Enhanced Care Management and Community Supports Contract Submission Checklist

☐ ***Medi-Cal Managed Care Program Enhanced Care Management (ECM) and Community Supports (CS) Provider Agreement***

Do not enter a contract effective date as Anthem Blue Cross will add it upon counter signature.

☐ ***Disclosure of Ownership Form*** **(located within *Exhibit F* of the agreement)**

☐ ***W-9 Form***

Sign and enter only **one** Tax ID number **(either** a Social Security number [SSN] **or** an Employer Identification Number [EIN]).

☐ **Proof of insurance**:

- ☐ *Professional Liability Face Sheet*
- ☐ *General Liability Face Sheet*
- ☐ *Commercial Auto Policy Declaration* (if applicable)

☐ ***Background Check Attestation***

☐ ***Business Associate Agreement including Required Information Security Controls Exhibit***

☐ ***Health Delivery Organization (HDO) Application (FACILITIES ONLY)***

All facility-based organizations are required to complete the HDO application.

☐ ***Appropriate Taxonomy has been added to Group's NPI via NPPES***

If you have multiple locations with distinct NPIs, you must add the appropriate taxonomy to **each** location providing ECM/CS services.

☐ ***Completed Excel Roster***

Do not convert the *Excel Roster* to PDF.

- ☐ Confirm **each** clinical practitioner has completed and attested their CAQH applications **and** indicate their CAQH provider ID numbers in the *Excel Roster* form provided (if applicable).
- ☐ Enroll the organization and the individuals within the organization through California Department of Health Care Services (DHCS) PAVE*** (instructions attached)**. Once approved, indicate the effective date in the *Excel Roster*. If application status is *in process*, and effective date is unavailable/pending, submit a screenshot reflecting the application was successfully submitted.

☐ Return **all** documents listed above via email to ECM_CS_Contracting@anthem.com.

* As applicable per state guidelines.

Post-submission: Once the packet is returned, it will be reviewed for completeness. If a response is not received within 10 business days, please feel free to send a follow-up email.

ANTHEM BLUE CROSS

MEDI-CAL MANAGED CARE PROGRAM

ENHANCED CARE MANAGEMENT (ECM) AND COMMUNITY SUPPORTS (CS) PROVIDER AGREEMENT

WITH

County of Fresno

ANTHEM BLUE CROSS
MEDI-CAL MANAGED CARE PROGRAM
ECM / CS ANCILLARY PROVIDER AGREEMENT

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EXHIBITS

This Enhanced Care Management (ECM) and Community Supports (CS) Provider Agreement (hereinafter "Agreement") is made and entered into by and between the Medicaid Division of Blue Cross of California doing business as Anthem Blue Cross and its affiliates (hereinafter "Anthem") and County of Fresno (hereinafter "Provider"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 "Affiliate" means an entity owned or controlled either directly or through a parent or subsidiary entity by Anthem, or under common control with Anthem.

1.2 "Anthem Rate" means the lesser of Provider's Charges for Covered Services, or the total payment amount that Provider and Anthem have agreed upon as set forth in Exhibit A and made a part of this Agreement. The Anthem Rate is payment-in-full to Provider for Covered Services when Anthem is financially responsible to pay Provider for those Covered Services.

1.3 “Anthem Medi-Cal Managed Care Plan” is the healthcare service plan maintained and operated by Anthem pursuant to state contracts with the California Department of Health Care Services. Enrollees of an Anthem Medi-Cal Managed Care Plan are Medi-Cal beneficiaries.

1.4 "Charges" means the amount that Provider routinely bills and accepts as payment for products, services and supplies.

1.5 "Claim" means either the uniform bill claim form, electronic claim form in the format prescribed by Anthem or an invoice in a format prescribed by Anthem and submitted by Provider for payment by Anthem for Health Services provided to a Covered Individual.

1.6 "Clean Claim” means a claim that can be processed without obtaining additional information from Provider or from a third party. A Clean Claim does not include a claim being reviewed for Medical Necessity or include a claim where the claim or Provider is under investigation for fraud, waste or abuse. [42 CFR 447.45(b)]

1.7 "Cost Share" means, with respect to Covered Services, the amount that a Covered Individual is required to pay under the terms of his or her Health Benefit Plan. Such payment may be referred to as a copayment, deductible, or other Covered Individual payment responsibility, and may either be a fixed amount or a percentage of the applicable payment owed for the Covered Services.

1.8 "Covered Individual" means for Medi-Cal beneficiaries, an “Eligible Beneficiary” as defined in the contract between Anthem and a state/federal Medicaid Program, who is enrolled in an Anthem Medi-Cal Managed Care Plan or Affiliate at the time Covered Services are provided. For purposes related to this Agreement, including all schedules, attachments, exhibits, manual(s), notices and communications related to this Agreement, the term "Covered Individual" may be used interchangeably with the terms Medi-Cal, Medicaid, Covered Person, Member, Enrollee, or Subscriber, and the meaning of each is synonymous with any such other.

1.9 "Covered Services" means Medically Necessary Health Services provided by Provider to a Covered Individual as determined exclusively by Anthem in accordance with guidelines, standards, policies or regulations promulgated by the California Department of Healthcare Services or Anthem. To be a Covered Service, the services must be provided by Provider on a date when the person was both eligible with, and enrolled in, an Anthem Medi-Cal Managed Care Plan or Affiliate.

1.10 “Delegated Entity” or “Delegated Provider” means a risk bearing organization as defined in Health and Safety Code section 1375.4, that when applicable, is financially responsible for Covered Services provided by Provider and the entity to whom Provider shall seek payment from for those delegated Covered Services.

1.11 "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. [see, 42 CFR 438.114]

1.12 "Health Benefit Plan" means either the document(s) describing the benefits and services covered under a Medi-Cal Managed Care Plan administered by Anthem pursuant to a contract with the California Department of Health Care Services whereby Anthem has agreed to provide managed care services to Medi-Cal beneficiaries enrolled in the Anthem Medi-Cal Managed Care Plan. Items, services or supplies not described in a Health Benefit Plan are not Covered Services.

1.13 "Health Services" means those services or supplies that Provider is licensed or certified, equipped and staffed to provide and are routinely provided to Provider’s individual patients.

1.14 "Medically Necessary" or "Medical Necessity" means, except as otherwise defined by the applicable Health Benefit Plan, procedures, supplies, equipment or services that are determined to be: (a) appropriate for the symptoms, diagnosis or treatment of the medical condition; (b) provided for the diagnosis or direct care and treatment of the medical condition; (c) within standards of good medical practice within the organized medical community; (d) not primarily for the convenience of the Covered Individual's physician or another provider, and (e) the most appropriate procedures, supplies, equipment or service which can safely be provided. The most appropriate procedures, supplies, equipment or service or supply must satisfy all of the following criteria: (i) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Covered Individual with the particular medical condition being treated than other alternatives; (ii) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and (iii) for inpatient facility admissions, the inpatient stay is necessary due to the kind of services the Covered Individual is receiving or the severity of the medical condition, and safe and adequate care cannot be received by the Covered Individual as an outpatient or in a less intensified medical setting.

1.15 "Network Participating Provider" means a provider, including physician, hospital, and ancillary healthcare provider, who has entered into a contract with Anthem to provide Health Services to Covered Individuals and participate in one or more of Anthem’s provider networks.

1.16 “Overpayment” means any funds that Provider receives or retains for providing services or supplies to Covered Individuals to which the Provider, after applicable reconciliation, is not entitled to keep.

1.17 “Provider Operations Manual” means the Anthem Medi-Cal Provider Operations Manual. The Provider Operations Manual is incorporated herein by this reference and applies to all Anthem Medi-Cal Managed Care Plans.

1.18 "Surcharge" means a fee which is charged to a Covered Individual by Provider for Health Service(s) but has not been approved by the applicable state regulatory authority, and is neither disclosed nor provided for in the Covered Individual's Health Benefit Plan.

1.19 Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered as referenced in Exhibit B.

1.20 Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), CS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan as referenced in Exhibit B.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Covered Individual Identification. Anthem shall provide a means of identifying a Covered Individual by issuing a paper, plastic, or other identification document to the Covered Individual, or by a telephonic, paper or electronic communication to the Provider. The identification will provide sufficient information so that Provider may contact Anthem to determine a Covered Individual's participation in a Health Benefit Plan. The identification alone will be insufficient to establish a Covered Individual's eligibility at the time a Health Service is provided. As such, Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself does not qualify the holder thereof as a Covered Individual, nor does the lack thereof mean that the person is not a Covered Individual.

2.1.1 Provider agrees that it will confirm that the person presenting the identification document is in fact the Covered Individual. Provider agrees that Anthem shall not be responsible for any fraudulent, deceptive or misuse of a Covered Individual’s identification document.

