

CONTENTS

<u>PARAGRAPH</u>	<u>PAGE</u>
Title Page.....	1
Contents.....	3
Referenced Contract Provisions	4
I. Alteration of Terms	5
II. Compliance.....	5
III. Confidentiality.....	8
IV. Delegation and Assignment.....	8
V. Facilities, Payments and Services.....	8
VI. Indemnification and Insurance.....	9
VII. Inspections and Audits	9
VIII. Licenses and Law	11
IX. Maximum Obligation.....	12
X. Nondiscrimination.....	12
XI. Notices.....	13
XII. Severability.....	14
XIII. Status of Parties.....	14
XIV. Term	14
XV. Termination	15
XVI. Third Party Beneficiary.....	16
XVII. Waiver of Default or Breach.....	16
Signature Page	17
 <u>EXHIBIT A</u>	
I. General Provisions	1
II. Obligations and Activities of Intermediary as Business Associate.....	1
III. Security Rule.....	2
IV. Permitted Uses and Disclosures by Intermediary	3
V. Obligations of County	3
VI. Business Associate Termination.....	3
 <u>EXHIBIT B</u>	
I. Definitions	1
II. Physician and Clinic Obligations.....	5
III. Intermediary Obligations	8
IV. Funding and Payments.....	9
V. County Obligations	13

1	VI. Committees/Groups	14
2	VII. Records	16
3	<u>EXHIBIT C</u>	
4	I. Reimbursable Medical Services	1
5	II. Reimbursable Medical Services – Expanded CI Services.....	2
6	III. Non-Reimbursable Services	2
7		
8	<u>EXHIBIT D</u>	
9	I. Reimbursement	1
10	II. Eligible Person	1
11	III. Initial Screening	2
12	IV. Final Screening of Patients Referred to Contracting Hospital/Clinic.....	2
13	V. Eligibility Processing	3
14		
15	<u>EXHIBIT E</u>	
16	I. Satisfaction of County Obligation	1
17	II. Hospital Account.....	1
18	III. Imprest Account	2
19	IV. Review of Claims	3
20	V. Conditions of Reimbursement	4
21	VI. Claim Denial/Appeal.....	5
22	VII. Third Party, Primary, or Other Insurance Covered Claims.....	5
23	VIII. Recovery Accounts	6
24	IX. Interim Payments to Physicians and Clinics	7
25	X. Payments to Other Providers	9
26	XI. Final Settlement	10
27	XII. Satisfaction of Claims	11
28	XIII. Claims Processing Standards and Sanctions	12
29		
30	<u>EXHIBIT F</u>	
31	I. General Requirements.....	1
32	II. Additional Reports	1
33	III. System Maintenance and Documentation Requirements	5
34	IV. Data Elements	6
35		
36	<u>EXHIBIT G</u>	
37	I. Hospital Periodic Interim Payments (PIP)	1

1 **REFERENCED CONTRACT PROVISIONS**

2
3 **Term:** September 1, 2007 through February 28, 2009

4
5 **Aggregate MSI Maximum Obligation:** \$57,834,697

6 **Aggregate CI Maximum Obligation:** \$13,403,712

7 **Aggregate CHIP Maximum Obligation:** \$ 278,689

8 **Total Aggregate Maximum Obligation (MSI Base Funding):** \$71,517,098

9
10 **Notices to COUNTY and INTERMEDIARY:**

11
12
13 **COUNTY:** County of Orange Health Care Agency
14 MSI Program Manager
15 405 W. 5th Street, 6th Floor
16 Santa Ana, CA 92701

17
18 County of Orange Health Care Agency
19 Strategic Projects Administration
20 405 W. 5th Street, 7th Floor
21 Santa Ana, CA 92701

22
23 **INTERMEDIARY:** Advanced Medical Management, Inc.
24 5000 Airport Plaza Drive, Suite 150
25 Long Beach, CA 90815-1260
26 Voice: (562) 766-2000
27 Fax: (562) 766-2006

28
29 **INTERMEDIARY'S Insurance Coverages:**

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

1 **I. ALTERATION OF TERMS**

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

8 **II. COMPLIANCE**

9
10 A. COUNTY'S Health Care Agency (HCA) has established a Compliance Program for the purpose
11 of ensuring adherence to all rules and regulations related to federal and state health care programs.

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

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

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

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

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

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

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

33 b. Conduct themselves honestly, fairly, courteously and with a high degree of integrity in
34 their professional dealings related to this Agreement and avoid any conduct that could reasonably be
35 expected to reflect adversely upon the integrity of CONTRACTOR and/or COUNTY.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 D. REIMBURSEMENT STANDARDS

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

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

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

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

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

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

28 2. Such training will be made available to Covered Individuals within thirty (30) calendar
29 days of employment or engagement.

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

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

34 //

35 //

36 //

37 //

1 **III. CONFIDENTIALITY**

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

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

12
13 **IV. DELEGATION AND ASSIGNMENT**

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

24 B. INTERMEDIARY may not assign the rights hereunder, either in whole or in part, without the
25 prior written consent of COUNTY, which consent shall not be unreasonably conditioned, withheld, or
26 delayed. Any change in the control structure, including but not limited to, the sale or transfer of more
27 than fifty percent (50%) of the assets or stocks of INTERMEDIARY, change to another corporate
28 structure, including a change to a sole proprietorship, or a change in fifty percent (50%) or more of
29 INTERMEDIARY'S directors at one time shall be deemed an assignment pursuant to this paragraph.
30 Any attempted assignment or delegation in derogation of this paragraph shall be void.

31
32 **V. FACILITIES, PAYMENTS AND SERVICES**

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

1 **VI. INDEMNIFICATION AND INSURANCE**

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

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

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

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

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

22 b. “This insurance shall not be canceled, limited or non-renewed until after thirty (30)
23 calendar days written notice has been given to County of Orange, HCA/Strategic Projects
24 Administration, 405 W. 5th Street, 7th Floor, Santa Ana, California 92701.”

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

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

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

33
34 **VII. INSPECTIONS AND AUDITS**

35 A. ADMINISTRATOR, any authorized representative of COUNTY, any authorized representative
36 of the State of California, the Secretary of the United States Department of Health and Human Services,
37 the Comptroller General of the United States, or any of their authorized representatives, shall have

1 access to any books, documents, and records, including, but not limited to, medical and patient records,
2 of INTERMEDIARY which such persons deem reasonably pertinent to this Agreement, for the purpose
3 of responding to a patient complaint or, conducting an audit, review, evaluation, or examination, or
4 making transcripts during the periods of retention set forth in the Records Paragraph of Exhibit B to this
5 Agreement. The above mentioned persons, may at all reasonable times, inspect or otherwise evaluate
6 the services provided pursuant to this Agreement and the premises in which they are provided; provided,
7 however, such inspections or evaluations shall not interfere with patient care.

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

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

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

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

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

34 C. AUDIT RESPONSE

35 1. Following an audit report, in the event of non-compliance with applicable laws and
36 regulations governing funds provided through this Agreement, COUNTY may terminate this Agreement
37 as provided for in the Termination Paragraph of this Agreement or may direct INTERMEDIARY to

1 immediately implement appropriate corrective action. A plan of corrective action shall be submitted to
2 ADMINISTRATOR in writing within thirty (30) calendar days after receiving notice from
3 ADMINISTRATOR.

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

11
12 **VIII. LICENSES AND LAW**

13 A. INTERMEDIARY, its officers, agents, employees, affiliates, and subcontractors shall,
14 throughout the term of this Agreement, maintain all necessary licenses, permits, approvals, certificates,
15 accreditations, waivers and exemptions necessary for the provision of its services hereunder, and
16 required by the laws, regulations, or requirements of the United States, the State of California,
17 COUNTY, and any other applicable governmental agencies. INTERMEDIARY shall notify
18 ADMINISTRATOR immediately and in writing of its inability to obtain or maintain, irrespective of the
19 pendency of an appeal, permits, licenses, approvals, certificates, accreditations, waivers and exemptions.
20 Said inability shall be cause for termination of this Agreement.

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

25 C. Enforcement of Child Support Obligations

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

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

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

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

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

37 //

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

7 3. It is expressly understood that this data will be transmitted to governmental agencies
8 charged with the establishment and enforcement of child support orders.

