any unapproved claims for Medical Services provided during the period July 1, 2012 through June 30, 2013 shall be null and void after November 30, 2013 and any unapproved claims for Medical Services provided during the period July 1, 2013 through December 31, 2013 shall be null and void after May 31, 2014.

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.

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V. CLAIM DENIAL/APPEAL

A. INTERMEDIARY shall notify, in writing, All Providers and their respective MSI Patients 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 may appeal to the MSI Medical Director 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 MSI Medical Director, no later than thirty (30) calendar days after notification of denial. The MSI Medical Director 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 MSI Medical Director, 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.

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

A. Reimbursement provided through the 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 provide 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. The 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" as follows, which shall mean All Providers except Contracting Hospitals.

2. If any Provider through its own efforts, identifies Medi-Cal coverage, third party settlement, primary or other insurance coverage for services reimbursed through the Agreement, such Provider(s) shall, within thirty (30) calendar days of such identification, unless disputed in accordance with subparagraph G.5. below, reimburse INTERMEDIARY an amount equal to the MSI Payment. At ADMINISTRATOR's sole discretion, Skilled Nursing Facility providers may reimburse INTERMEDIARY an amount equal to the Medi-Cal coverage, third party settlement, primary or other insurance coverage for services or MSI reimbursement amount, whichever is less.

3. If Medi-Cal coverage, third party settlement, primary or other insurance coverage is identified due to efforts of COUNTY's contracted Recovery Services (Recovery Services) specified in subparagraph G.7. below, the Provider shall, within thirty (30) days of notice from Recovery Services, unless disputed in accordance with subparagraph G.5. below, reimburse COUNTY through INTERMEDIARY an amount equal to the MSI payment. Third-party settlement payments may be paid directly to COUNTY or INTERMEDIARY, as directed by ADMINISTRATOR if the date(s) of service related to the claim are such that the Provider has already written off the patient account.

4. 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 COUNTY through INTERMEDIARY the amount of the MSI payment within thirty (30) calendar days notification of said fact.

5. Should a Provider wish to dispute the reimbursement of MSI payment as a result of the identification of Medi-Cal coverage, third party settlement, primary or other insurance coverage either by the Provider or through Recovery Services, the Provider shall give written notice, within thirty (30) days of notice of information, to ADMINISTRATOR's MSI Program Manager (MSI Manager) setting forth in specific terms the existence and nature of any dispute or concern related to the information provided through Recovery Services or the reimbursement due COUNTY. MSI Manager shall have fifteen (15) working days following such notice to obtain resolution of any issue(s) identified in this manner, provided, however, by mutual consent this period of time may be extended. If MSI Manager determines that the recovery information is accurate and appropriate, the Provider shall, within thirty (30) calendar days of receipt, reimburse COUNTY through INTERMEDIARY an amount equal to the

MSI payment.

6. For purposes of computing the amount of reimbursement due from Provider, after Final Settlement, the services provided an Eligible Person shall be valued at the percentage of reimbursement for the applicable contract period.

7. COUNTY shall engage INTERMEDIARY, or authorize INTERMEDIARY to enter into a separate Agreement, for the provision of Recovery Services for the purpose of actively pursuing reimbursement of claims paid for MSI Eligibles later determined to be eligible for Medi-Cal or having third party, primary or other primary other insurance. All Providers shall cooperate in recovering these costs. Except as otherwise directed by ADMINISTRATOR, monies recovered due to the efforts of Recovery Services shall be reimbursed to COUNTY through INTERMEDIARY and shall be deemed "Active Recovery Funds." Monies recovered or identified in advance of notice from Recovery Services, and forwarded directly to INTERMEDIARY by Provider, shall be deemed "Passive Recovery Funds." For Active Recovery Funds only, an administrative fee, as negotiated between ADMINISTRATOR and INTERMEDIARY, may be deducted by INTERMEDIARY and then ten percent (10%) of the balance shall be deposited into the HCA Recovery Account, with the remainder into the appropriate service account.

a. INTERMEDIARY will develop and submit for approval to ADMINISTRATOR, an accountability procedure that identifies and tracks the passive recovery funds received versus the active recovery funds received by INTERMEDIARY from Providers.

b. ADMINISTRATOR will not provide INTERMEDIARY with an administrative fee for recovery services until an accountability procedure has been approved.

c. Recovery Services provided by INTERMEDIARY may be subject to random audits performed by ADMINISTRATOR.

8. Any references to third party settlements above shall not apply to services provided to MSI Eligibles who are also claimable to Department for LIHP Funding. Third party settlements shall not be pursued for services provided to MSI Eligibles who are also claimable to Department for LIHP Funding.

VII. RECOVERY ACCOUNTS

A. INTERMEDIARY shall collect and deposit refunds and any third-party payments related to any Medical Service rendered by any Provider to the service account from which the Provider was paid.

B. Funds in the Recovery Accounts shall be deposited in the corresponding service accounts within the Imprest Account, and paid to Providers in the same manner as are other Funds in these Accounts.

C. Any funds recovered after Final Settlement shall be, at ADMINISTRATOR's sole discretion, returned to COUNTY, used for reimbursement of other MSI Program costs through INTERMEDIARY, and/or retained by INTERMEDIARY for use in a subsequent Agreement between COUNTY and INTERMEDIARY.

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VIII. INTERIM PAYMENTS TO PHYSICIANS AND CONTRACTING CLINICS

A. "Medical Fee Schedule" means the Medicare Resource-Based Relative Value Scale (RBRVS) listed in the Federal Register or the version in effect on July 1st of 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 the Agreement. The value of the RVU shall be modified by INTERMEDIARY as the Medical Fee Schedule is modified by Law or regulation and in effect for at the beginning of each Period of the Agreement. INTERMEDIARY shall notify ADMINISTRATOR prior to making any modifications.

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

1. For Medical Services provided during the term of the Agreement:

Service	Medical Home Physicians	Non-Medical Home Physicians	Non-FQHC Contracting Clinics	FQHC Contracting Clinics
Medical for Period One	60%	50%	60%	60%
Medical for Period Two and Three	60%	50%	55%	55%
Anesthesia	100%	100%	100%	100%

2. ADMINISTRATOR may, at its sole discretion, modify the percentage of the interim reimbursement to Physicians and/or Contracting Clinics specified in subparagraph C.1. above, at any time during the term of the Agreement.

D. 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 shall not be 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.

E. Claims for Dental Services shall be:

1. For non-FQHC Contracting Clinics reimbursed at State Medi-Cal (Denti-Cal) rates from

the available Dental Funding.

2. For FQHC Contracting Clinics reimbursed from the available Dental Funding at the PPS rate negotiated between the Contracting Clinic and Department, which rate may vary by location if the Contracting Clinic has more than one site designated as an FQHC Clinic.

3. Limited to one thousand dollars ($1,000) per MSI Eligible per MSI eligibility year, and shall not be subject to Final Settlement.

4. In the event that the total of all payments for Dental Services exceeds the amount available in Dental Funding for the Fiscal Year, any additional payments for Dental Services may 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.