2.1.2 Anthem will provide verification of a Covered Individual's eligibility when Provider requests such verification. Provider acknowledges and agrees that any eligibility information provided by Anthem will not be deemed, interpreted, or considered as approval or authorization of the Medical Necessity of any Health Services provided, nor that any services provided are Covered Services.

2.2 Provider Services. Provider agrees to provide Covered Individuals with those Health Services and/or supplies set forth in Exhibit B, attached hereto and incorporated by reference herein, within the county location(s) listed in Exhibit C.

2.2.1 Provider agrees to adhere to the ECM / Scope of Work (SOW) as reference in Exhibit E attached hereto and incorporated by reference herein.

2.3 Provider Non-discrimination.

2.3.1 Provider agrees that its primary consideration shall be the quality of health care services rendered to Covered Individuals. As such, Provider agrees that it will provide Health Services to Covered Individuals in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or use any policy or practice that has the effect of discriminating against any Covered Individual because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, health status or need for health care services, the filing of any compliant or grievance, status as a litigant, status as a Medicaid beneficiary, sexual orientation, or any other basis prohibited by law. Provider shall not be required to provide any type, or kind of Health Service to Covered Individuals that the Provider does not customarily provide to others.

2.3.2 As required by Anthem's Medi-Cal contracts with the State of California, Provider, its agents and employees, shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, sexual orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (over 40), marital status, and use of family and medical care leave pursuant to state or federal law. Provider shall insure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, its agents and employees, shall ensure that the evaluation and treatment of its employees and applicants for employment are free from such discrimination and harassment. Provider, its agents and employees, shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated there under (Title 2, California Code of Regulations, Section 11099 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full.

2.4 Standard of Care. Provider shall provide Health Services to Covered Individuals at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements. Should a Covered Individual suffer any complication or preventable adverse event as a direct result of the treatment and care provided by Provider, Provider agrees that Anthem does not have to pay Provider for the Medically Necessary treatment or care required to treat the complication or preventable adverse event that resulted from Provider's negligence.

2.5 Cost Effective Care. Provider shall provide Covered Services in the most cost effective setting and manner.

2.6 Publication and Use of Provider Information. For the term of this Agreement, Provider agrees that Anthem may use, publish, disclose, and display information and disclaimers, as applicable, relating to Provider. Anthem will make good faith efforts to share data with Provider prior to initial disclosure or publication of any information related to a procedure or service for its transparency initiative(s) impacting Provider, such as but not limited to, Anthem Care Comparison.

2.6.1 To the extent permitted by the requirements of the Knox-Keene Act, including Health and Safety Code Section 1395.5, for the term of this Agreement, Provider agrees to provide, and authorize Anthem to publish, its name, tax identification number or other provider identification number, and other information reasonably required by an employer, individual or government entity in Anthem marketing and informational materials. Anthem agrees that Provider may identify itself as a Network Participating Provider in the Network(s) in which Provider participates without prior approval from Anthem, provided Provider strictly follows the publishing guidelines for use of Anthem's name, symbols, trademarks, or service marks, as set forth in the provider manual(s), and that such participation in the Network is then in effect. Provider's ability to identify its participation as a Network Participating Provider without Anthem's consent excludes the issuance of any press release. Anthem shall have the right of prior approval of any other use of Anthem's symbols, trademarks, or service marks presently existing or later established. Except as provided in this section, each party reserves the right to control the use of its name and all symbols, trademarks, or service marks presently existing or later established. With the exception of limited downloading and copying rights which may be expressly posted by Anthem on its web sites, and which may be amended in Anthem's sole discretion, no rights are granted to Provider to reproduce, store, transmit or modify the content of such web sites in any

manner, to link to the home page, to deeplink to any content, or frame any portion of the web sites without Anthem's written permission.

2.7 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may each identify Provider as an Anthem Medi-Cal Managed Care Plan Network Participating Provider.

2.8 Submission of Provider Claims.

2.8.1 Provider shall submit all Claims for Covered Services within three hundred sixty-five (365) days from the date Covered Services are rendered to a Covered Individual using the national standard specifications and code sets as referenced in Exhibit A. In the event Provider is unable to submit claims using the national standard (UB04 or CMS 1500) specifications and DHCS-defined code sets, Provider shall submit an invoice to Anthem with a minimum set of data elements necessary for Anthem to convert the invoice to an encounter for submission to DHCS. If Anthem is the secondary payor, the three hundred sixty-five (365) day period will not begin until Provider receives notification of the primary payor's financial responsibility.

2.8.2 Provider agrees to bill Anthem at least monthly for any Covered Individual receiving extended Health Services from Provider. An extended Health Service is any on-going treatment in excess of 30 days.

2.8.3 Depending on the specific services provided to Covered Individuals under this ancillary provider agreement, Provider shall submit Claims on the applicable Universal Billing Form 04 (UB-04) promulgated by the National Uniform Billing Committee ("NUBC") or the CMS 1500 claim form, or any successor forms promulgated by either the NUBC or CMS. Claims shall be submitted in a format that is consistent with industry standards and acceptable to Anthem. Claims will be submitted electronically, or if electronic submission is not available, utilizing paper forms. Additionally, Provider Claims shall meet all billing requirements set forth in Anthem’s Provider Operations Manual. This manual provides additional guidance regarding Claim submission, including clarification on billing procedures for special circumstances such as when Anthem is the secondary payor. Provider agrees to comply with the billing procedures included in Anthem’s Provider Operations Manual.

2.8.4 Preventable Adverse Events ("PAEs"). When applicable, Provider shall include accurate and current CMS present-on-admission ("POA") indicators on all inpatient Claims submitted to Anthem for payment. Anthem will use such POA indicators and other applicable and CMS codes and conventions to identify PAEs and adjust inpatient payments to Provider under this Agreement consistent with instructions provided by CMS, and CMS’s practices and DRG groupers (hereinafter collectively, "CMS PAE Policies").

2.8.5 Provider agrees that Anthem may obtain and review all Provider information, medical records, or documents regarding any Claim. When requested by Anthem, Provider shall furnish records, documents or other information necessary to verify the Health Services provided, the Charges for such Health Services, or to determine Anthem’s financial liability for the Health Services listed on a Claim or invoice. When Anthem requests the additional information, medical records or documents, Provider shall provide the requested material and information within ninety (90) days, or before the expiration of the three hundred sixty-five (365) day period referenced above, whichever is longer. All materials and information will be provided to Anthem at no cost to Anthem or the Covered Individual. Once Anthem determines its payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Covered Individual's Health Benefit Plan.

2.9 Timely Payment of Clean Claims.

2.9.1 Anthem will adjudicate Clean Claims submitted by Provider within thirty (30) working days of the date Anthem receives the claim. For purposes of determining compliance with the stated time frames, the date of receipt is the date that Anthem receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

2.9.2 Payment shall be made in accordance with above stated timeframe unless the Claim, or portion thereof, is contested. If all or part of a Claim is contested, Anthem will notify Provider in writing within thirty (30) working days of receipt of the Claim. Anthem may contest a Claim where Anthem has not received all information necessary to determine its liability for the Claim, or has not been granted reasonable access to information or material concerning Provider services. Information that may be necessary to determine Anthem's liability includes reports or investigations concerning fraud, waste and abuse, necessary consents, releases, and assignments, a claim on appeal, relevant medical records, or other information necessary to determine Medical Necessity for the health care services provided.

2.9.3 The times frames set forth above shall in no way prevent or limit Anthem's right to recover any partial or complete payments made to Provider for Covered Services when Anthem determines that it has for any reason overpaid a Claim.

2.10 Payment in Full and Hold Harmless.

2.10.1 Provider agrees that the Anthem Rates set forth in Exhibit A and made a part of this Agreement shall apply to Health Services provided to Covered Individuals when Anthem is financially responsible for payment of the Covered Services.

2.10.2 Provider agrees that it will only seek payment for Covered Services from Anthem, or when applicable, from a Delegated Entity that has agreed to be financially responsible for the payment of the Covered Services provided by Provider. When Anthem has delegated financial responsibility for services provided by Provider to a Delegated Entity, Provider shall look only to the Delegated Entity for payment of those services.

2.10.3 Provider agrees that in no event, including nonpayment or insolvency by Anthem or a Delegated Entity, will Provider or any person acting on Provider's behalf, bill, charge, seek payment from, or have any recourse against a Covered Individual, or a person acting on the Covered Individual's behalf, for Covered Services provided pursuant to this Agreement. Provider agrees that it will not hold, or attempt to hold, a Covered Individual liable for the payment of Covered Services should Anthem, its Delegated Provider, or the State of California not pay Provider for Covered Services. Provider agrees not to balance bill a Covered Individual. If Anthem receives notice of any such conduct, it will take appropriate action.