9
10 **IX. MAXIMUM OBLIGATION**

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

16
17 **X. NONDISCRIMINATION**

18 **A. EMPLOYMENT**

19 1. During the performance of this Agreement, INTERMEDIARY shall not unlawfully
20 discriminate against any employee or applicant for employment because of their ethnic group
21 identification, race, religion, ancestry, color, creed, sex, marital status, national origin, age (40 and
22 over), sexual preference, medical condition, or physical or mental disability. INTERMEDIARY shall
23 warrant that the evaluation and treatment of employees and applicants for employment is free from
24 discrimination in the areas of: employment, upgrade, demotion or transfer; recruitment or recruitment
25 advertising; layoff or termination; rate of pay or other forms of compensation; and selection for training,
26 including apprenticeship. There shall be posted in conspicuous places, available to employees and
27 applicants for employment, notices from ADMINISTRATOR and/or the United States Equal
28 Employment Opportunity Commission setting forth the provisions of this Equal Opportunity Clause.

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

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

1 //

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

6 B. SERVICES, BENEFITS, AND FACILITIES - INTERMEDIARY shall not discriminate in the
7 provision of services, the allocation of benefits, or in the accommodation in facilities on the basis of
8 ethnic group identification, race, religion, ancestry, creed, color, sex, marital status, national origin, age
9 (40 and over), sexual preference, medical condition, or physical or mental disability in accordance with
10 Title VI of the Civil Rights Act of 1964, 42 U.S.C.A. §2000d and all other pertinent rules and
11 regulations promulgated pursuant thereto, and as otherwise provided by State law and regulations, as all
12 may now exist or be hereafter amended or changed.

13 C. PERSONS WITH DISABILITIES - INTERMEDIARY agrees to comply with the provisions of
14 §504 of the Rehabilitation Act of 1973 (29 U.S.C.A. 794 et seq., as implemented in 45 CFR 84.1
15 et seq.), and the Americans with Disabilities Act of 1990 (42 U.S.C.A. 12101, et seq.), pertaining to the
16 prohibition of discrimination against qualified persons with disabilities, as they exist now or may be
17 hereafter amended together with succeeding legislation.

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

23
24 **XI. NOTICES**

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

- 27 1. When delivered personally; or
- 28 2. Three (3) calendar days from the date sent by certified or registered mail in the United
29 States Postal Service, return receipt requested, postage prepaid, or first class postage prepaid, and
30 addressed as specified on Page 4 of this Agreement; or
- 31 3. When faxed, transmission confirmed; or
- 32 4. When sent by electronic mail; or
- 33 5. When delivered by U.S. Postal Service Express Mail, Federal Express, United Parcel
34 Service or other expedited delivery service.

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

1 //
2 C. Any party to this Agreement may change the address at which it wishes to receive notice by
3 giving notice to the other party in the manner set forth above. For purposes of this Agreement, any
4 notice to be provided by COUNTY may be given by ADMINISTRATOR.
5

6 **XII. SEVERABILITY**

7 If a court of competent jurisdiction declares any provision of this Agreement or application thereof
8 to any party, person or circumstances to be invalid or if any provision of this Agreement contravenes
9 any Federal, State, or County statute, ordinance, or regulation, the remaining provisions of this
10 Agreement or the application thereof shall remain valid, and the remaining provisions of this Agreement
11 shall remain in full force and effect, and to that extent the provisions of the Agreement are severable,
12 unless to do so would defeat an essential business purpose of this Agreement.
13

14 **XIII. STATUS OF PARTIES**

15 Each party is, and shall at all times be deemed to be, independent and shall be wholly responsible
16 for the manner in which it performs the services required of it by the terms of this Agreement. Each
17 party is entirely responsible for compensating staff and consultants employed by that party. This
18 Agreement shall not be construed as creating the relationship of employer or employee, or principal and
19 agent, between COUNTY and INTERMEDIARY or of either party's employees, agent, consultants or
20 subcontractors. Each party assumes exclusively the responsibility for the acts of its employees, agents,
21 consultants, or subcontractors as they relate to the services to be provided during the course and scope
22 of their employment.
23

24 **XIV. TERM**

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

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

33 C. Any administrative duty or obligation to be performed pursuant to this Agreement on a
34 weekend or holiday may be performed on the next regular business day.
35 //
36 //
37 //

1 //
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37

XV. TERMINATION

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

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

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

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

E. CONTINGENT FUNDING

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

- a. The continued availability of sufficient State and County funds for reimbursement of COUNTY'S expenditures, and
- b. Inclusion of sufficient funding for the services hereunder in the applicable budget approved by the Board of Supervisors.

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

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

F. In the event that this Agreement is terminated prior to the completion of the term as specified on Page 4 of this Agreement, ADMINISTRATOR may, at its sole discretion, reduce the Aggregate

1 //
2 Maximum Obligation of this Agreement in an amount consistent with the reduced term of the
3 Agreement.

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

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

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

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

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

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

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

24
25 **XVI. THIRD PARTY BENEFICIARY**

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

28
29 **XVII. WAIVER OF DEFAULT OR BREACH**

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

35 //

36 //

37 //

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

3
4 ADVANCED MEDICAL MANAGEMENT, INC.

5
6 DATE: _____

DATE: _____

7
8 BY: _____

BY: _____

9 TITLE: _____

TITLE: _____

10
11
12 SIGNED AND CERTIFIED THAT A COPY OF
13 THIS DOCUMENT HAS BEEN DELIVERED
14 TO THE CHAIRMAN OF THE BOARD.

COUNTY OF ORANGE

15 BY: _____

CHAIRMAN OF THE BOARD
OF SUPERVISORS

16 BY: _____

17 DARLENE J. BLOOM

18 Clerk of the Board of Supervisors
19 of Orange County, California

20 DATED: _____

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

24
25 BY: _____

DATED: _____

26 DEPUTY

27
28
29 If Contractor is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, Chief Executive Officer,
30 the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any
31 Assistant Treasurer. If the Agreement is signed by one (1) authorized individual only, a copy of the corporate resolution or by-laws
32 whereby the board of directors has empowered said authorized individual to act on its behalf by his or her signature alone is required.

33 //

34 //

35 //

36 //

37 //

1 EXHIBIT A
2 TO AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE
5 MEDICAL SERVICES INITIATIVE PROGRAM
6 BUSINESS ASSOCIATE TERMS AND CONDITIONS
7 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009
8

9 **I. GENERAL PROVISIONS**

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

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

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

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

23
24 **II. OBLIGATIONS AND ACTIVITIES OF INTERMEDIARY**
25 **AS BUSINESS ASSOCIATE**

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

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

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

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

35 E. INTERMEDIARY agrees to ensure that any agent, including a subcontractor, to whom it
36 provides PHI received from COUNTY, or PHI created or received by INTERMEDIARY on behalf of
37 //

1 COUNTY, agrees to the same restrictions and conditions set forth in the business associate provisions
2 of the Privacy Rule that apply through this Agreement.

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

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

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

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

18 J. INTERMEDIARY agrees to provide COUNTY or an individual client, as directed by
19 COUNTY, in a time and manner to be determined by COUNTY, that information collected in
20 accordance with subparagraph II.I. of this Exhibit A to the Agreement, in order to permit COUNTY to
21 respond to a request by an individual client for an accounting of disclosures of PHI in accordance with
22 45 CFR Section 164.528.

23 24 **III. SECURITY RULE**

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

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

33 C. Security Incidents. INTERMEDIARY shall report any security incident of which it becomes
34 aware to Client. For purposes of this agreement, a "security incident" means the attempted or successful
35 unauthorized access, use, disclosure, modification, or destruction of information or interference with
36 system operations. This does not include trivial incidents that occur on a daily basis, such as scans,
37 "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by

1 INTERMEDIARY.

2 **IV. PERMITTED USES AND DISCLOSURES BY INTERMEDIARY**

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

7
8 **V. OBLIGATIONS OF COUNTY**

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

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

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

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

20 **VI. BUSINESS ASSOCIATE TERMINATION**

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

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

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

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

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

1 | such PHI.
2 |
3 |
4 |
5 |
6 |
7 |
8 |
9 |
10 |
11 |
12 |
13 |
14 |
15 |
16 |
17 |
18 |
19 |
20 |
21 |
22 |
23 |
24 |
25 |
26 |
27 |
28 |
29 |
30 |
31 |
32 |
33 |
34 |
35 |
36 |
37 |

1 EXHIBIT B
2 TO AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE
5 MEDICAL SERVICES INITIATIVE PROGRAM
6 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009

7
8 **I. DEFINITIONS**

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

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

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

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

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

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

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

29 E. "Clinic" means any provider registered with the MSI Program that is not considered to be a
30 Contracting Clinic or a Physician.