F. Prior to Final Settlement, ADMINISTRATOR shall instruct INTERMEDIARY on the distribution methodology for the Quality and Outcomes Framework incentive to those physicians who provide Medical Home 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:

1. Number of MSI Patients assigned to Physician as a Medical Home

2. Meeting the access requirements as specified in the STCs specifically, providing Primary care appointments within thirty (30) business days of the request for Period One and within twenty (20) business days of the request for Period Two and Period Three

3. Chronic Disease Management

4. Preventive Measures

5. MSI Connect adoption and usage

G. Prior to Final Settlement, ADMINISTRATOR shall instruct INTERMEDIARY on the distribution methodology for the Quality and Outcomes Framework incentive to non-FQHC Contracting Clinics who provide Medical Home 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 of MSI Eligibles assigned to Contracting Clinic as a Medical Home

2 Meeting the access requirements as specified in the STCs, specifically providing Primary care appointments within thirty (30) business days of the request for Period One and within twenty (20) business days of the request for Period Two and Period Three

3 Chronic disease management

4 Preventive Measures

5 MSI Connect adoption and usage"

IX. PAYMENTS TO OUT-OF-NETWORK AND OTHER PROVIDERS

A. Out-of- Network Providers shall be reimbursed for Emergency Services and/or Care and Post-Stabilization Care as follows:

1. Acute Care Hospital Emergency Inpatient Services provided by non-Contracting Hospitals shall be paid at thirty percent (30%) of the Southern California unweighted average of per diem rates for Acute Care Hospital Emergency Inpatient Services paid to hospitals, participating in the Selective Provider Contracting Program (SPCP). These rates shall be as published by Department in an All Plan Letter and provided by ADMINISTRATOR to INTERMEDIARY as soon as they are made available.

2. Post-Stabilization Inpatient Services provided by non-Contracting Hospitals shall be paid at thirty percent (30%) of the Southern California unweighted average of per diem rates for Post-Stabilization Inpatient Services paid to hospitals participating in the SPCP. These rates shall be as published by Department in an All Plan Letter and provided by ADMINISTRATOR to INTERMEDIARY as soon as they are made available.

3. For Emergency Services and/or Care and Post-Stabilization Care Services, Out-of-Network Physicians and Other Providers shall be reimbursed at thirty percent (30%) of the applicable regulatory fee-for-service rate under California's Medicaid State Plan.

4. All payments to Out-of-Network Providers shall not be eligible for Final Settlement.

5. INTERMEDIARY shall include in its remittance to Out-of-Network Providers that, in accordance with State and Federal Law, the Out-of-Network Provider must accept reimbursement from COUNTY as payment in full and cannot pursue additional payment from the MSI Eligible nor hold the MSI Eligible liable for payment.

B. Ambulance operators, home health services Providers, and Providers of durable medical equipment, shall be reimbursed at the Contract Rates specified in I.I. of Exhibit A to the Agreement, for similar services and goods and are not subject to Final Settlement.

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. The cost of such reimbursement for any or all of said Providers should be charged to by INTERMEDIARY one hundred percent (100%) to the Outpatient Trust Fund Account.

C. Skilled Nursing Facility (SNF) Payments – For SNF services arranged for by COUNTY's UMD, 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.

D. 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.

X. FINAL SETTLEMENT

~~A. INTERMEDIARY shall complete final reimbursement to All Providers, as specified below (Final Settlement) for each Fiscal Year. Final Settlement should be accomplished no later than December 31st for Period One and Period Two, and by June 30th of Period Three.~~

A. INTERMEDIARY shall complete final reimbursement to All Providers, as specified below (Final Settlement) for each Fiscal Year. Final Settlement should be accomplished no later than December 31st for Period One and Period Two, and by June 30th of Period Three. The Final Settlement deadlines maybe extended, in whole or in part, at sole discretion of ADMINISTRATOR.

B. Prior to Final Settlement, INTERMEDIARY, with ADMINISTRATOR, shall complete an estimated preliminary reimbursement to All Providers to determine redistribution of funds in order to maximize LIHP Funding (Preliminary Final Settlement) and ensure that MOE is met. ADMINISTRATOR and INTERMEDIARY shall agree on timelines to begin and complete each step of Preliminary Final Settlement to ensure timely completion of Final Settlement. Throughout the Preliminary Final Settlement process, ADMINISTRATOR shall determine the amount of MSI Base Funding and LIHP funds that shall be allocated to each Account based on actual claims paid for MSI Eligibles.

1. Any adjustments to the MSI Base Funding, including the calculated difference between the estimated value of each service account's claims, including Pharmacy claims paid through COUNTY and the amount of MSI Base Funding identified for service, including Pharmacy claims paid through COUNTY shall be reported by ADMINISTRATOR to INTERMEDIARY.

2. If the amount of actual Pharmacy claims is less than the MSI Base Funding identified for Pharmacy claims, COUNTY shall deposit this amounts into the MSI Trust Fund and prior to Preliminary Final Settlement, INTERMEDIARY shall invoice COUNTY for this amount, which amount COUNTY shall pay, and INTERMEDIARY shall deposit into an interest-bearing account ('Holding Account') pending continued calculation of the Preliminary Final Settlement and MOE.

3. If the total of all Pharmacy claims is greater than the identified MSI Base Funding for Pharmacy Claims, ADMINISTRATOR shall make adjustments to the MSI Base Funding as appropriate, including, but not limited to, funding the balance needed for COUNTY's Pharmacy claims from the Outpatient Trust Fund Account.

4. 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.

C. Immediately prior to Final Settlement, INTERMEDIARY shall deposit any Recovery Trust Fund Account balances into the appropriate service account in the Imprest Account and shall advise ADMINISTRATOR of any funds in the HCA Recovery Account.

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 these amounts, which amounts COUNTY shall pay, and INTERMEDIARY shall deposit in the appropriate service account of the Imprest account. INTERMEDIARY shall disburse such Funds, and any other accounts maintained for the purposes of the Agreement, and any earned interest, to All Providers in the manner specified below.

1. Settlement to Contracting Hospitals – After deductions of payments to Out-of-Network 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 – INTERMEDIARY shall distribute all monies remaining in INTERMEDIARY's Physician Account after all approved Physician Claims have been paid pursuant to the Agreement. INTERMEDIARY shall distribute these monies as follows:

a. Step 1: Payments to all physician groups as specified in subparagraph VIII. of this Exhibit B shall be made at percentages or amounts specified in the Agreement.

b. Step 2: INTERMEDIARY shall calculate the amount of funding required to reimburse each Physician except those exempt from Final Settlement as specified herein, , at one hundred percent (100%) of Allowable Charges for the Period. The difference between the interim payment and the amount calculated shall be paid to Physicians as Final Settlement.

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

a. No Provider shall be reimbursed more than billed charges or one hundred percent (100%) of Allowable Charges, whichever is less.

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

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 the 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 for prior MSI Agreement periods – If Department allocates additional Coverage Initiative Funding to COUNTY for services provided prior to November 1, 2010,ADMINISTRATOR shall direct INTERMEDIARY to distribute said additional funds in accordance with the Final Settlement procedures set forth in the applicable Agreement with INTERMEDIARY that corresponds with the additional funding.~~

E. Supplemental Final Settlement for prior MSI Agreement periods:

1. If Department allocates additional Coverage Initiative Funding to COUNTY in excess of its allocation for Program Year (PY) 2008-09 and/or PY 2009-10 based on claims previously submitted to Department (or resubmitted at Department's request) for services provided in PY 2008-09 and/or PY 2009-10, ADMINISTRATOR, at its sole discretion, shall direct INTERMEDIARY to either:

a. Distribute said additional funds in accordance with the Final Settlement procedures set forth in the applicable Agreement with INTERMEDIARY that corresponds with the additional funding; or

b. Allocate additional funding for any contract period from July 1, 2011 through December 31, 2013 as specified herein, in which Final Settlement has been completed or remains in process. If such funds are allocated, ADMINISTRATOR shall direct INTERMEDIARY to distribute said additional funds, in whole or in part, to Hospitals, Physicians, and/or Clinics, as determined by ADMINISTRATOR at its sole discretion, in accordance with the Final Settlement procedures for the Period specified herein that correspond with the additional funding.