This section does not prohibit Provider from collecting payment from the Covered Individual for:

2.10.3.1 Applicable Cost Shares;

2.10.3.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

(a) The waiver notifies the Covered Individual that the Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

(b) The waiver notifies the Covered Individual of the Health Service being provided and the date(s) of service;

(c) The waiver notifies the Covered Individual of the approximate cost of the Health Service; and

(d) The waiver is signed by the Covered Individual prior to receipt of the Health Service.

2.10.3.3 Any reduction in or denial of payment as a result of the Covered Individual's failure to comply with his/her utilization management program.

2.11 Provider Requirements for Services Provided to CCS Eligible Individuals.

2.11.1 Provider agrees that for Covered Individuals whose health condition is eligible for California Children's Services ("CCS"), Provider will submit a referral for CCS coverage within the time limits specified by CCS and Anthem. Provider agrees to provide Anthem with the names of all Covered Individuals whose condition may make the Covered Individual eligible to receive CCS covered services. Provider will not seek payment from Anthem, and Anthem will not pay Provider, for Health Services denied by CCS because the referral was not timely submitted by Provider to CCS.

2.11.2 If Provider is certified by CCS to provide CCS covered services to eligible Covered Individuals, Provider agrees that such services shall be provided by, or provided by order of, a CCS paneled provider. Provider will not seek payment from Anthem, and Anthem will not pay Provider, for Health Services denied by CCS because the care or treatment was not provided by a paneled provider.

2.11.3 If Provider is not certified by CCS to provide CCS covered services to eligible Covered Individuals, Provider shall transfer the care and treatment of a CCS eligible Covered Individual to the nearest CCS certified Provider within the time limits set by CCS or Anthem. When possible, the transfer shall be to a CCS paneled Network Participating Provider. Provider will not seek payment from Anthem, and Anthem will not pay Provider, for CCS covered Health Services provided to the Covered Individual if Provider fails to transfer a Covered Individual to a CCS certified Provider.

2.11.4 Provider agrees that under no situation or circumstances will Provider bill, or seek payment from, Covered Individuals for CCS covered services that were not paid.

2.12 Appeals/Adjustment Requests. If Provider believes a Claim for Covered Services has been improperly adjudicated or paid by Anthem, Provider shall submit a provider dispute request appealing Anthem's adjudication or payment of the Claim within one (1) year from the date of payment or explanation of payment. The provider dispute request shall be submitted in accordance with Anthem's payment appeal or adjustment process contained in Anthem's Provider Operations Manual. Provider acknowledges and agrees that a provider dispute request submitted more than one year after payment or explanation of payment, will be denied and no additional compensation will be paid to Provider on the Claim, and Provider will not be permitted to bill Anthem, or the Covered Individual for those services for which payment was denied.

2.13 Returning or Adjusting Overpayments.

2.13.1 Provider agrees to report and return all Overpayments it has received for services provided under this Agreement. Such Overpayments shall be reported and returned within 60 days after the date on which the Overpayment was first identified. [See, 42 U.S.C. 1320a-7k(d)].

2.13.2 Anthem may recover any Overpayment made to Provider where Anthem determined that all or part of any payment was an Overpayment under this Agreement. Where Anthem determines an Overpayment occurred, Anthem will notify Provider of the Overpayment and request a refund from Provider, in accordance with applicable laws and regulations. If Provider does not contest Anthem's notice of the Overpayment, Anthem will deduct from and set off against, the Overpayment amount from any amounts due and payable from Anthem to Provider for Covered Services provided at any time under this Agreement, in accordance with applicable laws and regulations. The Provider Operations Manual states the procedures concerning Overpayment recoveries.

2.13.3 Notwithstanding any other provision of this Agreement, a lien held by Provider under California Civil Code 3045.1, *et seq*. (or any similar law) shall not increase the maximum payment amount that Provider receives for providing Covered Services. Provider may only claim and collect under any such lien an amount which, when added to all amounts Provider has received from all other sources for such Covered Services, will not exceed the maximum compensation payable under this Agreement. Anthem may, under third party liability, third party recovery, or similar provisions of benefit agreements, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Anthem. Anthem's right to such a refund will not, in any case, alter the maximum compensation Provider is entitled to receive under this Agreement for Covered Services.

2.14 Coordination of Benefits/Subrogation. Provider agrees to cooperate with Anthem regarding subrogation and coordination of benefits as set forth in the Provider Operations Manual. Provider shall make reasonable inquiry of Covered Individuals to learn whether the Covered Individual has health insurance or health benefit coverage other than from Anthem, or is entitled to payment by a third party under any other insurance or plan of any type. Provider shall promptly notify Anthem after receipt of information regarding a Covered Individual who may have a claim involving subrogation or coordination of benefits.

Provider acknowledges and agrees that the process for coordination of benefits to individuals whose coverage is based on their eligibility in a government healthcare program shall be as follows:

2.14.1 In all cases where Health Services are provided to a Covered Individual enrolled in an Anthem Medi-Cal Managed Care Plan, Anthem shall be the payor of last resort. As such, whenever benefits are to be coordinated with some other payor for Health Services provided to a Medi-Cal Managed Care Plan enrollee, Anthem shall be the secondary payor for all treatment and care provided to the Covered Individual.

2.14.2 In all cases where Health Services are provided to a Covered Individual who is enrolled in both the Medicare and Medi-Cal programs and Medicare is primary, Anthem's payment as the secondary payor shall be limited to the Medicare beneficiary's co-pay, deductible or co-insurance amount.

2.15 Fraud, Waste and Abuse.

2.15.1 Provider shall report to Anthem's compliance officer any incident of suspected fraud, waste or abuse, as defined in title 42 Code of Federal Regulation section 455.2. Where Provider has a reason to believe that an incident of fraud, waste or abuse has occurred by Provider, or by Provider's employee, agent, subcontractor, or other individual. Provider shall report that belief to Anthem within ten (10) working days of first suspecting any incident of fraud, waste or abuse.

2.15.2 Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against suspected incidents of fraud, waste or abuse arising from the delivery of Health Services provided to any patient covered under an Anthem Medi-Cal Managed Care Plan. Upon the request of Anthem, or any state or federal agency, Provider shall discuss with the state or federal agency appropriate actions prior to and during the course of any investigation into fraud, waste or abuse.

2.15.3 This contract shall immediately terminate for cause if at any time during the lifetime of this agreement Provider is excluded from participating in a Federal health care program under 42 U.S.C. sections 1320a-7 or 1320a-7a.

2.16 Provider Subcontractors. Anthem agrees that Provider may fulfill its contractual duties and obligations under this Agreement through subcontractors or delegates (Subcontractors and delegates are collectively referred to as "subcontractors"), subject to the conditions stated below:

2.16.1 Provider shall provide Anthem with a minimum of thirty (30) days prior written notice before entering into any subcontractor agreement for Health Services when the Health Services being sub-contracted away from Provider are Health Services currently provided by Provider and are Provider's obligation under this Agreement.

2.16.2 Provider acknowledges and agrees that it shall be solely responsible for paying subcontractor(s) for all Health Services provided by its subcontractor(s), and to indemnify and hold harmless Anthem, Covered Individuals and the Department of Health Care Services for any mistake, failure, or breach of this Agreement committed by subcontractor(s).

2.16.3 Provider agrees that it will require all subcontractors to abide by the terms and conditions of this Agreement when providing Health Services to Covered Individuals.

2.16.4 Provider agrees that it will require as a condition of any subcontract for Health Services, that the subcontractor make available for inspection and duplication the subcontract and the subcontractor's books and records regarding Health Services provided to Covered Individuals. The subcontract agreement shall allow inspection and duplication by the Department of Managed Health Care, the Department of Health Care Services, MRMIB, the Center for Medicare and Medicaid Services, the Department of Justice, or Anthem consistent with the requirements of section 3.3 of this Agreement.

2.17 Compliance with Provider Operations Manual and Policies, Programs and Procedures. Provider acknowledges that the Provider Operations Manual is an integral part of the obligations contemplated by this agreement. As such, Provider agrees to abide by, and comply with, the Provider Operations Manual, and other policies, programs and procedures established and implemented by Anthem (collectively "Policies"). Anthem may modify the Provider Operations Manual and Policies by providing notice to Provider at least ninety (90) calendar days in advance of the effective date of material modifications thereto.

2.18 In Network Referrals and Transfers. Provider shall, when medically appropriate, refer and transfer Covered Individuals to Network Participating Providers. Provider acknowledges that as a condition to coverage and payment for services provided to a Covered Individual, the services must be authorized by Anthem, or by the Network Participating Provider responsible for the Covered Individual's care. Provider agrees to obtain telephone authorization from the Network Participating Provider for any unscheduled Health Services. If prior authorization cannot be obtained, Provider agrees to notify the Network Participating Provider no later than the next working day.