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

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

35 H. "Consultation" means the rendering by a specialty physician of an opinion or advice, or
36 prescribing treatment by telephone, when determined to be medically necessary by the on-duty
37 emergency department physician and specialty physician, as appropriate. Such Consultation includes

1 review of the patient's medical record, and the examination and treatment of the patient in person, when
2 appropriate, by a specialty physician who is qualified to give an opinion or render treatment necessary
3 to stabilize the patient.

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

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

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

11 L. "Contract Rate" means:

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

15 2. For Other Providers, except those providing Dental Services, means one hundred percent
16 (100%) of the National Medicare Resource Based Relative Value Scale (RBRVS) or other
17 reimbursement system as may be agreed upon pursuant to this Agreement, for services provided by
18 Physicians, and the applicable National Medicare Rate for services claimed by providers of home health
19 services and durable medical equipment providers; the applicable Medi-Cal Rate for ambulance
20 services; and pharmacy services at the rate determined by COUNTY'S pharmacy benefits manager.

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

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

26 N. "Dental Funding" means the amount of CI Funding identified by COUNTY specifically for the
27 reimbursement of all Dental Services as set forth in Exhibit C to this Agreement.

28 O. "Dental Services" means Medical Services relating to or used on the teeth necessary to protect
29 life, prevent significant disability, or prevent serious deterioration of health, as well as preventative
30 services and early intervention funded through CI Funding as set forth in Exhibit C to this Agreement.

31 P. "Department" means the California Department of Health Care Services.

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

34 R. "Emergency Services and/or Care" means lawfully provided medical screening, examination,
35 and evaluation by a physician, or other physician-supervised personnel in a hospital to determine if an
36 emergency medical condition exists, and includes treatment necessary to relieve the condition; provided,
37 however, such treatment shall be within the capabilities required of the hospital as a condition of its

1 //

2 emergency medical services permit, on file with the Office of Statewide Health Planning and
3 Development.

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

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

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

10 V. "General Relief" means the cash assistance program approved by COUNTY'S Board of
11 Supervisors for needy persons who do not qualify for other cash assistance programs.

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

14 X. "Medical Service(s)" means a medical service necessary to protect life, prevent significant
15 disability, or prevent serious deterioration of health as well as preventative services and early
16 intervention funded through CI Funding. Guidelines for Reimbursable Medical Services are set forth in
17 Exhibit C to this Agreement.

18 Y. "MSI" means Medical Services Initiative

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

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

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

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

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

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

1 //

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

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

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

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

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

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

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

16 AM. "Program Year" means the period commencing September 1 and ending August 31.

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

22 AO. "Quarter" means a three (3) month period beginning September 1, December 1, March 1 or
23 June 1; e.g., Fourth Quarter means the period covering June, July, and August.

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

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

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

34 AS. "Special Permit Medical Service" means a burn center service, cardiovascular surgery service,
35 radiation therapy service, trauma center service, renal transplant center service, acute psychiatric
36 service, or a service provided by a hospital with a special rehabilitation unit licensed in accordance with
37 appropriate laws and, if applicable, with Section 70351 et seq. of Title 22. Special Permit Medical

1 //

2 Service shall also include such types or kinds of transfers as may be approved in writing by
3 ADMINISTRATOR.

4 AT. “Special Permit Transfer” means a MSI Patient, who needs a Special Permit Medical Service
5 that is not available from a Hospital, which another Hospital elects to accept for treatment.

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

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

14 AW. “Transfer Patient” means a person accepted by a Contracting Hospital, or transferred by a
15 hospital to another hospital or health facility.

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

20 21 **II. PHYSICIAN AND CLINIC OBLIGATIONS**

22 A. Physicians, and Clinics billing services through the Physicians Trust Fund Account, shall
23 provide Medical Services to all indigent persons covered by this Agreement presenting for treatment.
24 As a condition of reimbursement for Medical Services provided by Physicians and Clinics to Eligibles,
25 Physicians and Clinics shall comply with this Agreement, including Exhibit E hereto. Claims for such
26 services shall be processed and reimbursed by INTERMEDIARY as Physician Claims.
27 ADMINISTRATOR may withhold or delay payment due any Physician or Clinic for failure to comply
28 with the terms of this Agreement.

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

33 2. Acceptance by Physicians and Clinics of reimbursement made by INTERMEDIARY for
34 services provided in accordance with this Agreement shall be deemed satisfaction in full, with respect to
35 the COUNTY’S obligations for the services for which payment was made.

36 B. ADMINISTRATOR, any authorized representative of COUNTY, any authorized representative
37 of the State of California, the Secretary of the United States Department of Health and Human Services,

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

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

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

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

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

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

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

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

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

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

37 C. Physician and Clinic shall actively participate and cooperate with any person specified in

1 subparagraph B. above in any evaluation of the services provided pursuant to this Agreement, and shall
2 provide the above-mentioned persons adequate office space to conduct such evaluation. Such space
3 must be capable of being locked and secured to protect the work of said persons during the period of
4 their evaluation.

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

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

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

15 3. Physician and Clinic shall ensure the maintenance of medical records required by Sections
16 70747 through and including 70751 of the California Code of Regulations, as they exist now or may
17 hereafter be amended, and other records related to a MSI Patient's eligibility for services, the service
18 rendered, the medical necessity of the service, and the quality of the care provided. Records shall be
19 maintained in accordance with Section 51476 of Title 22 of the California Code of Regulations, as it
20 exists now or may hereafter be amended.

21 4. Records Retention

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

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

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

32 E. All Providers shall comply with the requirements of Section 114 of the Clean Air Act, as
33 amended, and Section 308 of the Federal Water Pollution Control Act, respectively relating to
34 inspection, monitoring, entry, reports and information, as well as other requirements specified in Section
35 114 of the Clean Air Act and Section 308 of the Federal Water Pollution Control Act, and all
36 regulations and guidelines issued there under.

37 F. No services shall be performed in a facility on the Environmental Protection Agency (EPA) List

1 of Violating Facilities until the EPA eliminates the name of such facility from such listing.

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

4 H. The Orange County Medical Association (OCMA) shall provide administrative support services
5 that directly support the purposes of this Agreement. Such services shall include, but not be limited to
6 referral services, and assistance for all physicians practicing in Orange County, provider
7 training/education, and activities that facilitate communication between patients, providers, and the
8 parties to this Agreement.

9 I. The Orange County Coalition of Community Clinics (COCCC) shall provide administrative
10 support services that directly support the purposes of this Agreement. Such services shall include, but
11 not be limited to assistance for Clinics in Orange County participating in the MSI Program, provider
12 training/education, and activities that facilitate communication between patients, providers, and the
13 parties to this Agreement.

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

16 17 **III. INTERMEDIARY OBLIGATIONS**

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

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

- 24 1. Receiving, compiling, preserving, and reporting information and data.
- 25 2. Receiving eligibility data, performing utilization review, and processing, denying,
26 approving all claims submitted in accordance with Exhibit E.
- 27 3. Providing a process for patient appeals of denied services.
- 28 4. Receiving, maintaining, collecting, and accounting for Funds.
- 29 5. Reimbursing Claims and making other required payments.

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

33 D. Patient Appeals - INTERMEDIARY shall provide a formal opportunity for patients to appeal
34 denial of services to their providers (Appeals System). The Appeals System shall meet the
35 requirements, if any, established by any court with jurisdiction.

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

1 INTERMEDIARY to undertake.

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

6
7 **IV. FUNDING AND PAYMENTS**

8 A. "MSI Base Funding" – means the Total Aggregate Maximum Obligation of COUNTY for
9 reimbursement of all MSI Program services which shall be as specified on Page 4 of this Agreement

10 B. COUNTY shall first reserve \$1,546,065 from the MSI Base Funding for reimbursement of
11 services provided by INTERMEDIARY. The balance of MSI Base Funding shall be deposited in the
12 MSI Trust Fund or allocated as specified in subparagraph C. below.