2. For any contract period from July 1, 2011 through December 31, 2013, COUNTY may, at its sole discretion, allocate additional MSI Base Funding for any period in which Final Settlement has been completed or remains in process. If such funds are allocated, ADMINISTRATOR shall direct INTERMEDIARY to distribute said additional funds, in whole or in part, to Hospitals, Physicians, and/or Clinics, as determined by ADMINISTRATOR at its sole discretion, in accordance with the Final Settlement procedures for the Period specified herein that correspond with the additional funding.

F. Paragraph X., "FINAL SETTLEMENT", of this Exhibit B to the Agreement will apply during the term of the Agreement and will survive termination or expiration of the Agreement.

XI. SATISFACTION OF CLAIMS

Acceptance by All Providers of payments made by INTERMEDIARY in accordance with the 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 V. of this Exhibit B.

XII. 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, denial, or payment.

B. INTERMEDIARY shall make available to ADMINISTRATOR an electronic monthly Processing Timeliness Report.

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 and due solely to the actions or inactions of INTERMEDIARY.

1. The Penalty Assessment, if any, shall be equal to one hundred dollars ($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 the 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 C
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH JUNE 30, 2014

MEDICAL SERVICES INITIATIVE PROGRAM

INTERMEDIARY DATA REPORTING REQUIREMENTS

I. GENERAL REQUIREMENTS

A. INTERMEDIARY shall provide or make available 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 COUNTY'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 the 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 all reports requested in this Exhibit C to persons designated by ADMINISTRATOR.

F. INTERMEDIARY shall provide online access to its internal data reporting system to persons designated by ADMINISTRATOR for the purposes of creating ad-hoc reports. All reporting listed below shall be available to ADMINISTRATOR for ad-hoc reporting through the internal reporting system.

G. 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 or make available 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 the Agreement.

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. Upon sole discretion of ADMINISTRATOR, data posted and accessible on-line by ADMINISTRATOR may be deemed as delivered by INTERMEDIARY as a machine readable copy.

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 the 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 all available data for the Fiscal Year running. A final annual report for services provided for each Fiscal Year shall be completed no later than the Final Settlement for each Fiscal 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 made available to ADMINISTRATOR's MSI Program Manager as specified in the Referenced Contract Provisions section of the Agreement.

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

2. 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. (Monthly and following Final Settlement)

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 made available to ADMINISTRATOR as specified on Page 5 of the 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.

3. Utilization Review Reports, to be provided as requested by ADMINISTRATOR, 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. Twenty-five (25) Most Costly Surgical, twenty-five (25) Most Costly Non-Surgical, and twenty-five (25) MSI 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, ICD9/10 Code, facility, service dates, disposition.

c. Fifty (50) Most Costly Patients: Listing each selected patient by name, case number, Contract Rates, primary diagnosis, ICD9/10 Code, initial service data, disposition.

d. Inpatients With Length of Stay Exceeding fifteen (15) Days: Listing each selected patient by name, case number, total days, case type, primary diagnosis, ICD9/10 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.

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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)

g. Listing of MSI 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)

4. Utilization Monitoring Reports to be provided as requested by ADMINISTRATOR and 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.

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.

c. Inpatient Experience by ICD9/10 Code: 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 ICD9/10 major disease groups, by hospital by charges.

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.

5. Program Monitoring Reports to Include:

a. MSI Profile of All MSI 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. (Monthly with a Bi-Annual and Annual end of Fiscal Year summary)

b. Encounters by ICD9/10 Codes and Services Rendered by Patient Characteristics: For all pools combined and each pool and service type combination, a table of encounters by ICD9/10 major disease groups and median age of MSI 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 (ICD9/10 major disease groups). (As Requested)

6. Denial Reports, as requested by ADMINISTRATOR, 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.

7. Annual/Periodic Reports:

a. Alphabetic listing of all claims by patient name, 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. (As requested)

b. Cumulative, alphabetic listing of physician Providers to include Provider name, tax I.D. number, total billed, total allowed, and total paid. (As Requested)

c. Reports of final payout results, settlements, and adjustments including listings of payments for each provider pool and Provider.

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.

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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 the 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

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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

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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. Billing/Claims Processing:

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. Bi-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 D-1
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH JUNE 30, 2014

MEDICAL SERVICES INITIATIVE PROGRAM

HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services provided during the period July 1, 2011 through June 30, 2012 for Period One, which payment may be revised pursuant to Paragraph II. of Exhibit B to the Agreement.

HOSPITAL	PIP PAYMENTS
Anaheim General Hospital	$ 5,000
Anaheim Memorial Medical Center	$ 228,355
Chapman Medical Center, Inc., dba Chapman Medical Center	$ 13,400
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$ 63,447
Fountain Valley Regional Hospital	$ 393,809
Garden Grove Hospital & Medical Center	$ 45,397
Hoag Memorial Hospital Presbyterian (includes Newport Beach and Irvine)	$ 198,546
Kaiser Foundation Hospitals, Inc.-Anaheim and Irvine	$ 10,939
Los Alamitos Medical Center	$ 28,442
Mission Hospital (includes Mission Viejo and Laguna Beach)	$ 243,396
Orange Coast Memorial Medical Center	$ 76,301
Placentia Linda Community Hospital	$ 30,356
Prime Healthcare Anaheim	$ 80,129
Prime Healthcare Huntington Beach	$ 54,422
Prime Healthcare La Palma	$ 16,956
Regents of the University of California	$ 572,391
Saddleback Memorial Medical Center (includes Laguna Hills and San Clemente)	$ 108,298
Saint Joseph Hospital - Orange	$ 177,761
Saint Jude Medical Center	$ 191,435
WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	$ 25,980
WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	$ 175,026
Total PIP Payments	**$ 2,739,786**

EXHIBIT D-2
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH JUNE 30, 2014

MEDICAL SERVICES INITIATIVE PROGRAM

HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services provided during the period July 1, 2012 through June 30, 2013 for Period Two, which payment may be revised pursuant to Paragraph II. of Exhibit B to the Agreement.

HOSPITAL	PIP PAYMENTS
Anaheim General Hospital	$ 21,327
AHMC Anaheim Regional Medical Center, L.P.	$267,079
Chapman Medical Center, Inc., dba Chapman Medical Center	$19,286
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$70,247
Fountain Valley Regional Hospital	$354,898
Hoag Memorial Hospital Presbyterian (includes Newport Beach and Irvine)	$218,199
Kaiser Foundation Hospitals, Inc.-Anaheim and Irvine	$12,927
Los Alamitos Medical Center	$34,028
Mission Hospital (includes Mission Viejo and Laguna Beach)	$266,896
Orange Coast Memorial Medical Center	$99,726
Placentia Linda Community Hospital	$30,609
Prime Healthcare Anaheim	$86,399
Prime Healthcare Garden Grove	$ 74,176
Prime Healthcare Huntington Beach	$60,673
Prime Healthcare La Palma	$10,832
Regents of the University of California	$501,196
Saddleback Memorial Medical Center (includes Laguna Hills and San Clemente)	$81,608
Saint Joseph Hospital - Orange	$158,100
Saint Jude Medical Center	$165,813
WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	$20,168
WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	$185,599
Total PIP Payments	**$2,739,786**

EXHIBIT D-3
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH JUNE 30, 2014

MEDICAL SERVICES INITIATIVE PROGRAM

HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services provided during the period July 1, 2013 through December 31, 2013 for Period Three, which payment may be revised pursuant to Paragraph II. of Exhibit B to the Agreement.