2.19 Programs and Provider Panels. Provider acknowledges that Anthem may have, develop, or contract to develop, various networks or programs that have a variety of provider panels, program components and other requirements. Provider agrees that Anthem may discontinue, or modify such networks or programs without notifying Provider or obtaining Provider's acquiescence to the discontinuance or modification of such networks or programs.

2.20 Provider's Inability to Carry Out Duties. Provider shall promptly send written notice, in accordance with the Notice section of this Agreement, to Anthem of:

2.20.1 Any change in Provider's business address;

2.20.2 Any legal, governmental, or other action involving Provider which could materially impair the ability of Provider to carry out its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.20.3 Any change in accreditation, Provider affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.21 Provider Accreditation. Provider agrees that all times while the parties are contracted pursuant to this Agreement, it will maintain in good standing all licenses required by law, as well as its certification to participate in the Medicare and Medicaid programs. If applicable, Provider further agrees that it shall meet or exceed the standards required by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Healthcare Facilities Accreditation Program (HFAP), or Medicare Program certification. Copies of such licenses, certifications and standards are attached as referenced in Exhibit D and made a part of this Agreement. Provider agrees to provide copies of all such, licenses, certifications and standards to Anthem each year that they are issued, and upon Anthem's written request.

2.22 Marketing and Promotion. Provider agrees to make reasonable efforts to assist Anthem in its marketing of Health Benefit Plans. To the extent permitted by 42 C.F.R. section 438.104 and the Knox-Keene Act, including Health and Safety Code Section 1395.5, Provider shall ensure that it maintains Anthem signs and health promotion, membership, and marketing materials as reasonably requested by Anthem, consistent with the signage visibility and marketing support granted to third party payers other than Anthem.

2.23 Language Assistance Program. Anthem maintains a language assistance program that ensures limited English proficient ("LEP") Covered Individuals have access to language assistance when accessing health care services. When language assistance is needed by a Covered Individual, Provider agrees to coordinate, cooperate and comply with Anthem's language assistance program as set forth in Anthem's Provider Operations Manual. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.

2.24 Utilization Management. Provider acknowledges that Anthem has an established utilization management program that will determine whether Health Services provided to Covered Individuals are Medically Necessary. Provider agrees that Anthem is responsible for the authorization of Covered Services provided to Covered Individuals and agrees to cooperate with Anthem's utilization management process.

2.24.1 Provider shall request a pre-service authorization at least three (3) working days prior to any scheduled medical service or supply so as to avoid retrospective denial of payment for such services or supplies.

2.24.2 Provider further agrees to participate, when applicable, in the concurrent utilization management process and promptly notify Anthem in instances where it is anticipated that a Covered Individual's care and treatment exceeds the care and treatment already authorized as Medically Necessary.

2.24.3 Provider agrees to be bound by Anthem's utilization management determinations subject to the dispute resolution process contained in section 7.1.1.

2.25 Notice of Provider Ownership. As required by the Department of Health Care Services' contract with Anthem, Provider agrees to provide the following information to Anthem and permit Anthem to disclose the information to the Department of Health Care Services.

2.25.1 The names of all officers and owners of Provider.

2.25.2 The names of all stockholders owning more than ten percent (10%) of the stock issued by Provider.

2.25.3 The names of all creditors holding more than five percent (5%) of the debt of Provider.

The information required by this section is included in Exhibit F and made a part of this Agreement. Provider agrees to provide Anthem with written notice of any changes to the information listed in subsections 2.25.1 through 2.25.3 within days of the effective date of the change.

2.26 Federal, State and Contract Requirements. As a Medi-Cal managed care organization, Anthem is subject to Federal requirements mandated by the Social Security Act, state requirements contained in the Knox-Keene Act and the Welfare and Institutions Code, and obligations contained in its state contract with Department of Health Care Services. Any contractual provision required to be in this Agreement under any of the cited laws or contract shall bind Anthem and Provider, whether or not the contractual provision is expressly provided in this Agreement. Provider certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in any of such programs by any Federal agency or by any department, agency or political subdivision of the State. For purposes of this paragraph, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Provider's operations. Provider shall be required to submit a Disclosure of Ownership and Control Interest Statement form included in Exhibit F during the initial contracting, recontracting and/or recredentialing process or upon request by Anthem. The Provider further agrees to notify Anthem within thirty-five (35) days of any changes to the required disclosures.

2.27 Provider agrees to submit all reports required by Anthem necessary to comply with Medi-Cal Managed Care Program requirements. Provider agrees to submit to Anthem complete, accurate, reasonable, and timely provider data and encounter data necessary for Anthem to comply with the Department of Health Care Services' data reporting requirements.

2.28 Provider shall comply with applicable monitoring provisions of the contract between Anthem and Department of Health Care Services and any monitoring request by the Department of Health Care Services. Further, Provider agrees that Anthem shall revoke the delegation of activities or obligations, or specify other remedies in instances where Department of Health Care Services or Anthem determine that Provider has not performed satisfactorily.

2.29 Provider is entitled to all protections afforded to it under the Health Care Provider's Bill of Rights, including but not limited to Health & Safety Code §1375.7.

2.30 Anthem agrees to provide cultural competency, sensitivity and diversity training for Provider and Provider Subcontractors.

2.31 If Provider is responsible for the coordination of care for Covered Individuals, Anthem agrees to share with Provider any utilization data that Department of Health Care Services has provided to Anthem and Provider agrees to receive the utilization data provided and use it as Provider is able for the purpose of Covered Individual care coordination.

2.32 PROVIDER agrees to cooperate with Anthem's administration of its internal quality of care review and provider grievance resolution procedures.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary Information. All information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. Neither party shall disclose any information proprietary to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services to a Covered Individual; (4) upon the express written consent of the parties; or (5) as required by law or regulation, except that either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information.

3.2 Confidentiality of Personally Identifiable Information. Both parties agree to abide by state and federal laws and regulations regarding confidentiality of the Covered Individual's personally identifiable information.

3.3 Access to Provider Records.

3.3.1 Provider agrees that Anthem or its authorized representative may review, audit, and duplicate data and other records maintained by Provider regarding services Provider provides to Covered Individuals, and the cost thereof to the extent permitted by state and federal law including but not limited to the Agreement between Anthem and the Department of Health Care Services. Records include but are not limited to: medical and clinical records, encounter data, and records relating to billing, payment and assignment. Provider shall make such records and information available to Anthem or its authorized representative at all reasonable times at Provider's place of business upon Anthem's request. Such books and records shall be made available to Anthem in a form maintained in accordance with the general standards applicable to such books or record keeping.

3.3.2 Provider further agrees that the Directors or their designated representatives from the California Department of Managed Health Care, the California Department of Health Care Services, the Department of Health and Human Services ("DHHS"), the Centers for Medicaid and Medicare Services ("CMS"), Inspector General and the Department of Justice may inspect, audit and copy all financial, medical or other records maintained by Provider as may be necessary to ensure Anthem's compliance with the requirements of the Knox-Keene Act, the Medi-Cal program, or Anthem's contract with DHCS. [42 CFR

438.6(g)] Access to Provider's records and data for any government inspection shall be consistent to the access provided to Anthem under section 3.3.1. Should any governmental regulatory entity request certified documents, information, or data as part of that entity's inspection or audit, Provider agrees to have an authorized officer certify the accuracy of the documents, information or data produced by Provider. Furthermore, Provider agrees to make available all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the services Provider provides to Covered Individuals furnished under the terms of this Agreement.

3.3.3 Provider agrees that it will maintain its books, records and other papers for at least ten (10) years from the final date of the Medi-Cal Managed Care Program Agreement between Anthem and the Department of Health Care Services or from the date of completion of any audit, whichever is later. In addition, such obligation will not terminate upon the termination of this Agreement. Anthem agrees to reimburse Provider quarterly for reasonable expenses related to its review or audit not to exceed the lesser of ten (10) cents per page or a total of twenty-five dollars ($25.00) related to the duplication and preparation of requested records. Anthem maintains the right to audit such records to determine the appropriateness of payments made. Anthem's audit policy is described in its Provider Operations Manual.

If Department of Health Care Services, CMS or DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, Department of Health Care Services, CMS or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, Department of Health Care Services has the right to suspend or terminate the Provider from participation in the Medi-Cal Managed Care Program; seek recovery of payments made to the Provider; impose other sanctions under the Medi-Cal State Plan contract between Department of Health Care Services and CMS, and direct Anthem to terminate this Agreement due to fraud.

3.3.4 Anthem agrees and acknowledges that Provider's participation with the obligations contained in this section shall not be a waiver of Provider's right to maintain as confidential all proceedings of its Quality Assurance Committee, Professional Review Committee, or any other similar committee whose deliberations and findings are protected by California Evidence Code Section 1156 through 1157.7. These confidentiality provisions shall remain in effect notwithstanding any subsequent termination of this Agreement.