13 C. MSI Trust Fund and Allocations

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

18 a. An estimated \$278,689 to the "CHIP-MSI Trust Fund Account." Said deposit shall not
19 be greater than the actual allocation received by COUNTY as determined by the actual allocation letter
20 received by COUNTY from the State Department of Health Services. Said deposits shall not commence
21 until said allocation letter, and corresponding funding, is received by COUNTY.

22 b. The remainder of the Monthly Trust Fund Transfer shall be deposited as follows:

- 23 1) \$33,644,568 to the "Hospital Trust Fund Account"
24 2) \$12,106,693 to the "Physicians Trust Fund Account"
25 3) \$2,600,000 to the "Clinic Trust Fund Account"
26 4) \$1,000,000 to the "Outpatient Trust Fund Account"

27 2. Except as otherwise specified above, Monthly Trust Fund Deposits shall commence by
28 September 10, 2007, and continue thereafter by the tenth (10th) day of each month through and
29 including August 10, 2008.

30 3. COUNTY, at ADMINISTRATOR'S sole discretion, may deposit an additional amount not
31 to exceed \$1,000,000 into the "Outpatient Trust Fund Account" prior to August 30, 2008.

32 4. The balance of those funds deposited into the "Clinic Trust Fund Account" in accordance
33 with the Prior Agreement and Prior Clinic Agreement, less payments made and/or funds reallocated in
34 accordance with the Prior Agreement and Prior Clinic Agreement, shall be retained in the "Clinic Trust
35 Fund Account" which amount shall not exceed \$1,937,681.

36 5. The balance of those funds deposited into the "Outpatient Trust Fund Account" in
37 accordance with the Prior Agreement less payments made and/or funds reallocated in accordance with

1 //
2 the Prior Agreement, shall be retained in the “Outpatient Trust Fund Account” which amount shall not
3 exceed \$2,595,000.

4 6. Monies in the MSI Trust Fund shall be treated in the same fashion as all other monies held
5 by COUNTY in trust funds, and COUNTY may commingle said monies with other monies for purposes
6 of investment. Interest earned on MSI Trust Fund monies shall be apportioned seventy percent (70%) to
7 the Hospital Trust Fund Account and thirty percent (30%) to the Physicians Trust Fund Account;
8 provided, however no interest shall be credited to MSI Funds before they are deposited in the MSI Trust
9 Fund, nor before this Agreement becomes effective as specified in the Term Paragraph of this
10 Agreement.

11 7. Of the balance of the MSI Base Funding, COUNTY shall allocate the Coverage Initiative
12 Funding as follows. Said amounts shall not be greater than the actual allocation received by COUNTY
13 from Department. Said amounts shall not be available until CI Funding is received by COUNTY. At
14 ADMINISTRATOR’S sole discretion, CI Funding provided through this and any other agreements for
15 the MSI Program may be modified to ensure full expenditure of all CI Funding allocated to COUNTY
16 for each Program Year.

- 17 a. \$5,377,238 towards Hospital Funding
- 18 b. \$6,726,958 towards Physician Funding
- 19 c. \$917,312 towards Clinic Funding
- 20 d. \$382,204 towards Outpatient Funding
- 21 e. \$1,404,690 towards Dental Funding

- 22 8. The total of all funding identified by County is as follows:
- 23 a. \$39,021,806 towards Hospital Funding, plus \$278,689 maintained separately.
 - 24 b. \$18,833,651 towards Physician Funding
 - 25 c. \$5,454,993 towards Clinic Funding
 - 26 d. \$3,977,204 towards Outpatient Funding
 - 27 e. \$1,404,690 towards Dental Funding

28 **D. MSI Funding Disbursements**

29 1. Hospital Funding and CHIP-MSI Trust Fund Account Funds – Disbursements to
30 Contracting Hospitals shall be in accordance with the MSI Hospital Agreement.

31 2. Physician Funding

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

35 b. Reserve – Until Final Settlement, COUNTY may not pay any monies to
36 INTERMEDIARY for reimbursement of Physician Claims, if such payment would reduce the Physicians
37 Trust Fund Account balance to less than \$1,250,000. This reserve is intended to ensure that adequate

1 //

2 Funds are available to satisfy any obligation of the Physicians Trust Fund Account to pay for the
3 physicians' share of additional payments to INTERMEDIARY and Other Providers, as provided herein.

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

6 4. Outpatient Funding

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

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

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

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

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

30 d. In the event that the total of all payments to non-hospital outpatient providers is less
31 than the amount of Outpatient Funding available, at ADMINISTRATOR'S sole discretion, the balance
32 shall either carry forward and be included in as Outpatient Funding in a subsequent agreement or shall
33 be retained by COUNTY.

34 5. Dental Funding

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

1 //

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

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

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

14 a. Ambulance, Home Health and Durable Medical Equipment Providers - COUNTY shall
15 pay INTERMEDIARY Funds necessary to cover reimbursements to ambulance operators, home health
16 providers, and durable medical equipment providers. In order to ensure availability of services,
17 COUNTY may enter into separate agreements with providers of such services. Said agreements shall
18 specify that payment shall be made by INTERMEDIARY on behalf of COUNTY.

19 b. Skilled Nursing Facilities (SNF'S) – COUNTY shall pay INTERMEDIARY the
20 amount necessary to cover reimbursement to SNF's accepting MSI Eligibles referred by COUNTY'S
21 Utilization Management Department. Such amount shall be deducted as follows: one-hundred percent
22 (100%) of the institutional costs from the Hospital Funding and one-hundred percent (100%) of the
23 professional costs from the Physician Funding. ADMINISTRATOR may expand SNF services to
24 include MSI Pendings.

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

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

37 7. Final Settlement - Prior to Final Settlement, COUNTY shall deposit any Recovery Trust

1 Fund Account monies into the MSI Trust Fund. COUNTY shall pay the balance of the MSI Trust Fund,
2 including all Hospital Funding and Physicians Funding, to INTERMEDIARY. INTERMEDIARY shall
3 use these Funds to make Final Settlement of claims as provided herein, including Exhibit E.

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

7 E. INTERMEDIARY Payments -- For services provided in accordance with this Agreement and
8 all other agreements for the MSI Program, COUNTY shall pay INTERMEDIARY \$85,892.50 monthly
9 in arrears, from September 1, 2007, through February 28, 2009, up to a total maximum of \$1,546,065.
10 The final monthly payment to INTERMEDIARY shall not be made until ADMINISTRATOR
11 determines that INTERMEDIARY has satisfactorily completed its Final Settlement duties in accordance
12 with this Agreement.

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

17 18 **V. COUNTY OBLIGATIONS**

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

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

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

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

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

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

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

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

36 b. MSI Program services available through Contracting Clinics.

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

1 UMD.

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

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

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

7
8 **VI. COMMITTEES/GROUPS**

9 **A. Medical Review Committee**

10 1. Medical Review Committee (MRC) shall be formed by the parties, and shall perform the
11 duties specified in this Agreement through February 28, 2009.

12 2. The MRC shall consist of the following members:

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

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

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

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

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

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

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

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

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

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

- 1 10. Decisions of the MRC shall be final and binding.
- 2 11. At ADMINISTRATOR’S request, MRC may be asked to investigate allegations of
- 3 Inappropriate Patient Referrals as defined in the MSI Hospital Agreement.
- 4 12. INTERMEDIARY shall be responsible for hosting all meetings of the MRC.
- 5 a. Prior to each MRC meeting INTERMEDIARY staff shall research/organize pertinent
- 6 information relating to the following:
- 7 1) Pharmacy Issues.
- 8 2) Review of additions and deletions to the MSI pharmacy formulary.
- 9 3) Prior-authorization requests presented by UMD.
- 10 3) Patient and /or Provider Appeals-Claims initially denied as out of scope.
- 11 4) Excessive provider utilization.
- 12 5) Pharmacy Review of payment consideration for non-formulary medications.
- 13 6) Retrospective review of high dollar surgeries.
- 14 7) Evaluation of claims where examiners are unable to render decision.
- 15 8) Prepare and submit agenda to MRC members.
- 16 b. During the MRC meeting INTERMEDIARY staff shall be responsible for:
- 17 1) Calling the meeting to order and determining the sequence of topics.
- 18 2) Gathering/organizing records according to MRC decisions (disposition of denials
- 19 vs. approvals);
- 20 3) Presenting patient appeals not previously determined by INTERMEDIARY staff;
- 21 4) Provide additional information for MRC members on issues as needed;
- 22 5) Meeting adjournment/Scheduling future meetings.
- 23 c. After each MRC meeting, INTERMEDIARY staff shall be responsible for follow up
- 24 and communication of MRC’S decision for denied cases as follows:
- 25 1) INTERMEDIARY shall enter the following comment in the “Notes” section of the
- 26 claim screen “appeal was denied in accordance with MRC”.
- 27 2) INTERMEDIARY shall send provider(s) a letter informing them of the MRC
- 28 decision.
- 29 3) “Notice of Review Decision” letter is sent to patients.
- 30 d. After each MRC meeting, INTERMEDIARY staff shall be responsible for follow up
- 31 and communication of MRC’S decision for approved cases as follows:
- 32 1) Claims are given to examiner and reprocessed.
- 33 2) INTERMEDIARY shall enter the following comment in the “Notes” section of the
- 34 claim screen: “appeal was approved in accordance with MRC”.
- 35 3) INTERMEDIARY shall send provider(s) a letter informing them of MRC decision.
- 36 e. INTERMEDIARY shall prepare and distribute minutes to each MRC member and any
- 37 other individuals designated by the MSI Program Manager.