HOSPITAL	**PIP PAYMENTS**
Anaheim General Hospital	$0
AHMC Anaheim Regional Medical Center, L.P.	$0
Chapman Medical Center, Inc., dba Chapman Medical Center	$0
Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	$0
Fountain Valley Regional Hospital	$0
Hoag Memorial Hospital Presbyterian (includes Newport Beach and Irvine)	$0
Kaiser Foundation Hospitals, Inc.-Anaheim and Irvine	$0
Los Alamitos Medical Center	$0
Mission Hospital (includes Mission Viejo and Laguna Beach)	$0
Orange Coast Memorial Medical Center	$0
Placentia Linda Community Hospital	$0
Prime Healthcare Anaheim	$0
Prime Healthcare Garden Grove	$0
Prime Healthcare Huntington Beach	$0
Prime Healthcare La Palma	$0
Regents of the University of California	$0
Saddleback Memorial Medical Center (includes Laguna Hills and San Clemente)	$0
Saint Joseph Hospital - Orange	$0
Saint Jude 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	**$0**

EXHIBIT E
TO AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS WITH
ADVANCED MEDICAL MANAGEMENT, INC.
AUGUST 10, 2011 THROUGH SEPTEMBER 30, 2014

EMERGENCY MEDICAL SERVICES FUND PROGRAM

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 the Agreement.

A. "Active Labor" means labor at a time when there is inadequate time for safe transfer to another hospital before delivery, and/or transfer of the patient may threaten the health and safety of the patient or the unborn child.

B. "Cap-Initial" means initial payment of fifty percent (50%) of the Eligible Losses – TSR for Physicians' Allocation – TSR and for all other Physicians' Allocations except Physicians' Allocation-Other. For Physicians' Allocation – Other, Cap-Initial shall be specified by law or, if appropriate, directed by ADMINISTRATOR.

C. "Cap-Final" means, at Final Payout, final payment of one hundred percent (100%) of Eligible Losses – TSR for Physicians' Allocation – TSR and for all other Physicians' Allocations except Physicians' Allocation-Other. For Physicians' Allocation – Other, Cap-Final shall be specified by law or, if appropriate, as directed by ADMINISTRATOR.

D. "Claim" means a claim for compensation filed by a Physician in accordance with applicable laws, regulations, or requirements to receive funds from any Physicians' Allocation for services provided to a person who has not paid for Medical Emergency Services and for whom payment will not be made by any responsible third party, through any private coverage, or by any program funded in whole or in part by the federal government.

E. "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 room physician and/or specialty physician. 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.

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

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1. "Eligible Losses" means financial losses incurred by a Physician as the result of giving Emergency Medical Services in a Hospital to patients who do not have health insurance coverage for Emergency Services and/or Care, cannot afford to pay for Emergency Services and/or Care, and for whom payment will not be made by any responsible third party through any private coverage or by any program funded in whole or in part by the federal government. Eligible Losses shall not exceed Usual and Customary Charges.

2. "Eligible Losses-TSR" means financial losses incurred by a Physician as a result of giving Emergency Medical Services in a Hospital to patients who are unable to pay for such services, and for whom payment will not be made by a responsible third party through any private coverage or by any program funded in whole or in part by the federal government, which losses shall be reimbursed through the Physicians' Allocation - TSR. Eligible Losses-TSR shall not exceed Usual and Customary Charges. ADMINISTRATOR may modify this definition as allowed by law.

G. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health, or with respect to a pregnant woman (or her unborn child), in serious jeopardy; or

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part

H. "Emergency Services and/or Care" means lawfully provided medical screening, examination, and evaluation of a patient in a Hospital by a Physician to determine if an Emergency Medical Condition or Active Labor exists, and if it does, the care, treatment and surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or Active Labor (Health and Safety Code Section 1371.1); 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.

I. "EMSF Program" means collectively all Physician services and administrative services for which reimbursement is authorized by the Agreement.

J. "Final Payout" means the final reimbursement to providers, as specified in Paragraph IV.N. of this Exhibit E to the Agreement.

K. "Fiscal Year" means the period commencing July 1 and ending the following June 30.

L. "Fund" means the Emergency Medical Services Fund, an interest bearing trust fund established by the Orange County Board of Supervisors by Resolution No. 88-241 on February 24, 1988, as permitted by Health and Safety Code Section 1797.98a.

M. "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, Physician, patient, third party, or other entity as the result of any duty arising from the Agreement.

N. "Hospital" means a general acute care hospital located in Orange County with an emergency department licensed by the State of California to provide basic or comprehensive emergency services.

O. "MSI" means the Orange County Medical Services Initiative Program.

P. "On-Call Physician" means a physician available for medical consultation to Emergency Services staff to personally examine and treat the patient.

Q. "Payout" means the periodic disbursement to Physicians of the monies from the Physicians' Allocation in settlement of Claims filed in accordance with the terms of the Agreement and Health and Safety Code Section 1797.98c, as it now exists or may hereafter be amended.

R. "Physician" means a licensed physician or surgeon or patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a licensed physician or surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. For purposes of the expenditure of the Physicians' Allocation – TSR, "Physician" shall not include services provided by a nurse practitioner or physician's assistant.

S. "Physicians' Allocation" means that portion of the Fund designated for Physicians as specified by law and inclusive of the following:

1. "Physicians' Allocation – Collections" means the designated portion of funds received by COUNTY from penalty assessments on penal code violations.

2. "Physicians' Allocation – TSR" means Tobacco Settlement Revenues as specified by Measure H to provide reimbursement for the first twenty-four (24) hours of uncompensated Emergency Services and/or Care provided by Physicians.

3. "Physicians' Allocation – Other" means any funds not specifically identified in subparagraphs U.1. through U.4. above, but which may be received by COUNTY and expressly deemed by law, regulation, or other legal action, for reimbursement of uncompensated Emergency Services and/or Care provided by Physicians.

T. "Recovery Account" means a separate account maintained by INTERMEDIARY for monies received by INTERMEDIARY from Physicians, patients, or third party payors for services provided pursuant to the Agreement.

U. "Recovery Trust Fund Account" means an account maintained by COUNTY for monies received directly by COUNTY from Physicians, patients or Third Party payors for services provided pursuant to the Agreement.

V. "Stabilized" means the point at which, in the opinion of the treating Physician, the patient's medical condition is such that, within a reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the transfer of the patient (Health and Safety Code Section 1371.1(j)).

W. "Third Party Covered Claim" means a claim for reimbursement of Emergency Services and/or Care, which services are covered, at least in part, by a non-COUNTY third party payor.

X. "Undisbursed Payout" means an amount equal to the difference between the total of all payments by COUNTY to INTERMEDIARY intended for Payout, and the total of all Payouts made by INTERMEDIARY.

Y. "Usual and Customary Charge" means the amount which Physician normally or usually charges the majority of its patients for a specified type of service, including the types of Emergency Services and/or Care provided hereunder. Physician's Usual and Customary Charges shall be subject to review by ADMINISTRATOR, in conjunction with INTERMEDIARY and OCMA, to determine whether they conform to Usual and Customary Charges made by other Orange County physicians. If Physician's Usual and Customary Charges are determined to exceed those of other Orange County Physicians, Physician may be required to reduce charges as necessary to bring them into conformity.