3.4 Transfer of Medical Records. Provider shall share a Covered Individual's medical records, and forward medical records and clinical information in a timely manner to other health care providers treating a Covered Individual, at no cost to Anthem, the Covered Individual, or other treating healthcare providers.

3.5 Upon request by the Department of Health Care Services, Provider shall timely gather, preserve and provide to the Department, in the form and manner specified by the Department of Health Care Services, any information specified by the Department, subject to any lawful privileges, in Provider's or its subcontractors' possession, relating to threatened or pending litigation by or against the Department of Health Care Services. (If Provider asserts that any requested documents are covered by a privilege, Provider shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against the Department of Health Care Services. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify the Department of Health Care Services of any subpoenas, document production requests, or requests for records, received by Provider or its Subcontractors related to this Agreement or subcontracts entered into under this Agreement. The Department of Health Care

Services shall reimburse reasonable costs incurred by Provider in complying with these requests, subject to limitations established by the Department of Health Care Services.

ARTICLE IV
INSURANCE

4.1 Anthem Insurance. Anthem shall self-insure or maintain insurance as shall be necessary to insure Anthem and its employees, acting within the scope of their duties.

4.2 Provider Insurance.

4.2.1 Provider, at its sole expense, agrees to self-insure or maintain professional liability and comprehensive general liability in amounts acceptable to Anthem as set forth in the Anthem Provider Operations Manual.

4.2.2 Upon Request by Anthem, Provider agrees to provide Anthem with copies of insurance policies or evidence of the ability to respond to any and all damages, as provided in section 4.2.1.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Anthem and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Anthem be construed to be providers of Health Services or responsible for the provision of such Health Services. Provider shall be solely responsible to the Covered Individual for treatment and medical care with respect to the provision of Health Services. Provider may freely communicate with Covered Individuals regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

5.2 Blue Cross Blue Shield Association (BCBSA). Provider hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Provider and Anthem, that Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans ("Association"), permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the state where Anthem is located, and that Anthem is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any Association person, entity or organization, and that no Association person, entity or organization other than Anthem shall be held accountable or liable to Provider for any of Anthem's obligations to Provider created under this Agreement. Provider has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Provider to use the Brands. Any references to the Brands made by Provider in its own materials are subject to review and approval by Anthem. This section shall not create any additional obligations on the part of Anthem, other than those obligations already created under other provisions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. Anthem and Provider shall each indemnify, defend and hold harmless the other party, and its directors, officers, employees, agents and subsidiaries, from and against any and all losses, claims, damages, liabilities, costs and expenses (including, without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the indemnifying party's failure to perform its obligations under this Agreement, and/or the indemnifying party's violation of

any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Anthem be liable to Provider for any extra-contractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

6.3 Period of Limitations. Unless otherwise provided for in this Agreement, neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim. The deadline for initiating an action shall not be tolled by the appeal process, meet and confer process, provider dispute resolution process or any other administrative process. To the extent a dispute is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between Anthem and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures and any applicable state law exhaustion requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures set forth below.

7.1.1 Medical Necessity/Experimental or Investigational Disputes. Any dispute concerning whether a service provided or to be provided by Provider to a Covered Individual is not a Covered Service because such service is not Medically Necessary, or is experimental or investigational shall be resolved by an independent review organization (IRO). If the issue has already been reviewed by an IRO at the Covered Individual's request, then Anthem and Provider agree to be bound by the findings of such IRO. If not, then the Provider shall choose the IRO from a list provided by Anthem containing two or more such organizations. Anthem and Provider agree to be bound by the findings of such IRO with respect to such dispute. Anthem and Provider further agree to equally split the costs charged by the IRO for conducting each case review. This process shall be the exclusive means for resolving medical necessity / experimental or investigational disputes.

7.1.2 With respect to disputes other than those addressed in subsection 7.1.1, to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Anthem Provider Operations Manual may require Provider to submit with respect to such dispute. If the total amount in dispute as

set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees within twenty (20) calendar days following the date on which the receiving party receives the demand letter, the parties' shall meet and confer in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, within ninety (90) calendar dates following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services (JAMS) shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of section 7.1 above that remains unresolved at the conclusion of the applicable process outlined in section 7.1 above shall be resolved by binding arbitration in the manner set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above. An arbitration demand shall not aggregate more than one hundred (100) disputed claims involving Covered Individuals arising out of this Agreement.

7.2.1 Selection and Replacement of Arbitrator(s). If the total amount in dispute as set forth in the demand letter is less than two million dollars ($2,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute as set forth in the demand letter is two million dollars ($2,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.2 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.3 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities to pursue, on a class basis, any dispute; provided however, that if an arbitrator or court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

ARTICLE VIII
TERM AND TERMINATION

8.1 Department of Health Care Services Contract Approval. Provider acknowledges that this Agreement, and any subsequent amendment to this Agreement, shall become effective only upon the written approval by the Department of Health Care Services, or by operation of law as follows: (i) for the initial Agreement, where the Department of Health Care Services has acknowledged receipt of the Agreement and neither approves or disapproves the Agreement within sixty (60) days

of its receipt; (ii) for any amendment to the Agreement governing compensation, services, or term, where the Department of Health Care Services has acknowledged receipt of the amendment and neither approves or disapproves the amendment within thirty (30) days of its receipt.

8.2 Initial Term of Agreement. The initial term of this Agreement shall commence at 12:01 AM on the Effective Date and shall continue in effect for a term of one (1) year ("Initial Term"), automatically renewing for consecutive one (1) year terms unless otherwise terminated as provided herein.

8.3 Termination Without Cause. At any time, either party may terminate or renegotiate this Agreement without cause with such termination to be effective on or after the expiration date of the Initial Term, by giving at least one hundred and twenty (120) days prior written notice of termination to the other party.

8.4 Future Negotiations. Notwithstanding any provision to the contrary contained in this Agreement, if the parties enter into discussions or negotiations concerning a new Provider Agreement which is to take effect subsequent to the termination or expiration of this Agreement and the parties are unable to reach agreement on the terms of the new Provider Agreement prior to the effective date of termination or expiration, the Provider shall accept as payment in full the Anthem Rate in effect under this Agreement on the day immediately prior to the termination or expiration until such time as a new Provider Agreement is effective, or until ninety (90) days after the date upon which either the Provider or Anthem gives written notice to the other terminating negotiations (such time period to be referred to as the "Interim Period").

During the Interim Period, the non-price terms, including but not limited to any hold harmless provisions of this Agreement shall be applicable, and any limitations contained in the Agreement by which Provider charge increases are capped when calculating payment under a percentage of charge methodology shall also be extended into the Interim Period, as follows: all of the charge capping percentages, measurement periods, notification requirements and methodologies in effect on the day immediately prior to termination or expiration of the Agreement shall be extended into, and through the end of, the Interim Period.

8.5 Breach of Agreement. Except for circumstances giving rise to the Termination With Cause section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.6 Termination With Cause.

8.6.1 This Agreement may be terminated automatically and immediately by Anthem if:

8.6.1.1 Provider commits any act or conduct for which its license(s), permit(s), or governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services is suspended, revoked, lost or voluntarily surrendered in whole or in part; or

8.6.1.2 Provider commits any act or conduct which results in a governmental, regulatory or accrediting entity placing Provider on probation;

8.6.1.3 Provider commits a fraud or makes any material misstatement or omission on any document related to this Agreement which it submits to Anthem or to a third party; or

8.6.1.4 Provider files for bankruptcy, makes an assignment for the benefit of its creditors without Anthem's written consent, or if a receiver is appointed over Provider's business or assets; or

8.6.1.5 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.6.1.6 Provider fails to maintain Anthem's credentialing or certification standards; or

8.6.1.7 Anthem reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being or safety of patients may be jeopardized; or

8.6.1.8 Provider has been abusive to a Covered Individual; or

8.6.2 This Agreement may be terminated automatically and immediately by Provider if:

8.6.2.1 Anthem commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.6.2.2 Anthem commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or

8.6.2.3 Anthem files for bankruptcy, or if a receiver is appointed; or

8.6.2.4 Anthem's insurance coverage as required by this Agreement lapses for any reason.

8.7 Transactions Prior to Termination. Termination shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the date of such termination.