1 //
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36 //
37 //

VII. RECORDS

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

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

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

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

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

C. Records Retention

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

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

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

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

1 //
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37

1 EXHIBIT C
2 TO AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE
5 MEDICAL SERVICES INITIATIVE PROGRAM
6 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009
7
8 GUIDELINES FOR REIMBURSABLE MEDICAL SERVICES
9

10 **I. REIMBURSABLE MEDICAL SERVICES – STANDARD MSI PROGRAM**

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

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

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

20 b. Home health services.

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

24 d. Acute dental services.

25 e. Outpatient hemodialysis and home hemodialysis services.

26 f. Blood and blood derivatives.

27 g. Durable medical equipment, prosthetic and medical supplies.

28 h. Initial psychiatric evaluation as required for triage.

29 i. Emergency medical transportation.

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

34 k. Skilled Nursing Facility (SNF) Services arranged for by COUNTY'S Utilization
35 Management Department in lieu of acute inpatient hospitalization for which the length of stay shall not
36 exceed fourteen (14) days unless approved by the Medical Review Committee or COUNTY'S
37 Utilization Management Department and subsequently approved by the MRC.

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

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

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

16
17 **II. REIMBURSABLE MEDICAL SERVICES – EXPANDED CI SERVICES**

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

- 23 A. Commercially available urine “dip-stick” pregnancy testing.
- 24 B. Routine physical examinations.
- 25 C. Routine dental prophylactic and radiological studies. Additional dental services may be added
26 by ADMINISTRATOR upon approval of Medical Review Committee.
- 27 E. General Primary Care visits including, but not limited to, treatment of colds, flu, sore throats,
28 and back aches.
- 29 F. Office visits which aid in the management of certain chronic diseases such as diabetes.

30
31 **III. NON-REIMBURSABLE SERVICES**

32 The following services are not reimbursable through this Agreement, except as may be provided for
33 in the MSI Clinic Agreement. INTERMEDIARY acting on behalf of COUNTY, may add to this list of
34 Non-Reimbursable Services with MRC approval. This list is not exhaustive and may be reviewed on a
35 case by case basis by INTERMEDIARY on behalf of COUNTY.

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

- 1 B. Organ transplants.
- 2 C. Pregnancy related services, including complications of pregnancy.
- 3 D. Physician services in extended or long-term care facility services.
- 4 E. Adult day care health services.
- 5 F. Eyeglasses for refraction and eye appliances, hearing aids and radial keratotomy.
- 6 G. Acupuncture, chiropractic, optometry, podiatry.
- 7 H. Diagnostic and therapeutic services for male and female infertility, voluntary sterilization and
- 8 birth control.
- 9 I. Routine injections of antigen to ameliorate allergic conditions.
- 10 J. All cosmetic procedures.
- 11 K. Ultrasound, massage and therapeutic thermal packs.
- 12 L. Inpatient and outpatient mental health services that are available through County of Orange
- 13 Behavioral Health Services
- 14 M. Any service not included under Title XIX of the Social Security Act.
- 15 N. Non-emergency medical transportation, except as otherwise authorized elsewhere in this
- 16 Agreement.

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

22 //
23 //
24 //
25 //
26 //
27 //
28 //
29 //
30 //
31 //
32 //
33 //
34 //
35 //
36 //
37 //

1 EXHIBIT D
2 TO AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE
5 MEDICAL SERVICES INITIATIVE PROGRAM
6 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009
7
8 ELIGIBILITY
9

10 **I. REIMBURSEMENT**

11 Reimbursement provided through this Agreement is only intended to cover those indigent patients
12 who would not be eligible for medical benefits from the State Medi-Cal Program, or whose medically
13 necessary services would not be covered by other non-COUNTY third party payors.
14

15 **II. ELIGIBLE PERSON**

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

17 1. Is an adult legal resident between and including the ages of twenty-one (21) and sixty-four
18 (64) years. Applicants shall meet United States citizenship requirements in accordance with Section
19 6036 of the Deficit Reduction Act of 2005, entitled "Improved Enforcement of Documentation
20 Requirements";

21 2. Is a legal resident of Orange County;

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

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

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

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

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

32 B. CI Eligibility Criteria - As a result of CI Funding, persons may qualify as an MSI Eligible by
33 meeting all criteria specified in subparagraph II.A.1 through A.6. above.

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

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

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

2 D. Medi-Cal Eligibility

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

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

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

11 E. A person approved for General Relief shall be an “Eligible Person” or “MSI Eligible.”

12
13 **III. INITIAL SCREENING**

14 A. As part of their usual registration or financial screening process, All Providers submitting
15 claims for payment of Medical Services through this Agreement shall use their reasonable best efforts to
16 screen whether a patient:

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

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

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

24
25 **IV. FINAL SCREENING OF PATIENTS REFERRED**
26 **TO CONTRACTING HOSPITAL/CLINIC**

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

31 1. Complete an MSI Program screening form, and refer patients who appear to be Medi-Cal
32 eligible to Orange County Social Services Agency (SSA) Eligibility Technicians.

33 2. Complete an MSI application for patients who appear to be MSI Eligible. Said applications
34 shall be submitted, in a manner specified by ADMINISTRATOR, to the “Application Processor,”

35 B. MSI applications shall include:

36 1. The patient's attestation and signature that under penalty of perjury all information
37 contained in the MSI application is true and correct.

2. Verification of social security number whenever possible.
 3. Documentation of legal residency status in accordance with the Deficit Reduction Act of 2005 (DRA).
 4. The patient's attestation and signature on the application forms that requirements for spend down of excess resources must be completed by the last day of the month as a condition of eligibility.
 5. Any additional information that may be reasonably required in determining eligibility, including a statement of medical need if deemed necessary.
- C. Contracting Hospitals and Qualified Clinics shall maintain sufficient staff to expeditiously obtain and screen information, and complete MSI applications as required by this Exhibit D to the Agreement.
- D. Contracting Hospitals and Qualified Clinics shall be required to own and maintain the necessary equipment to submit adequate messenger service to ensure timely delivery of applications, referrals and eligibility information to and from COUNTY.

V. ELIGIBILITY PROCESSING

- A. Contracting Hospitals and Qualified Clinics shall electronically submit MSI applications and refer MSI patients to the Application Processor in a timely manner.
- B. Contracting Hospitals and Qualified Clinics shall refer patients who are potentially Medi-Cal eligible to SSA in a timely manner.
- C. As a condition of eligibility processing by the Application Processor, MSI applications, and any required documentation, shall be received by the Application Processor no later than the end of the third month following the month during which services were provided. Applications received after this deadline shall be denied.
- D. The Application Processor shall be solely responsible for determining whether a person meets the eligibility criteria as set forth in this Agreement.
- E. Patients determined to be Eligible Persons by the Application Processor shall be eligible for a twelve month period, commencing the first day of the month in which Medical Services were first rendered.
- F. INTERMEDIARY shall:
1. Collect all MSI eligibility data by direct on-line input provided by COUNTY'S Contractor.
 2. Print and distribute, daily, the "Notice of Action" forms as to the disposition of claims to both patient and provider.