II. PHYSICIAN OBLIGATIONS

A. In consideration of payments by COUNTY to INTERMEDIARY for payment for Emergency Services and/or Care pursuant to the Agreement, COUNTY's obligation to Physicians shall be satisfied.

B. Acceptance by Physicians of payments made by INTERMEDIARY in accordance with the Agreement shall be deemed satisfaction in full of any obligation to Physicians, and no Physician shall seek additional reimbursement from a patient, with respect to those claims for Emergency Services and/or Care for which payment has been made.

C. Physicians shall provide Emergency Services and/or Care to all persons presenting for emergency treatment. As a condition of reimbursement of Claims for Emergency Services and/or Care provided by Physicians, Physicians shall comply with the Agreement and the terms of their enrollment and the EMSF Program Rules, as they may be amended.

D. Physicians shall be required to enroll for participation in the EMSF Program. Enrollment periods cover one (1) Fiscal Year. Physicians may enroll on-line at any time by visiting the Emergency Medical Services Fund (EMSF) section of INTERMEDIARY's website at http://ochca.amm.cc. The enrollment period shall be in effect for the period July 1st through June 30th of each Period. By participating in the EMSF Program, each Physician acknowledges that the requirements of Health and Safety Code Section 1797.98c, and/or any other applicable laws, regulations, or requirements, including any amendments thereto, for all Claims submitted by Physician have been fulfilled, including, but not limited to:

1. Physician has inquired if there is a responsible private or public, including MSI, third party source of payment;

2. Physician expects to receive reimbursement for the Emergency Services and/or Care provided (i.e., the service was not provided gratuitously);

3. At least one-hundred twenty (120) calendar days have passed from the date the Physician initially provided services and the physician billed the patient or responsible third party without receipt of any payment/denial during that period and Physician has attempted to collect from patient or

responsible third party a minimum of two (2) times and received no payment; or the claims have been rejected for payment by the patient and any responsible third party.

E. Physicians shall assist COUNTY, and INTERMEDIARY in the conduct of any appeal hearings conducted by COUNTY or INTERMEDIARY in accordance with the Agreement.

F. Reimbursement provided through the Agreement shall be payment of last resort. Prior to submitting any Claim to INTERMEDIARY for reimbursement of Emergency Services and/or Care, Physicians shall:

1. Use their reasonable best efforts to determine whether the claim is MSI, a third party, or Primary Other Insurance covered claim.

2. Bill and use their reasonable best efforts to collect MSI, third party or Primary Other Insurance covered claims to the full extent of such coverage.

G. With submission of a Claim, Physician shall give proof of non-coverage to INTERMEDIARY, if a third party or Primary Other Insurance denies coverage of the Claim. The Agreement shall not reimburse deductibles and co-payments required by a person's Primary Other Insurance coverage.

H. Physician 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.

I. If Physician receives any patient payment, third party or government reimbursement, or reimbursement from a third party settlement, for services reimbursed through the Agreement, Physician shall reimburse INTERMEDIARY the amount equal to the EMSF payment.

J. As a condition of reimbursement through the Agreement, all Claims for reimbursement of Emergency Services and/or Care shall be:

1. Initially received by INTERMEDIARY by June 30th of each Period.

2. Submitted and completed in accordance with the Agreement.

3. Submitted no later than one (1) year after the date of service.

K. Unless otherwise directed by ADMINISTRATOR, all claims shall be submitted to:

Advanced Medical Management, Inc.
P.O. Box 3509
Long Beach, California 90853

L. Physicians may resubmit denied claims to INTERMEDIARY; provided, however, Physicians shall complete any necessary corrective action, and resubmit the claim no later than thirty (30) days after notification of the rejection.

M. Physicians submitting Claims for reimbursement under the 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.

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N. RECORDS RETENTION

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

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

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

4. All books of accounts and records shall be made available at a location within the County of Orange, unless otherwise authorized, in writing, by ADMINISTRATOR.

III. INTERMEDIARY OBLIGATIONS

A. INTERMEDIARY shall perform as fiscal intermediary on behalf of Physicians and COUNTY.

B. During the term of the Agreement, and for such time thereafter as required by the Agreement, INTERMEDIARY shall continuously provide sufficient staffing including production, supervisory and management staff to ensure timely and efficient performance of the services herein.

1. INTERMEDIARY agrees to provide the resources necessary to address any backlog claims processing or an increased influx of claims within the time periods specified herein.

2. INTERMEDIARY agrees that staff providing claims adjudication services shall, to the extent possible and practical, be dedicated to the performance of the duties herein for the EMSF program.

3. INTERMEDIARY shall ensure that a designated point of contact and alternate, when necessary, is available at all times during regular business hours to respond to requests from ADMINISTRATOR.

4. INTERMEDIARY agrees that all services provided pursuant to the Agreement shall be provided at INTERMEDIARY's primary place of business and that no services may be outsourced outside the contiguous United States of America without prior written consent of ADMINISTRATOR.

C. During the term of the Agreement, and for such time thereafter as required by the Agreement, INTERMEDIARY shall continuously provide fiscal intermediary services including, but not limited to, the following:

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

2. Processing, denying, approving all Claims submitted.

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

4. Reimbursing Claims and making other required payments.

5. Establishing and maintaining all necessary policies and procedures pertaining to INTERMEDIARY's responsibilities pursuant to the Agreement.

6. Routine storage and destruction of records.

7. Special retrieval of records.

D. INTERMEDIARY shall cooperate with any audit requested by ADMINISTRATOR pursuant to the Agreement and shall provide all claims records for the audit within (5) business days of the date of the request. INTERMEDIARY shall ensure that their response to any audit shall in no way delay claims adjudication services provided in accordance with the Agreement.

E. INTERMEDIARY shall reimburse Physicians up to the Cap-Initial for initial payment for Emergency Services and/or Care provided up to the time the patient is Stabilized, which services shall have been provided in general acute care hospitals that provide basic or comprehensive emergency services.

F. INTERMEDIARY shall require Physicians to submit Claims for reimbursement of Eligible Losses and Eligible Losses-TSR on CMS 1500 claim forms which INTERMEDIARY shall be able to receive and process in an electronic or paper format that has been authorized by ADMINISTRATOR. Electronic Claims shall be processed in accordance with HIPAA Transaction and Code Sets standards and requirements. Paper Claims must be legible and accurately completed to be considered.

1. INTERMEDIARY shall review all Claims to determine whether the services for which reimbursement is sought are Emergency Services and/or Care, reimbursable pursuant to the Agreement, and whether such services were rendered within appropriate time limits.

2. INTERMEDIARY shall review Claims and may provide a medical review, as appropriate, in accordance with its Operations Manual. 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.

3. INTERMEDIARY shall deny all Claims that do not meet the conditions and requirements of the Agreement and/or state regulations for Claim submission, processing, and reimbursement.

4. COUNTY shall engage INTERMEDIARY, or authorize INTERMEDIARY to enter into a separate Agreement, for the provision of Recovery Services for the purpose of actively pursuing reimbursement of claims paid for EMSF patients later determined to be eligible for Medi-Cal, MSI, or having third party, primary or other primary insurance. All Providers shall cooperate in recovering these costs. Except as otherwise directed by ADMINISTRATOR, monies recovered due to the efforts of Recovery Services shall be reimbursed to COUNTY through INTERMEDIARY and shall be deemed "Active Recovery Funds." Monies recovered or identified in advance of notice from Recovery Services, and forwarded directly to INTERMEDIARY to Provider, shall be deemed "Passive Recovery Funds." For Active Recovery Funds only, an administrative fee, as negotiated between ADMINISTRATOR and INTERMEDIARY, may be deducted by INTERMEDIARY and then ten percent (10%) of the balance shall be deposited into the HCA Recovery Account, with the remainder into the appropriate service account.