8.8 Continuance of Care-Termination. If this Agreement is terminated, Provider shall continue to provide and be compensated for Covered Services under the terms of this Agreement to Covered Individuals who are Provider inpatients on the date of the termination until those Covered Individuals are discharged or can be safely transferred to another Network Participating Provider. If this Agreement is terminated for reasons other than the grounds set forth in the "Termination With Cause" provision, Provider, at Anthem's sole discretion, shall continue to provide and be compensated for Covered Services under the terms of this Agreement to Covered Individuals who at the time of termination are receiving services from Provider for one of the following conditions (as defined in Health and Safety Code Section 1373.96): (1) an acute condition; (2) a serious chronic condition; (3) a pregnancy; (4) a terminal illness; (5) care of a newborn child between birth and age thirty-six (36) months; or (6) performance of a surgery or other procedure that has been authorized by Plan (or the relevant delegated medical group/IPA) as part of a documented course of treatment and has been recommended and documented by Provider to occur within one hundred eighty (180) days of the termination date of this Agreement. For cases involving an acute condition, a terminal illness or a pregnancy, such services will continue through the duration of the acute condition, the terminal illness or the pregnancy, respectively. For cases involving a serious chronic condition, such services will continue until the course of treatment has been completed and arrangements have been made for a safe transfer to another participating Provider as determined by Plan in consultation with Provider, consistent with good professional practice, such period not to exceed twelve (12) months from the termination of this Agreement. For cases involving care of a newborn child, as specified above, such services will continue for a period not to exceed twelve (12) months from the termination of this Agreement.

After the effective date of termination, this Agreement shall remain in effect for the resolution of all matters unresolved as of that date.

In the event this Agreement is terminated, Provider agrees to assist Anthem in the transfer of Member medical care including making available to the Department and Anthem copies of medical records, patient files, and any other pertinent information held by Provider necessary for efficient case management of Members, as determined by the Director of the Department of Health Care Services. If applicable, Provider agrees to require its subcontractors to comply with this Section 8.8. The parties acknowledge that the cost of reproduction required by this provision will not be billed to members, but will be borne by the Provider.

8.9 Department of Health Care Services Notification. Provider agrees to timely notify the Department of Health Care Services of the termination of this Agreement.

8.10 Survival. In the event of termination of the Agreement, the following provisions shall survive:

8.10.1 Payment in Full and Hold Harmless (Section 2.10)

8.10.2 Appeals/Adjustment Requests (Section 2.12)

8.10.3 Confidentiality/Records (Article III)

8.10.4 Indemnification and Limitation of Liability (Article VI)

8.10.5 Dispute Resolution and Arbitration (Article VII)

8.10.6 Continuance of Care-Termination (Section 8.8)

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. Notwithstanding any other provision herein to the contrary, Anthem agrees to give Provider at least ninety (90) calendar days prior notice of any change by Anthem to a material term of this Agreement (except for any change necessary to comply with prospective changes required by the Department of Health Care Services, state or federal law or regulations or any accreditation requirements of a private sector accreditation organization and a shorter timeframe is required for compliance.) If Provider desires to negotiate the change (except for any change necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization), Provider shall notify Anthem no later than thirty (30) days after receipt of Anthem's notice. If the parties are unable to agree to such change or if Provider elects not to engage in any negotiations (and the change is not necessary to comply with state or federal law or regulations nor any accreditation requirements of a private sector accreditation organization), Provider may terminate this Agreement, notwithstanding the provisions of Article VIII of this Agreement, by providing Anthem, no later than forty-five (45) business days after receipt of Anthem's notice of the material change, with written notice of such intent to terminate this Agreement. Any such termination would not be effective until ninety (90) calendar days after Anthem's receipt of Provider's notice of intent to terminate.

Anthem agrees to inform Provider of prospective requirements added by the Department of Health Care Services to the contract between Anthem and the Department of Health Care Services before the requirement would be effective and Provider agrees to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by the Department of Health Care Services and to the extent possible.

9.2 Assignment. Neither Provider nor Anthem shall assign this Agreement or their respective rights, duties or obligations under this Agreement without the express written consent of the non-assigning party. Provider and Anthem agree that consent to an assignment shall not be unreasonably withheld. Any attempted assignment in violation of this provision shall be void as to the non-assigning party. Notwithstanding the foregoing, Provider agrees that any assignment or delegation of Provider's rights, duties or obligations under this Agreement or any Provider subcontract agreement shall be null and void unless prior written approval is obtained from the Department of Health Care Services.

Provider acknowledges and agrees that this section shall not apply to any of Anthem's duties or obligation that Anthem has capitated and delegated to a Delegated Entity.

9.3 Scope/Change in Status. Anthem and Provider agree that this Agreement applies to Health Services rendered at the locations as set forth on the Provider Locations Attachment of this Agreement. Anthem may limit this Agreement to Provider's locations, operations or business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the following events:

9.3.1 Provider otherwise changes its locations, business or operations, or business or corporate form or status; or

9.3.2 Provider is acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, expansion; or

9.3.3 Provider acquires or controls any other medical Provider, service or beds through any manner, Including but not limited to asset only purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.4 Provider (a) sells, transfers or conveys its business or any substantial portion of its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; or (b) enters into a management contract with another entity.

9.3.5 If Anthem consents in writing not to limit the Agreement to the original corporate entity, then Provider warrants and covenants that this Agreement will be assumed by the new entity unless the new entity already has an agreement with Anthem, in which case Anthem will determine which Agreement will prevail. Provider shall provide Anthem one hundred twenty (120) days prior written notice of any change in this section 9.3.

9.4 Definitions. Unless otherwise specifically noted, the definitions set forth in this Agreement will have the same meaning when used in any attachment, the Provider Operations Manual and Policies.

9.5 Entire Agreement. This Agreement (including items incorporated herein by reference) constitutes the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, floods, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.

9.7 Compliance with Medi-Cal Managed Care Program, Federal and State Laws. Anthem and Provider agree to comply with all requirements of the law relating to their obligations under this Agreement, all applicable requirements of the Medi-Cal Managed Care Program, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for

business operations, and as to Provider, its agents and employees, they shall be and remain licensed and certified (including Medicare certification in unqualified, unrestricted status) in accordance with all state and federal laws and regulations (including those applicable to utilization review and Claims payment) relating to the provision of Provider services to Covered Individuals. Provider shall supply evidence of such licensure, compliance and certifications to Anthem upon request. From time to time legislative bodies, boards, departments or agencies may enact, issue or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all such laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by such laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this section and any other provision in this Agreement, this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither it nor any of its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at http://www.epls.gov/ or its successor) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://www.oig.hhs.gov/fraud/exclusions.asp or its successor), or as otherwise designated by the Federal government. If Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to (1) immediately notify Anthem of such ineligible person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with, (1) the laws of the State of California unless such state laws are preempted by federal law, and (2), the laws and applicable regulations governing the Medi-Cal Managed Care contract between the Department of Health Care Services and Anthem.

9.9 Intent of the Parties. It is the intent of the parties that this fee-for-service Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent Anthem utilizes a designee, which in such event shall give rights only within the scope of such designation, and to the extent specified in the Payment in Full and Hold Harmless section of this Agreement.

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider from participating in or contracting with any provider, preferred provider organization, health maintenance organization, or health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Anthem does not warrant or guarantee that Provider will be utilized by any particular number of Covered Individuals.

9.11 Notices. All notices required or permitted to be given under this Agreement shall be in writing and shall be delivered to the party to whom notice is to be given either (i) by personal delivery (notice shall be deemed given on the date of delivery), (ii) by United Parcel Post (UPS) or other next day delivery service (notice shall be deemed given on the date of actual receipt), (iii) by first-class mail, postage prepaid certified or registered return receipt requested (notice shall be deemed given on the date of actual delivery) and (iv) by cablegram or telegram with confirmation of transmission (notice shall be deemed given on the date on the confirmation) (v) facsimile transmission with confirmation (notice shall be deemed given on the date on the confirmation) and (vi) electronic mail (notice shall be deemed given on the date of transmittal).

To ANTHEM Provider Engagement & Contracting Processing
Anthem State Sponsored Programs
21515 Burbank Blvd, 2nd Floor
Woodland Hills, California 91367
MS:CA9302-L02B

With copies to: Legal Department- State Sponsored Business
21515 Burbank Blvd, 3rd Floor
Woodland Hills, CA 91367
Attn: SSB Counsel
Fax#: (855) 852-8811

To PROVIDER at:

PROVIDER email:

All notices required or permitted to be given under this Agreement to the Department shall be in writing, deposited in the United States Postal Service as first class registered mail, postage prepaid to:

Regular Mail:
DEPARTMENT OF HEALTH CARE SERVICES
Medi-Cal Managed Care Division
MS# 4409
P.O. Box 997413
Sacramento, CA 95899-7413
Attn: Contracting Officer for Anthem Blue Cross

Federal Express:
DEPARTMENT OF HEALTH CARE SERVICES
Medi-Cal Managed Care Division
MS# 4409
1501 Capitol Avenue, 4th Floor
Sacramento, CA 94814

[Note: for GMC counties use MS# 4409]

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Interpretation. No provision of this Agreement shall be interpreted for or against any party because that party or his/her/its legal representative drafted the provision(s).

(REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK)

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES

THE EFFECTIVE DATE OF THIS AGREEMENT IS: **01/01/2026**

ANTHEM	County of Fresno
Signature	**Signature, Authorized Representative**
Michael Piellucci **Name**	Ernest Buddy Mendes **Name**
Regional Vice-President **Title**	Chairman, Fresno County Board of Supervis **Title**
12/03/2025 **Date**	12/9/25 **Date**
	94-6000512 **Tax ID**

ATTEST:
BERNICE E. SEIDEL
Clerk of the Board of Supervisors
County of Fresno, State of California
By _____ Deputy

Org No.: 56302037
Account No.: 3575
Fund No.: 0001
Subclass No.: 10000

EXHIBIT A

PROVIDER REIMBURSEMENT

Medi-Cal

Reimbursement for authorized Health Services shall be at one hundred percent (100%) of the attached ANTHEM Medi-CAL Proprietary Fee Schedule (Fee Schedule) per county.

Provider shall accept the above reimbursement for services or the Provider's billed amount, whichever is less as payment in full for those Covered Services provided to Members. Anthem may update or adjust the Fee Schedule from time to time upon ninety (90) days prior written notice to Provider.

Exhibit A-1
Provider Reimbursement - Transitional Rent Payment

Payment for Cost of Rent or Temporary Housing
Anthem will reimburse Transitional Rent providers for the actual cost of rent or temporary housing paid to the landlords or property owners up to a specified reimbursable ceiling. In alignment with DHCS requirements, Anthem will use the U.S Department of Housing and Urban Development's (HUD) Small Area Fair Market Rents (SAFMR) for the Transitional Rent reimbursable ceilings. The reimbursable ceilings are tied to a percentage of HUD's SAFMR. Anthem will not reimburse Transitional Rent providers for costs above the established SAFMR for the unit. See HUD's SAFMR's here:
FY2025 Advisory Small Area FMR Lookup System -- Select Geography

Allowable Unit Types:
DHCS defines "permanent" settings as those with a renewable lease agreement with a term of at least one month. A setting that can be permanent or interim is considered permanent if the Member has a renewable lease agreement. Where there is no lease agreement, or the lease term is not renewable, the setting is considered interim. The following includes allowable permanent and interim settings for Transitional Rent coverage that will be subject to specified reimbursable ceilings:

Allowable Permanent Settings

- Single-family and multi-family homes (e.g., duplexes)
- Apartments
- Housing in mobile home communities
- Accessory dwelling units (ADUs)
- Shared housing—where two or more people live in one rental unit
- Project-based or scattered site permanent supportive housing
- Single room occupancy (SRO) units
- Tiny homes
- Recovery housing
- License-exempt room and board

Allowable Interim Settings

- Single room occupancy (SRO) units
- Tiny homes
- Hotels/motels when serving as the Member's primary residence
- Interim settings with a small number of individuals per room (not large dormitory sleeping halls)
- Transitional and recovery housing with no lease agreement, including:
    - Bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming
    - License-exempt room and board
    - Peer respite

Reimbursable Ceilings for Rent or Temporary Housing

The following tables display the reimbursable ceilings for a per-month unit of service for allowable permanent and interim housing settings. Payments can be made on a per-diem basis. The per-diem reimbursable ceiling for a given setting is equal to the monthly rate divided by 28. Per-diem payments will be reserved for stays of less than a full month. Month-long stays will be required to be paid on a per-month basis. Total payments in a month will not exceed the per-month reimbursable ceiling.

Permanent Settings	Per-Month Reimbursable Ceiling
Allowable permanent setting (not SRO)	110% of SAFMR for the applicable unit size (i.e., efficiency, one-bedroom, two-bedroom, three-bedroom, or four-bedroom)
Allowable permanent setting meeting the definition of a single room occupancy (SRO) unit	82.5% of SAFMR for an efficiency unit
Shared housing—where two or more people live in one rental unit	Prorated share of 110% of SAFMR for the applicable unit size, with the share determined by the number of bedrooms occupied by the Member's household relative to the total bedrooms in the unit

Interim Settings	Per-Month Reimbursable Ceiling
Allowable interim setting when Member has their own room (including converted hotels/motels now serving individuals experiencing homelessness)	110% of SAFMR for the applicable unit size
Interim setting with a small number of individuals per room	Prorated share of 110% of SAFMR for an efficiency unit, with the share determined by the number of beds in the room occupied by the Member's household relative to the total number of beds in the room
Hotels/motels (i.e., commercial lodging) when serving as the Member's primary residence	150% of SAFMR for an efficiency unit

Administrative Fee

Anthem will pay the Transitional Rent provider an administrative fee for providing Transitional Rent services. Anthem is using the established DHCS Transitional Rent administrative fees and retaining a portion from DHCS and passing on the remainder to the Transitional Rent provider. The administrative fee for the month in which a Member is initially placed in a permanent setting is higher than the standard Transitional Rent administrative fee. The administrative fees vary based on region to account for differences in wages and other costs, and for challenges unique to rural areas, including travel costs for field-based providers and scarcity of housing. Each county is assigned to a DHCS established region.

The administrative fee is to cover the following Transitional Rent activities:

- Confirming an appropriate setting/unit.
- Ensuring the housing unit is habitable (e.g., coordinating a housing quality inspection).
- Helping the Member to review, understand, and execute the lease agreement, ensuring the lease agreement is compliant, legal, and reflects the needs of the Member, and confirming the rent payment due date.
- Structuring rent payment agreement with landlord or property owner. » Issuing timely payments to the landlord or other housing provider.
- Coordinating with the supportive services providers, which may include HTNS Provider, Housing Deposits Provider, HTSS Provider, ECM Provider, and/or other Medi-Cal or non-Medi-Cal funded providers who may be involved in service delivery for the Member

EXHIBIT B

COVERED SERVICES

PROVIDER shall indicate which CS and ECM will be rendered and which ECM population of focus will be served. Provider shall render services and be compensated in the counties (service area) listed in Exhibit C. Anthem may add counties in Exhibit C, to Provider's service area upon thirty (30) days written notice to Provider.

COMMUNITY SUPPORTS

Insert checkmark indicating which CS services provider will render under this agreement:

☐ Housing Transition Navigation Services
☒ Housing Deposits
☐ Housing Tenancy and Sustaining Services
☒ Transitional Rent
☐ Short-Term Post-Hospitalization Housing
☐ Recuperative Care (Medical Respite)
☐ Respite Services
☐ Day Habilitation Programs
☐ Assisted Living Facilities Transitions
☐ Community or Home Transition Services
☐ Personal Care and Homemaker Services
☐ Environmental Accessibility Adaptations (Home Modifications)
☐ Medically Tailored Meals
☐ Medically Supportive Food (Box/Voucher)
☐ Nutrition Counseling
☐ Sobering Centers
☐ Asthma Remediation

ENHANCED CARE MANAGEMENT

Insert checkmark indicating which of the ECM populations of focus provider will render services to under this agreement:

☐ Children and Youth Involved in Child Welfare
☐ Individuals Experiencing Homelessness ☐ Adults ☐ Families ☐ Youth
☐ Individuals with Serious Mental Health and/or SUD Needs ☐ Adults ☐ Youth
☐ Individuals Transitioning from Incarceration ☐ Adults ☐ Youth
☐ Adults Living in the Community and At Risk for LTC Institutionalization
☐ Adult Nursing Facility Residents Transitioning to the Community
☐ Individuals At Risk for Avoidable Hospital or ED Utilization (formerly "High Utilizers" ☐ Adults ☐ Youth
☐ Children and Youth Enrolled in California Children's Services (CCS) with additional needs beyond the CCS condition
☐ Birth Equity ☐ Adults ☐ Youth

ENHANCED CARE MANAGEMENT STREET MEDICINE

MCPs may cover the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers in the role of the Member's assigned Primary Care Provider (PCP), through a direct contract with the MCP, as an ECM Provider, as a Community Supports Provider, or as a referring or treating contracted Provider.

Street medicine health and social services address the unique needs and circumstances of individuals experiencing unsheltered homelessness, covered services are to be delivered directly to them in their own environment.

Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location does not qualify as street medicine, it is considered mobile medicine, as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location. Please note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine

The street medicine benefit covers up to the full array of services necessary to meet immediate needs, including but not limited to, preventive services, and the treatment of acute and chronic conditions.

Provider shall render services and be compensated in the counties (service area) listed in Exhibit C. Anthem may add counties in Exhibit C, to Provider's service area upon thirty (30) days written notice to Provider.