33 //
34 //
35 //
36 //
37 //

1 EXHIBIT E
2 AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE
5 MEDICAL SERVICES INITIATIVE PROGRAM
6 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009
7
8 CLAIMS AND DISBURSEMENTS
9

10 **I. SATISFACTION OF COUNTY OBLIGATION**

11 In consideration of payments made by COUNTY through INTERMEDIARY for payment for
12 Medical Services to MSI Eligibles pursuant to this Agreement, COUNTY'S obligation to All Providers,
13 and indigent persons for whom it may have any legal obligation to provide Medical Services, shall be
14 satisfied.
15

16 **II. HOSPITAL ACCOUNT**

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

20 B. Commencing September 15, 2007, and thereafter on the fifteenth (15th) day of each month
21 through and including August 15, 2008, COUNTY shall pay INTERMEDIARY, upon receipt of one or
22 more invoices approved by ADMINISTRATOR an amount equal to eighty percent (80%) of
23 COUNTY'S monthly available Hospital Funding.

24 C. INTERMEDIARY shall pay Contracting Hospitals, monthly in arrears, the "Periodic Interim
25 Payment" (herein after referred to as PIP Payment) stipulated in Exhibit G to this Agreement, which
26 payment and Exhibit may be revised by ADMINISTRATOR if MSI Base Funding is reduced as
27 provided herein, if CI Funding to COUNTY has not been received from Department, or if data received
28 from the INTERMEDIARY supports a revised PIP payment to a Contracting Hospital, provided,
29 however, that the total of all PIP payments shall not exceed \$2,601,454 per month.

30 D. PIP payments shall be disbursed from the Hospital Account, monthly in arrears, commencing
31 October 1, 2007, and thereafter, on or about the first (1st) day of each month through September 1,
32 2008; provided, however, that the Contracting Hospital has returned a fully executed agreement to
33 COUNTY, or its designee.

34 E. Additionally, COUNTY shall pay INTERMEDIARY, upon receipt of one or more invoices
35 approved by ADMINISTRATOR, \$75,000 per month for the purpose of reimbursing Contracting
36 Hospitals' share of Other Provider expenses as specified in Subparagraph IV.D.6 of Exhibit B to this
37 Agreement.

1 **III. IMPREST ACCOUNT**

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

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

8 a. Commencing September 1, 2007, and thereafter on the tenth (10th) day of each month
9 through and including August 10, 2008, INTERMEDIARY shall submit one or more invoices and
10 COUNTY shall pay INTERMEDIARY an amount equal to one-twelfth (1/12th) of eighty percent (80%)
11 of the available Physician Funding, as specified in subparagraph IV.C.8.b. of Exhibit B to this
12 Agreement. Additional funds may be requested in accordance with Paragraph III.D. below.

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

14 2. INTERMEDIARY shall use an Imprest Account to deposit Clinic Funding disbursed by
15 COUNTY for the purpose of reimbursing Contracting Clinics, as specified in the MSI Clinic
16 Agreement.

17 a. Commencing September 10, 2007, COUNTY shall pay INTERMEDIARY an amount
18 equal to one-twelfth (1/12th) of eighty percent (80%) of the Clinic Funding, as specified in subparagraph
19 IV.C.8.c of Exhibit B to this Agreement. Additional payments thereafter shall be as determined by
20 ADMINISTRATOR based on demonstrated need by INTERMEDIARY and may be requested in
21 accordance with Paragraph III.D. below.

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

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

26 a. Commencing September 10, 2007, COUNTY shall pay INTERMEDIARY an amount
27 equal to one-twelfth (1/12th) of eighty percent (80%) of the Outpatient Funding, as specified in
28 subparagraph IV.C.8.d. of Exhibit B to this Agreement. Additional payments thereafter shall be as
29 determined by ADMINISTRATOR based on demonstrated need by INTERMEDIARY and may be
30 requested in accordance with Paragraph III.D. below.

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

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

36 a. Commencing September 10, 2007, COUNTY shall pay INTERMEDIARY an amount
37 equal to one-twelfth (1/12th) of eighty percent (80%) of the Dental Funding, as specified in

1 subparagraph IV.C.8.e. of Exhibit B to this Agreement. Additional payments thereafter shall be as
2 determined by ADMINISTRATOR based on demonstrated need by INTERMEDIARY and may be
3 requested in accordance with Paragraph III.D. below.

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

6 B. Except as otherwise provided herein, the Imprest Account shall not exceed a maximum of
7 \$3,000,000, and shall be managed so as to maximize the interest earned upon Funds in the Account.

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

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

17 E. Monthly, beginning October 20, 2007, INTERMEDIARY shall provide ADMINISTRATOR a
18 copy of the prior month's bank statement(s) and reconciliation with respect to all monies disbursed
19 pursuant to this Agreement.

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

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

29 30 **IV. REVIEW OF CLAIMS**

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

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

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

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

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

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

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

18
19 **V. CONDITIONS OF REIMBURSEMENT**

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

22 1. Claims for Medical Services provided during the period September 1, 2007 through August
23 31, 2008, except for:

24 a. Claims covered by a court order.

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

27 2. Submitted and completed in accordance with this Agreement.

28 3. Initially received by INTERMEDIARY no later than ninety (90) calendar days following
29 the date of service or the date of the Notice of Action that establishes MSI eligibility, whichever is later;
30 provided, however that claims to be considered in Final Settlement shall be received no later than
31 September 30, 2007.

32 B. INTERMEDIARY shall initially approve or deny all claims no later than December 31, 2008.

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

36 D. Any unapproved claims for Medical Services provided during the period September 1, 2007
37 through August 31, 2008 shall be null and void after January 31, 2009.

1 **VI. CLAIM DENIAL/APPEAL**

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

4 B. Notice shall be deemed effective:

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

7 2. When faxed, transmission confirmed; or

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

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

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

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

21
22 **VII. THIRD PARTY, PRIMARY, OR OTHER INSURANCE COVERED CLAIMS**

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

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

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

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

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

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

37 //

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

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

6 G. Provider Refunds of Claims Reimbursed By Other Payments

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

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

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

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

20 5. If it is determined that a patient whose care was previously reimbursed with MSI funding
21 was eligible for third party reimbursement or primary other insurance, retroactively or otherwise, and
22 Provider could have sought such reimbursement and failed to do so, Provider shall reimburse
23 INTERMEDIARY the amount of the MSI payment within thirty (30) calendar days notification of said
24 fact.

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

34
35 **VIII. RECOVERY ACCOUNTS**

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

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

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

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

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

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

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

19 B. At Final Settlement

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

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

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

30
31 **IX. INTERIM PAYMENTS TO PHYSICIANS AND CLINICS**

32 A. "Medical Fee Schedule" means the Medicare Resource-Based Relative Value Scale (RBRVS)
33 listed in the Federal Register on November 22, 1996 or the version in effect at time of execution of this
34 Agreement.

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

1 //

2 C. Upon approval of Physician Claims, INTERMEDIARY shall make interim reimbursements for
3 Physician Claims at seventy percent (70%) of the applicable rate established below for medicine, x-ray,
4 lab services and surgical services (collectively "Medical") and at one-hundred percent (100%) of the
5 applicable rate for anesthesia.

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

	100% of		
	Conversion Factor		Interim Payment
<u>SERVICE</u>	<u>per RVU</u>		<u>per RVU</u>
Medical	\$37.8975	x 70%	\$26.53
Anesthesia	\$16.19	x 100%	\$16.19

15 2. Upon approval of COUNTY'S Utilization Management Department, INTERMEDIARY
16 shall reimburse certain physician groups specified by COUNTY'S Utilization Management Department,
17 and authorized in writing by ADMINISTRATOR, at rates negotiated by ADMINISTRATOR. Such
18 agreements with COUNTY shall be limited to types of specialties and/or geographic areas for which
19 physician services are not otherwise available. The rates negotiated shall constitute payment in full and
20 are not subject to Final Settlement. ADMINISTRATOR shall provide copies of all said agreements to
21 INTERMEDIARY and ADMINISTRATOR and INTERMEDIARY shall mutually agree on how claims
22 for said agreements shall be processed.

23 D. If, at any time, the interim payments for Physicians Claims are projected to equal the total
24 monies allocated to the Physician Funding, less the \$1,250,000 Reserve required by this Agreement,
25 prior to November 30, 2008, ADMINISTRATOR may, at its sole discretion, reduce the percentage of
26 the interim reimbursement to physicians specified in Subparagraph C.1. above.