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a. INTERMEDIARY will develop and submit for approval to ADMINISTRATOR, an accountability procedure that identifies and tracks the passive recovery funds received versus the active recovery funds received by INTERMEDIARY from Providers.

b. ADMINISTRATOR will not provide INTERMEDIARY with an administrative fee for recovery services until an accountability procedure has been approved.

c. Recovery Services provided by INTERMEDIARY may be subject to random audits performed by ADMINISTRATOR.

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

G. COUNTY shall enter into or authorize INTERMEDIARY to enter into a separate Agreement for the provision of providing a Medi-Cal eligibility list. INTERMEDIARY shall match all EMSF Claims against the Medi-Cal eligibility list and MSI information, as available, at least every two (2) weeks to determine eligibility of Claims.

1. If a Claim is determined to be eligible for Medi-Cal reimbursement, INTERMEDIARY shall notify Physician with their remittance advice in the next payment cycle that their Claim is denied based on information from the database.

2. If a Claim is determined to be eligible for MSI based on patient eligibility, INTERMEDIARY shall process the Claim as an MSI claim if it meets all criteria for MSI payment. If the Claim does not meet all criteria for MSI Payment, INTERMEDIARY shall process the claim as an EMSF claim, pursuant to all EMSF criteria.

H. INTERMEDIARY shall completely process (defined as paid or denied) all Claims received by June 30th of each Period by July 31st of each Period.

I. INTERMEDIARY shall process all claims received as soon as possible, and in no event later than sixty-five (65) calendar days after their receipt. Processed Claims, for purposes of the Agreement, is defined as claims paid, denied, or pended at ADMINISTRATOR's request, within sixty-five (65) calendar days of receipt and includes, but is not limited to, administrative time to receive claims into INTERMEDIARY's claims processing system, processing time through its pre-processing (On-Base) system, adjudication processing time through its (E-Z Cap) system, and administrative time to create and mail payments to providers. INTERMEDIARY shall process, as defined above, ninety percent (90%) of all claims received within sixty-five (65) calendar days of their receipt by INTERMEDIARY, unless INTERMEDIARY does not have sufficient funds in the Account to pay such claims, or if INTERMEDIARY has been directed by ADMINISTRATOR to hold claims pending COUNTY's receipt and disbursement of Funds.

1. INTERMEDIARY shall submit to ADMINISTRATOR a monthly Processing Timeliness Report, as required by this Exhibit E to the Agreement.

2. At its 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. INTERMEDIARY shall be subject to such penalty for its performance commencing ninety (90) calendar days after execution by the parties.

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

b. Penalty Assessments, if any, shall be retained in the Fund for distribution to Physicians in accordance with the Agreement.

c. If claims received during any month exceed the previous three (3)-month average by at least twenty-five percent (25%), INTERMEDIARY shall be provided an additional ten (10) days to process such claims; provider, however, INTERMEDIARY may request additional processing time commensurate with the actual number of Claims received.

J. Any unapproved Claims for Emergency Services and/or Care which are received by June 30th of each Period shall be null and void after January 31st following termination of each Period.

K. INTERMEDIARY shall notify Physicians in writing of the reason for any denial of a Claim(s).

L. Claims payment to Physicians shall be calculated as a percentage of the national Medicare Resource Based Relative Value Scale (RBRVS) so as to achieve equitable distribution of funding to physicians in each fiscal year.

1. OCMA and ADMINISTRATOR shall mutually agree, in writing, on the version and percent of RBRVS to be used for each Period and ADMINISTRATOR may periodically adjust this percentage of RBRVS in accordance with available funding.

2. If it is determined after March 31st, for each Period that continued payment of the established RBRVS through June 30th, for each Period, will exceed available Funds, ADMINISTRATOR may direct INTERMEDIARY to pay Claims up to the amount of remaining available Funds at the presently established RBRVS, less estimated administrative costs for INTERMEDIARY, COUNTY, and any other Agreements in support of the EMSF Program; suspend payment of all remaining Claims submitted through June 30th; or pay those suspended Claims in the following Fiscal Year at the RBRVS established for that following Fiscal Year.

3. At Final Payout, if adjustments to reduce the RBRVS were made during the Fiscal Year, funds shall be first used to pay those Physicians who received payment at an RBRVS less than that paid to any Physicians at any other time during the Fiscal Year, up to the maximum RBRVS paid during the year, not to exceed the allowable Cap-Final. Any other remaining Funds shall then be distributed as provided in Paragraph IX.M. below.

4. At Final Payout, if adjustments to increase the RBRVS were made during the Fiscal Year, funds shall be first used to pay those Physicians who received payment at an RBRVS less than that paid to any Physicians at any other time during the Fiscal Year, up to the maximum RBRVS paid during the year, not to exceed the allowable Cap-Final. Any other remaining Funds shall then be distributed as provided in Paragraph IX.M. below.

M. No later than July 31st of each Period, ADMINISTRATOR shall report to INTERMEDIARY the Fund balance, if any, to be distributed through Final Payout. INTERMEDIARY shall invoice COUNTY for this amount, which amount COUNTY shall pay, and INTERMEDIARY shall deposit in the Account. INTERMEDIARY shall disburse such Funds, the balance of all other monies in the Account and any other accounts maintained for the purposes of the Agreement, and any earned interest, to Physicians in the manner specified in the Agreement. After adjustments, if any, in accordance with subparagraphs IX.M. 3. and 4. above, Funds shall be distributed proportionately, based on the dollar amount of Claims submitted and paid to all physicians and surgeons who submitted qualifying claims during the year, in accordance with Health and Safety Code Section 1797.98a(d).

1. No later than August 31st of each Period, INTERMEDIARY shall submit a Final Payout Report, by Physician and Physician Group, as appropriate, to ADMINISTRATOR for approval.

2. Immediately prior to Final Payout, INTERMEDIARY shall deposit any Recovery Trust Fund Account balance into the Fund.

3. INTERMEDIARY shall complete Final Payout to Physicians, no later than September 30th of each Period; provided, however, ADMINISTRATOR and INTERMEDIARY may mutually agree, in writing, to extend this date.

N. INTERMEDIARY shall provide to ADMINISTRATOR the distribution of Claims within four (4) calendar days of each Payout to Physicians (i.e., the number and dollar value of Claims submitted, paid and denied), and the percentage of reimbursement of those Claims when compared against the actual billed charges (loss) of the provider.

O. As a follow up to an independent financial audit under a separate contract with COUNTY, if any amount paid for a Claim is determined to be ineligible, unsubstantiated, or paid by any other payment source, INTERMEDIARY shall demand a refund from the Physician equal to the amount of that payment plus twenty-five percent (25%).

1. If a pattern of ineligible or unsubstantiated Claims, or Claims paid by any other payment source, is identified, in addition to the refund, INTERMEDIARY shall demand a penalty which is equal to one hundred percent (100%) of the refund to compensate for audit costs and lost use of Physicians' Allocation funds.

2. If the pattern of ineligible or unsubstantiated claims found pursuant to subparagraph O.1. above is determined by ADMINISTRATOR to be continuing, the Physician may be excluded from submitting future requests for reimbursement.

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3. Any refunds or penalties shall be paid to INTERMEDIARY and deposited into the Recovery Account.