27 1. At Final Settlement, \$250,000 of the Reserve shall be used for the MSI Physician Pay-for-
28 Performance Program.

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

- 34 a. Number of Medical Home Patients
- 35 b. Number of Medical Home Visits

36 E. If interim payments for Physician Claims equal the total monies allocated to the Physicians
37 Trust Fund Account, less the \$1,250,000 Reserve required by this Agreement, no further reimbursement

1 //
2 of Physicians Claims shall be made, until INTERMEDIARY determines through Final Settlement
3 whether any Physician Funding remain for distribution.

4
5 **X. INTERIM PAYMENTS TO CONTRACTING CLINICS**

6 A. Upon approval of Clinic Claims, the INTERMEDIARY shall make interim reimbursements for
7 Clinic Claims, except Dental Services, at eighty-five percent (85%) of the applicable rate established
8 below for medicine, x-ray, lab services and surgical services (collectively "Medical") and at one-
9 hundred percent (100%) of the applicable rate for anesthesia. The conversion factor per RVU is as
10 follows, which factor shall be modified by the INTERMEDIARY as the Medical Fee Schedule is
11 modified by Law or regulation and in effect upon execution of this Agreement.

	100% of		
	Conversion Factor		Interim Payment
<u>SERVICE</u>	<u>per RVU</u>		<u>per RVU</u>
Medical	\$37.8975	x 85%	\$28.42
Anesthesia	\$16.19	100%	\$16.19

12
13
14
15
16
17 B. Claims experience during the first six (6) months of the term of this Agreement shall be
18 reviewed by ADMINISTRATOR and the percentage of the interim reimbursement to Contracting
19 Clinics may be adjusted based on availability of funding.

20 1. If, at any time, the interim payments for Clinic Claims are projected to equal the total
21 monies allocated to the Clinic Funding, less \$260,000 reserve required by the MSI Clinic Agreement,
22 prior to September 30, 2008, ADMINISTRATOR may, at its sole discretion, reduce the percentage of
23 the interim reimbursement to Contracting Clinics specified in Subparagraph A. above.

24 2. If interim payments for Clinic Claims equal the total monies allocated to the Clinic
25 Funding, less the \$260,000 Reserve required by the MSI Clinic Agreement, no further reimbursement of
26 Clinic Claims shall be made, until INTERMEDIARY determines through Final Settlement whether any
27 Funds remain for distribution.

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

35
36 **XI. PAYMENTS TO OTHER PROVIDERS**

37 A. Ambulance operators, home health services providers, and providers of durable medical

1 equipment, shall be reimbursed at one hundred percent (100%) of prevailing Medicare or Medi-Cal
2 rates, as specified in I.L.2 of Exhibit B to this agreement, for similar services and goods and are not
3 subject to Final Settlement as defined for all Other Providers. Prior to Final Settlement, at
4 ADMINISTRATOR'S sole discretion, ADMINISTRATOR shall direct INTERMEDIARY to reconcile
5 any or all reimbursement in either one of the following manners:

6 1. The cost of such reimbursement shall be charged by INTERMEDIARY seventy percent
7 (70%) to the Hospital Trust Fund Account, and thirty percent (30%) to the Physicians Trust Fund
8 Account, except for ambulance costs as specified in subparagraph IV.D.4.b. of Exhibit B to this
9 Agreement; or,

10 2. The cost of such reimbursement for any or all of said providers should be charged to by
11 INTERMEDIARY 100% to the Outpatient Trust Fund Account.

12 B. Skilled Nursing Facility (SNF) Payments – For SNF services arranged for by COUNTY'S
13 Utilization Management Department, INTERMEDIARY shall make payment to such facilities at rates
14 negotiated by COUNTY. The costs of such reimbursements shall be charged one hundred percent
15 (100%) of the institutional costs to the Hospital Trust Fund Account and one hundred percent (100%) of
16 the professional costs to the Physicians Trust Fund Account. Such SNF facilities shall not be considered
17 eligible for Points as calculated for Final Settlement in accordance the MSI Hospital Agreement.

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

21
22 **XII. FINAL SETTLEMENT**

23 A. INTERMEDIARY shall complete final reimbursement to All Providers, as specified below
24 (Final Settlement). Final Settlement shall be accomplished no later than February 28, 2009.

25 B. Immediately prior to Final Settlement, INTERMEDIARY shall deposit any Hospital Recovery
26 Trust Fund Account balance into its Hospital Account and any Physicians Recovery Trust Fund
27 Account balance into its Imprest Account and shall advise ADMINISTRATOR of any funds in the HCA
28 Recovery Account.

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

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

1 //

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

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

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

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

$$\begin{array}{r}
 \text{Individual} \quad \text{Total Agreement Term interim} \quad \text{Funds} \\
 \text{Physician} = \frac{\text{payments to individual physician}}{\text{Total Agreement Term interim}} \times \frac{\text{Remaining in}}{\text{INTERMEDIARY}} \\
 \text{Share} \quad \quad \quad \text{payments for all Physicians Claims} \quad \quad \text{Physicians Account}
 \end{array}$$

15
16
17
18
19 4. Settlement Limitation - Total interim payments shall be adjusted for other insurance, voided
20 claims and refunds.

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

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

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

34
35 **XIII. SATISFACTION OF CLAIMS**

36 Acceptance by All Providers of payments made by INTERMEDIARY in accordance with this
37 Agreement shall be deemed satisfaction in full of any obligation to All Providers, and no provider shall

1 seek additional reimbursement from an MSI Eligible patient, with respect to those claims for Medical
2 //
3 Services for which payment has been made by the MSI Program, notwithstanding a provider's right to
4 appeal any denied claim, as provided for in subparagraph VI. of this Exhibit E.

5
6 **XIV. CLAIMS PROCESSING STANDARDS AND SANCTIONS**

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

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

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

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

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

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

23 //
24 //
25 //
26 //
27 //
28 //
29 //
30 //
31 //
32 //
33 //
34 //
35 //
36 //
37 //

1 EXHIBIT F
2 AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE
5 MEDICAL SERVICES INITIATIVE PROGRAM
6 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009
7 INTERMEDIARY DATA REPORTING REQUIREMENTS
8

9 **I. GENERAL REQUIREMENTS**

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

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

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

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

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

23 F. INTERMEDIARY shall advise ADMINISTRATOR of reports or information requested by
24 HASC, OCMA, or COCCC or outside parties and shall direct these requests to ADMINISTRATOR.
25 INTERMEDIARY shall not provide any such requests for information to HASC, OCMA or COCCC or
26 outside parties unless specifically approved by ADMINISTRATOR.
27

28 **II. ADDITIONAL REPORTS**

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

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

33 2. Additional cross tabulations of the characteristics of Eligible Persons, Contracting
34 Hospitals, and Other Providers by assessment and treatment descriptors as may be requested, in writing,
35 by ADMINISTRATOR, if such cross tabulations are capable of computation from the data collected and
36 processed by INTERMEDIARY pursuant to this Agreement.
37

//

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

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

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

12 D. INTERMEDIARY shall collect, compile, preserve and report the following information and
13 data. Unless otherwise specified, reports shall be run each month and consist of data for the prior three
14 (3) months running. A final annual report for services provided for the period of September 1, 2007
15 through August 31, 2008 shall be completed no later than Final Settlement. INTERMEDIARY shall
16 ensure the internal consistency of all reports. Some reports, or databases used to generate such reports,
17 may be requested in machine readable format at a later date. Format of all reports shall be determined
18 by COUNTY in accordance with State and COUNTY requirements as they currently exist or may be
19 amended. Unless otherwise specified, all reports shall be sent to ADMINISTRATOR'S MSI Program
20 Manager as specified on Page 4 of this Agreement.

21 1. Data for Medically Indigent Care Reporting System (MICRS) from all sources (clinics,
22 hospitals, physicians, etc.) based on claims submitted to INTERMEDIARY shall be processed and
23 forwarded to COUNTY in State specified format.

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

26 3. Financial monitoring reports to include:

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

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

- 33 1) Hospital Pool by Contracting Hospital.
- 34 2) Physician Pool by individual provider.
- 35 3) Ambulance, Home Health, and Durable Medical Equipment providers.
- 36 4) Clinic Pool by Individual Provider.
- 37 5) Pharmaceuticals.

- 6) Ambulance claims relating to Receiving Hospital transfers.
- 7) Non-Hospital Outpatient Service Providers.
- 8) Dental Pool by individual provider.