P. Appeal Process for Denied Claims:

1. INTERMEDIARY shall notify, in writing, All Providers and their respective MSI Patients of the reason for any denial of a claim(s).

2. Notice shall be deemed effective:

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

b. When faxed, transmission confirmed; or

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

3. 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 ninety (90) calendar days after notification of the denial.

4. All Providers or their respective EMSF patients may appeal to ADMINISTRATOR's Medical Director 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 ADMINISTRATOR's Medical Director, no later than ninety (90) calendar days after notification of denial. ADMINISTRATOR's Medical Director shall decide upon the appeal within thirty (30) calendar days.

5. If a denied claim is not resubmitted and/or appealed in writing to ADMINISTRATOR's Medical Director, within ninety (90) 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.

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

R. INTERMEDIARY shall maintain a telephone number dedicated to facilitating communication with Physicians and/or their billing offices and an on-line inquiry system regarding claim status or other issues. INTERMEDIARY shall notify Physicians in writing of such phone number or on-line inquiry system and its hours of operation.

IV. COUNTY OBLIGATIONS

A. COUNTY shall provide general oversight of the EMSF Program, including appropriate financial and contract monitoring and review and analysis of data gathered and reported. COUNTY shall also provide appropriate evaluation and standards assurance of the EMSF Program.

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B. COUNTY shall administer the Physicians' Allocation in accordance with all applicable governmental laws, regulations, and requirements as they exist now or may be hereafter amended or changed. If any portion of the Agreement is deemed to be or becomes inconsistent with the law, including any regulations thereto, the law shall prevail. Deposits into the Fund shall be as follows:

1. Physicians' Allocation – Court Fine Collections: COUNTY shall deposit in the Fund, fifty-eight percent (58%) of collections made pursuant to Penal Code Section 1463, as it now exists or may hereafter be amended or changed. Health and Safety Code Section 1797.98a(b)(4) allows for the creation of a reserve of up to fifteen percent (15%) of collections. COUNTY may decide to create such a reserve. Such reserve amounts, if any, shall be deducted prior to COUNTY's deposit of collections in the Fund.

2. Physicians' Allocation – TSR: COUNTY shall appropriate in the County General Fund an amount equal to TSR funds specifically designated for emergency medical services provided by emergency room physicians and emergency room on-call physician specialists, in accordance with all applicable governmental laws, regulations, and requirements as they exist now or may hereafter be amended or changed.

3. Physicians' Allocation – Other: COUNTY shall deposit into the Fund, or in the County General Fund, as appropriate, any funds not specifically identified in the Agreement but expressly deemed by law, regulation, or other legal action, to be used for partial reimbursement of uncompensated Emergency Services and/or Care provided by Physicians.

C. Monies in the 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.

D. ADMINISTRATOR shall provide a monthly fund balance report to INTERMEDIARY, which shall include deposits and expenditures from all funds received by COUNTY for the EMSF Program.

V. FUNDING AND PAYMENTS

A. Total Administrative Costs

1. The total of all administrative costs paid to INTERMEDIARY, plus administrative costs retained by COUNTY, for its costs as well as costs for other Agreements in support of the EMSF Program, shall not exceed ten percent (10%) of all deposits to and appropriations for the Physicians' Allocation for each Period.

2. COUNTY shall be reimbursed for its administrative costs up to the actual cost of services or ten percent (10%) of all non-TSR deposits to and appropriations for the Physicians' Allocation plus one percent (1%) of the TSR deposits to and appropriations for the Physicians' Allocation, whichever is less.

3. To the extent that the total of all Administrative Costs paid are less than the ten percent (10%) maximum allowed for Administrative Costs, the savings shall remain in the Physicians' Allocation for distribution to Physicians.

B. INTERMEDIARY Payments – Administration

1. For fiscal intermediary services provided by INTERMEDIARY in accordance with the Agreement, COUNTY shall, upon receipt of an appropriate invoice, pay INTERMEDIARY monthly, in arrears, as follows; provided however the total for each Period shall not exceed COUNTY's Maximum Obligation to INTEMEDIARY for each Period as specified in the Referenced Contract Provisions of the Agreement:

a. Period One – Forty-four thousand eight-hundred fifty-three dollars ($44,853) per month for August 2011 through and including August 2012, and forty-four thousand eight-hundred fifty-six dollars ($44,856) for September 2012 up to a maximum total of six-hundred twenty-seven thousand nine-hundred forty-five dollars ($627,945);

b. Period Two - Forty-three thousand four-hundred fifty-four dollars ($43,454) per month up to a maximum total of six-hundred fifty-one thousand eight-hundred ten dollars ($651,810); and

c. Period Three - Forty-five thousand one-hundred six dollars ($45,106) per month up to a maximum total of six-hundred seventy-six thousand five-hundred ninety dollars ($676,590) for Period Three.

2. For each Period, should claims processed by INTERMEDIARY exceed one-hundred forty thousand (140,000) claims, INTERMEDIARY may submit an invoice for an additional fiscal intermediary services fee of four dollars ($4.00) per claim for each claim in excess of one-hundred forty thousand (140,000) claims. The additional intermediary services fee for each Period, if any, when combined with all other administrative costs shall not exceed ten (10%) of allowable administrative fees per Period, as specified in Paragraph A. above and are anticipated to not exceed sixty-two thousand seven hundred ninety-five dollars ($62,795) for Period One, sixty-five thousand one hundred eighty dollars ($65,180) for Period Two, and sixty-seven thousand six hundred sixty dollars ($67,660) for Period Three.

3. The final monthly administrative payment to INTERMEDIARY shall not be made until ADMINISTRATOR determines that INTERMEDIARY has satisfactorily completed its Final Payout duties in accordance with the Agreement.

4. Upon approval of ADMINISTRATOR, INTERMEDIARY may use a portion of any interest earned by the Funds to offset actual cost of postage associated with any mailings, except check and Explanation of Benefit (EOB) mailings, required in accordance with the Agreement. Contractor shall report to County the amount of interest charged against postage. INTERMEDIARY shall use any remaining interest to reimburse claims in accordance with the Agreement.

C. INTERMEDIARY Payments – Physician Reimbursement:

1. All funds received by INTERMEDIARY in accordance with this subparagraph VI.C. shall be used by INTERMEDIARY to reimburse Physician Claims.

2. COUNTY shall pay INTERMEDIARY, upon receipt of an appropriate invoice, an initial provisional payment of one-million one-hundred twenty-five thousand dollars ($1,125,000) for each

Period. Such funds shall be immediately deposited by INTERMEDIARY into an interest-bearing EMSF Account (Account) for reimbursement of EMSF Physician Claims received by INTERMEDIARY on or after July 1st of each Period.

3. Following the initial payment, for each Period, in accordance with subparagraph C.2. above, INTERMEDIARY shall submit appropriate invoices for payment of EMSF physician claims on a regular basis, which frequency shall be no less often than bi-weekly without the mutual consent of ADMINISTRATOR and INTERMEDIARY. Each individual invoice may be in an amount up to the COUNTY's initial provisional payment of one-million one-hundred twenty-five thousand dollars ($1,125,000), which amount may be modified by mutual consent of INTERMEDIARY and ADMINISTRATOR. INTERMEDIARY's invoices are due no later than two (2) business day after INTERMEDIARY's check run, unless otherwise approved by ADMINISTRATOR, and payments to INTERMEDIARY should be released by COUNTY no later than twenty-one (21) days after receipt of the correctly completed billing form; provided, however that the aggregate of all payments for physician claims shall not exceed all deposits to and appropriations for the Physicians' Allocation for each Period, less administrative costs described in section XI.B. above.

4. Upon determination by INTERMEDIARY that the Account requires additional funds for reimbursement of claims authorized in accordance with the Agreement, INTERMEDIARY shall submit a supplemental invoice to COUNTY, together with any documentation that may be required by ADMINISTRATOR.

5. Except as otherwise provided herein, the Account shall not exceed a maximum of two million dollars ($2,000,000), and shall be managed so as to maximize the interest earned upon Funds in the Account.

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

7. INTERMEDIARY's invoices shall be on forms approved or provided by ADMINISTRATOR. INTERMEDIARY shall use its best efforts to submit invoices to ADMINISTRATOR no later than two (2) business days following INTERMEDIARY's check run, unless otherwise agreed to by ADMINISTRATOR and INTERMEDIRY, and payments to INTERMEDIARY should be released by COUNTY no later than twenty-one (21) days after receipt of the correctly completed invoice form.

8. All billings to COUNTY shall be supported, at INTERMEDIARY's facility, by source documentation including, but not limited to, provider claims, ledgers, journals, bank statements, canceled checks, and records of services paid. In support of the monthly billing, INTERMEDIARY shall submit a Claims Processed Report on a form, or in an electronic format, approved or provided by ADMINISTRATOR.

a. For Emergency Services and/or Care provided within the first twenty-four (24)-hours of the hospital visit, reimbursement of Claims shall be through use of TSR Funds.

b. For Emergency Services and/or Care provided after twenty-four (24) hours, but not more than the immediately following two (2) calendar days after the date services are first provided, reimbursement of Claims shall be through use of all other Funds in accordance with all applicable laws and regulations governing their use.

c. Notwithstanding the preceding subparagraph b, if it is necessary to transfer a patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement of these Claims for the calendar day of transfer and on the immediately following two (2) calendar days shall be through use of all other Funds in accordance with all applicable laws and regulations governing their use.

d. If TSR Funds are exhausted, or ADMINISTRATOR agrees to an exception, then all other funds may be used to reimburse Claims for Emergency Services and/or Care provided within the first twenty-four (24)-hours of the hospital visit.

9. Monthly, INTERMEDIARY shall forward ADMINISTRATOR an electronic copy of the latest bank statement(s) and reconciliation with respect to all monies disbursed pursuant to the Agreement.

10. In the event INTERMEDIARY anticipates an expenditure pursuant to the Agreement in excess of the Account maximum specified above, INTERMEDIARY may request, in writing, an appropriate advance from COUNTY. Upon approval by ADMINISTRATOR, COUNTY shall disburse to INTERMEDIARY the requested Funds. INTERMEDIARY shall disburse advanced Funds to Physicians for claims submitted and processed. Such disbursement shall be made immediately upon receipt of the advance, unless otherwise approved, in writing, by COUNTY.

11. INTERMEDIARY shall collect and deposit refunds and any third party payments related to any Emergency Service and/or Care rendered by a Physician in a separate interest-bearing Recovery Account. At Final Payout, Funds in the Recovery Account shall be paid to Physicians in the same manner as are other Funds in the Account.

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EXHIBIT F
AGREEMENT FOR PROVISION OF
FISCAL INTERMEDIARY SERVICES
FOR MEDICAL SERVICES PROGRAMS

EMERGENCY MEDICAL SERVICES FUND PROGRAM
AUGUST 10, 2011 THROUGH SEPTEMBER 30, 2014

INTERMEDIARY DATA REPORTING REQUIREMENTS

I. GENERAL REQUIREMENTS

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

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

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

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

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

F. The parties agree that provider enrollment for the EMSF program shall be offered on an annual basis and the enrollment period shall cover one (1) Fiscal Year. The parties agree that provider enrollment will be conducted by INTERMEDIARY for the enrollment periods commencing July 1st through June 30th, for each Period. INTERMEDIARY shall maintain provider enrollment during the term of the Agreement.

1. Each July and January, INTERMEDIARY shall provide to ADMINISTRATOR, a list of all enrolled providers, including information for each provider as may be requested by ADMINISTRATOR. ADMINISTRATOR shall screen all enrolled providers 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. ADMINISTRATOR shall promptly notify INTERMEDIARY, OCMA, and the enrolled provider if they are found to be designated as an "Ineligible Person."

2. INTERMEDIARY shall, after its provision of the July, 2011 list to ADMINISTRATOR, screen all newly enrolled providers 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. INTERMEDIARY shall promptly notify OCMA, ADMINISTRATOR, and the enrolled provider if they are found to be designated as an "Ineligible Person." INTERMEDIARY shall maintain documentation of all screenings of newly enrolled providers which shall be made available for review by ADMINISTRATOR at ADMINISTRATOR's request.

II. ADDITIONAL REPORTS

A. INTERMEDIARY shall make available to ADMINISTRATOR 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. A machine readable copy of the data accumulated on those items specified in this Exhibit, upon four (4) business 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. INTERMEDIARY shall collect, compile, preserve and report the following information and data, at the intervals specified. A final annual report for Claims paid for each Period shall be completed no later than Final Payout for each Period or in the event there is no Final Payout, no later than September 30th for each Period. All reports shall be made available to ADMINISTRATOR.

1. EMSF ER Code Report: Claims status (pending, approved, denied) by individual Physician and service timeframe (first twenty-four [24] hours and twenty-five [25] to forty-eight [48] hours) showing key action dates for all logged Claims. This report may also be sorted by ICD9/10 (first twenty-four [24] hours and twenty-five [25] to forty-eight [48] hours) or age group patients. (Monthly)

2. Processing Timeliness Report: Shall be made available within four (4) calendar days of completion of the check run being reported. Included in the report will be the reporting period's number of claims received (for services provided during the first twenty-four [24] hours and twenty-five [25] to forty-eight [48] hours, and not within forty-eight [48] hours), processed, pending action-to-date; reporting period's claims being worked, current processing time from receipt to final action, for the periods zero to thirty (0-30) Days, thirty-one to forty-five (31-45) Days, forty-six to sixty-five (46-65) Days, sixty-six to ninety (66-90) Days, and Over ninety (90) Days, and a value depicting a percentage of claims processed within thirty (30) calendar days.

3. Recovery Account Status Report: Recovery Account balance, listing refunding Physicians and origin of reimbursement resulting in refund; disbursements from account reported in final payment summaries. (Monthly)

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

A. Demographic Characteristics based on Claims:

1. Full name

2. Social Security Number, if available

3. Date of birth

4. Sex

5. Other insurance coverage

6. Medi-Cal and MSI status and effective date, based on Medi-Cal Match

7. MSI status and effective date, based on MSI Match

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B. Characteristics of Providers:

1. Current name
2. Current identifier (tax ID)
3. Professional/billing address(es), including zip code
4. Physician/facility specialty

C. Characteristics of Service Delivery:

1. Date(s) of service encounters
2. Primary and secondary admitting diagnosis
3. Major procedures codes
4. Location of service delivery
5. Services rendered (users, encounters) by the physician provider, such as the ER service: surgery, anesthesia, radiology, laboratory/pathology, medical visit

D. Billing/Claims Processing:

1. Date of claim
2. Date claim received
3. Date claim processed
4. Date claim paid
5. Itemized billed charges for services rendered
6. Eligible Losses and Eligible Losses – TSR for services rendered
7. Disallowed charges for services rendered by reason for denial
8. Contract Rate for services rendered
9. Weekly check registers of claims processed
10. Cumulative numbers of claims; received, processed, paid, denied
11. Claim disposition

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