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

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

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

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

4. Utilization Review Reports to include:

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

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

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

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

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

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

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

//

1 5. Utilization Monitoring Reports to include:

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

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

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

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

20 6. Program Monitoring Reports to Include:

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

26 b. Encounters by ICD9 and Services Rendered by Patient Characteristics: For all pools
27 combined and each pool and service type combination, a table of encounters by ICD9 major disease
28 groups and median age of patients, sex, age group, ethnicity, IRCA alien status. (As Requested)

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

33 7. Denial Reports to Include:

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

1 1. Inpatient with subcategories: Acute, Inpatient and Step-Down

2 2. Emergency Room Admission

3 3. Emergency Room with subcategories: Minor, Minor w/ Ancillary, Surgical

4 4. Outpatient with subcategories: Minor, Minor w/ Ancillary, Surgical (Bi-Monthly)

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

8 8. Annual/Periodic Reports:

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

12 b. Cumulative, quarterly, alphabetic listing of physician providers to include provider
13 name, tax I.D. number, total billed, total allowed, and total paid; to be provided in hardcopy and
14 machine readable format by February 28, 2009. (As Requested)

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

17 1) Reports of final payout results, settlements, and adjustments including listings of
18 payments for each provider pool and provider. Semi-monthly preliminary final payout reports
19 commencing in January 2009.

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

23 3) Quarterly and annual estimated/actual data (reflecting final settlements) of
24 unduplicated users by specified identifiers (SSN, DOB, Name) which merge medical services and other
25 indigent services data for State reporting, in both hardcopy and floppy diskette as required by the
26 Medically Indigent Care Reporting System (MICRS).

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

31
32 **III. SYSTEM MAINTENANCE AND DOCUMENTATION REQUIREMENTS**

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

35 A. System Maintenance

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

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

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

5 4. Specification of new procedures effective dates.

6 5. Specification for transfer of historical files.

7 6. Updates for system modifications.

8 **B. Report Production**

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

10 a. Production schedule

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

13 c. Report production procedures

14 d. Flow charts showing file inputs, processing and outputs

15 e. Sample outputs for each report

16 2. Updates for report modifications.

17
18 **IV. DATA ELEMENTS**

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

21 **A. Demographic Characteristics of MSI Eligibles and Users:**

22 1. Full name

23 2. MSI Case Number

24 3. Social Security Number

25 4. Full mailing address, including zip code

26 5. Date of birth

27 6. Sex

28 7. Ethnicity

29 8. Employment

30 9. Monthly income

31 10. Household configuration

32 11. Other insurance coverage

33 12. Medi-Cal status and effective date

34 13. Accident case, if applicable

35 14. Eligibility certification date

36 15. Eligibility effective date(s)

37 16. Eligibility termination date(s)

- 1 17. Eligibility status for each of prior eighteen (18) months
- 2 18. Income Source
- 3 19. Type of Employment
- 4 20. Family Size
- 5 21. Employment Status
- 6 B. Characteristics of Providers:
- 7 1. Current name
- 8 2. Previous name, if applicable
- 9 3. Current identifier (tax ID)
- 10 4. Previous identifier (tax ID), if applicable
- 11 5. Professional/billing address(es), including zip code
- 12 6. Type of provider
- 13 7. Physician/facility specialty
- 14 C. Characteristics of Service Delivery:
- 15 1. Date(s) of service (encounter, inpatient admission and discharge)
- 16 2. Primary and secondary admitting diagnosis
- 17 3. Primary and secondary discharge diagnosis
- 18 4. Major procedures codes
- 19 5. Disposition (follow-up, referral, release, death, continuing care)
- 20 6. Location of service delivery (hospital, ambulance, outpatient clinic, physician office,
- 21 emergency room, other facility)
- 22 7. Services rendered (users, encounters) - ambulance provider
- 23 a. Pickup and delivery
- 24 b. Oxygen usage
- 25 c. Mileage
- 26 d. Night call
- 27 8. Services rendered (users, encounters) - hospital provider
- 28 a. Inpatient room; acute, step-down, critical care
- 29 b. Trauma admission
- 30 c. Inpatient pharmacy
- 31 d. Inpatient ancillary: laboratory/pathology, radiology, anesthesia, operating
- 32 room/recovery, other/miscellaneous
- 33 e. Emergency room: minor, minor with ancillary, major, surgery
- 34 f. Outpatient department: minor, minor with ancillary, major, surgery
- 35 g. Outpatient pharmacy
- 36 h. Detoxification, Physician Specialty
- 37 i. Ambulatory Surgery

- 1 9. Services rendered (users, encounters) - physician provider
- 2 a. Office visit
- 3 b. Hospital outpatient service; surgery, anesthesia, radiology, laboratory/pathology,
- 4 medical visit
- 5 c. Hospital inpatient service; surgery, anesthesia, radiology, laboratory/pathology,
- 6 medical visit
- 7 d. Dental services
- 8 e. Pharmacy
- 9 f. Medical Supplies
- 10 g. Physician Specialty
- 11 h. Ambulatory Surgery
- 12 10. Services rendered (users, encounters) - home health provider
- 13 a. Nursing services
- 14 b. Durable medical equipment provided
- 15 D. Billing/Claims Processing:
- 16 1. Date of claim
- 17 2. Date claim received
- 18 3. Date claim processed
- 19 4. Date claim paid
- 20 5. Itemized billed charges for services rendered
- 21 6. Allowable charges for services rendered
- 22 7. Data Source
- 23 8. Disallowed charges for services rendered by reason for denial
- 24 9. Contract Rate for services rendered
- 25 10. Points computed for services rendered
- 26 11. Weekly check registers of claims processed
- 27 12. Adjustments to claims; Medi-Cal, retractions, voids, refunds
- 28 13. Bill type: ambulance, hospital, physician, Home health, Durable Medical Equipment
- 29 14. Cumulative numbers of claims; received, processed, paid, denied
- 30 15. Claim disposition: pending, approved, denied
- 31 16. Processing time: mean, median, standard deviation
- 32 //
- 33 //
- 34 //
- 35 //
- 36 //
- 37 //

1 EXHIBIT G
2 AGREEMENT FOR PROVISION OF
3 FISCAL INTERMEDIARY SERVICES
4 FOR THE

5 MEDICAL SERVICES INITIATIVE PROGRAM
6 SEPTEMBER 1, 2007 THROUGH FEBRUARY 28, 2009

7 **I. HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)**

8 INTERMEDIARY shall pay Contracting Hospitals the PIP payment stipulated below for services
9 provided during the period September 1, 2007 through August 31, 2008, which payment may be revised
10 pursuant to Paragraph II. of Exhibit E to this Agreement.

11 <u>HOSPITAL</u>	12 <u>PIP PAYMENTS</u>
13 Anaheim General Hospital	\$35,126
14 Anaheim Memorial Medical Center	\$197,059
15 Chapman Medical Center, Inc., dba Chapman Medical Center	\$21,408
16 Coastal Communities Hospital, Inc., dba Coastal Communities Hospital	\$49,959
17 Fountain Valley Regional Hospital	\$209,418
18 Garden Grove Hospital & Medical Center	\$64,699
19 Hoag Memorial Hospital Presbyterian	\$178,901
20 Irvine Medical Center	\$22,087
21 Kaiser Foundation Hospitals, Inc.	\$0
22 Los Alamitos Medical Center	\$30,206
23 Mission Hospital	\$195,690
24 Orange Coast Memorial Medical Center	\$30,631
25 Placentia Linda Community Hospital	\$22,167
26 Prime Healthcare Anaheim	\$122,349
27 Prime Healthcare Huntington Beach	\$93,664
28 Prime Healthcare La Palma	\$15,463
29 Saddleback Memorial Medical Center (SMMC) (includes Laguna Hills Campus and San Clemente Campus)	\$110,701
30 Saint Joseph Hospital - Orange	\$131,158
31 Saint Jude Medical Center	\$151,218
32 South Coast Medical Center	\$16,314
33 Tustin Medical Center	\$14,458
34 UCI Medical Center	\$536,467
35 WMC-A, Inc., dba Western Medical Center Hospital -Anaheim	\$39,927
36 WMC-SA, Inc., dba Western Medical Center Hospital - Santa Ana	\$312,384
37 Total PIP Payments	\$2,601,454