Insert checkmark indicating which Street Medicine services provider will render under this agreement:

☐ Street Medicine Provider as an ECM Provider

EXHIBIT C

PROVIDER COUNTY SERVICE AREA

Provider can service Members within the following counties as check marked below:

COMMUNITY SUPPORTS

Bay Area	Gold Country	Central Valley	Eastern Sierra	Los Angeles	Kern
☐ Sacramento ☐ San Francisco ☐ Santa Clara	☐ Amador ☐ Calaveras ☐ El Dorado ☐ Tuolumne	☒ Fresno ☐ Kings ☐ Madera ☐ Tulare	☐ Alpine ☐ Inyo ☐ Mono	☐ Los Angeles	☐ Kern

ENHANCED CARE MANAGEMENT

Bay Area	Gold Country	Central Valley	Eastern Sierra	Los Angeles	Kern
☐ Sacramento ☐ San Francisco ☐ Santa Clara	☐ Amador ☐ Calaveras ☐ El Dorado ☐ Tuolumne	☐ Fresno ☐ Kings ☐ Madera ☐ Tulare	☐ Alpine ☐ Inyo ☐ Mono	☐ Los Angeles	☐ Kern

ENHANCED CARE MANAGEMENT STREET MEDICINE

Bay Area	Gold Country	Central Valley	Eastern Sierra	Los Angeles	Kern
☐ Sacramento ☐ San Francisco ☐ Santa Clara	☐ Amador ☐ Calaveras ☐ El Dorado ☐ Tuolumne	☐ Fresno ☐ Kings ☐ Madera ☐ Tulare	☐ Alpine ☐ Inyo ☐ Mono	☐ Los Angeles	☐ Kern

EXHIBIT D

COPIES OF LICENSES AND CERTIFICATES

PROVIDER to attach copies of the following documents:

1. Disclosure of Ownership and Control Interest Statement (located within Exhibit F)
2. W-9
3. Proof of Insurance as applicable
    - Professional Liability Insurance Face Sheet
    - General Liability Face Sheet
    - Commercial Auto Policy Declaration
4. Background Check Attestation
5. Roster
6. Business Associate Agreement as applicable
7. Health Delivery Organization (HDO) Application as applicable

EXHIBIT E

SCOPE OF WORK

I. DEFINITIONS

Key terms are defined as follows:

1. **Authorized Representative (AR):** An individual or organization that the Member designates to act on her behalf with respect to the implementation of ECM services.
2. **CalAIM:** a multi-year initiative by CA-DHCS to improve the quality of life and health outcomes high-risk populations by implementing broad delivery system reforms. Enhanced Care Management (ECM) is a key CalAIM initiative.
3. **California Department of Health Care Services (DHCS):** A Department within the California Health and Human Services Agency that administers Medi-Cal, a program that provides healthcare services to low-income people.
4. **Community Supports (CS):** Flexible wrap-around services that Anthem will integrate into its population health strategy. These services are not included in the State Plan, but are medically appropriate, cost-effective substitutes for state plan services included within the contract. Examples of Community Supports include but are not limited to housing transition and sustaining services, recuperative care, respite, home and community-based wrap around services for members to transition or reside safely in their home or community, and sobering centers.
5. **ECM Participant ("Participant"):** means an Anthem Medi-Cal Member who has been assigned by Anthem to receive ECM services from Provider.
6. **ECM Provider:** A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
7. **CS Provider:** A contracted Provider of DHCS-approved CS. CS Providers are entities with experience and/or training providing one or more of the CS approved by DHCS.
8. **CS Provider Guide:** Anthem's detailed expectations CS providers including required policies and procedures, as well as best practice recommendations. The CS Provider Guide is an essential companion to this Scope of Work.
9. **ECM Provider Guide:** Anthem's detailed expectations for ECM providers including required policies and procedures, as well as best practice recommendations. The ECM Provider Guide is an essential companion to this Scope of Work.
10. **Electronic Visit Verification (EVV)**: a federally mandated telephone and computer-based application program that electronically verifies in-home service visits. As a result, this program will aid in reducing fraud, waste, and abuse. The EVV program must verify each type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.
11. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high- need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
12. **Lead Care Manager:** A Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with Anthem, as described in the DHCS-MCP ECM and CS Contract, Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
13. **Managed Care Plan (MCP):** An organization contracted by DHCS to administer a standard set of healthcare benefits for a population of Medi-Cal participants. Anthem Blue Cross is a Medi-Cal MCP.

14. **Population of Focus (PoF):** One of the DHCS-defined populations that are eligible for ECM, including: Children and Youth Enrolled in California Children's Services (CCS) with Additional Needs Beyond the CCS Qualifying Condition, Children and Youth Involved in Child Welfare, Birth Equity, Individuals Transitioning from Incarceration, Individuals with Serious Mental Health and/or SUD Needs (SUD), Individuals Experiencing Homelessness, Individuals At Risk for Avoidable Hospital or ED Utilization, Adult Nursing Facility Residents Transitioning to the Community, and Adults Living in the Community and At Risk for LTC Institutionalization,. These populations are subject to change. For the most recent and complete PoF descriptions see DHCS ECM Policy Guide.
15. **Service Planning Area (SPA)**: A Los Angeles County Department of Public Health designated geographic regions. Los Angeles County is divided into 8 SPAs.
16. **Subcontract:** a written agreement entered into by the Provider with any of the following: A Provider of health care services who agrees to furnish ECM services. Or any other organization or person(s) who agree(s) to perform any administrative function or service for the Provider specifically related to fulfilling the Provider's obligations to DHCS and Anthem under the terms of this Agreement. "Subcontractor" means an individual or entity who has a Subcontract with Provider that relates directly or indirectly to the performance of the Provider's obligations under this Agreement with Anthem.
17. **Street Medicine:** A set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.
18. **Street Medicine Provider:** A licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) assigned as patient's primary care provider, who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).
19. **Supplemental Provider:** A licensed medical provider who offers primary care services to individuals experiencing homelessness in their lived environment (such as those living in a car, RV, abandoned building, or other outdoor areas) but is not the Member's assigned Primary Care Provider.
20. **Administrative Processes:** e.g., billing protocols, credentialing requirements, authorization guidelines, etc.
21. **Mobile Medicine:** Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified location; Does not qualify as street medicine.

Enhanced Care Management

I. Service Overview

1. Certified Population(s) focus: ECM provider is certified and has agreed to render services to the population (s) of focus as referenced in Exhibit B.
2. Population segment
   a. Inclusion Criteria (if applicable):

      N/A

   b. Exclusion Criteria (if applicable):Please identify any limitations or qualifications to accepting eligibility lists for any member who meets the population and ECM level of care criteria, e.g. only serve clients fleeing domestic violence.

      N/A

3. Service Capacity

    1. See Capacity Report

II. ECM Provider Requirements Provider Experience and Qualifications

1. ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve;
2. ECM Provider shall have experience and expertise with the services it will provide;
3. ECM Provider shall comply with all applicable state and federal laws and regulations and all ECM benefit requirements in the DHCS-MCP ECM and CS Contract and associated guidance;
4. ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary;
5. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways;
6. ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including CS Providers, to coordinate care as appropriate to each Member;
7. ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).
8. Contracted ECM Providers who are also contracted CS Providers should provide separate and distinct ECM and CS services to authorized members;

III. Medicaid Enrollment/Vetting for ECM Providers

1. If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    a. If APL 19-004 does not apply to an ECM Provider, the ECM Provider must comply with Anthem's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.
2. Refer to the Anthem ECM Provider Guide, Contracting, for more details.

IV. Identifying Members for ECM

1. ECM Provider is encouraged to identify Members who would benefit from ECM and send a request to Anthem, to determine if the Member is eligible for ECM, consistent with Anthem's process for such request.
2. Refer to the Anthem ECM Provider Guide, Methods to identify eligible members, for more details.

V. Member Assignment to an ECM Provider

1. MCP shall communicate new Member assignments to ECM Provider as soon as possible, but in any event no later than ten business days after ECM authorization.

2. With the exception noted below, ECM Provider shall immediately accept all members assigned by Anthem for ECM, provided that the member is attributed to a population of focus which the Provider is certified to serve. Provider shall not be allowed to serve a subset of preferred members to the exclusion of other eligible members in the population of focus (e.g., empaneled members, Provider referrals). The purpose of this policy is ensure sufficient capacity for all eligible members in a County. Provider may request to revisit this policy in the future.
    a. Exception: ECM Provider shall be permitted to decline a Member assignment if ECM Provider is at its pre-determined capacity.
        1. ECM Provider shall immediately alert Anthem if it does not have the capacity to accept a Member assignment.
3. Upon initiation of ECM, ECM Provider shall ensure each Member assigned has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports (CS), and other services that address social determinants of health (SDOH) needs, regardless of setting.
4. ECM Provider shall advise the Member on the process for changing ECM Providers, which is permitted at any time.
    a. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.
    b. ECM Provider shall notify Anthem if the Member wishes to change ECM Providers.
    c. MCP must implement any requested ECM Provider change within thirty (30) calendar days.
5. ECM Provider shall advise the Member on the process for changing Lead Care Manager, which is permitted at any time.
    a. ECM Provider shall advise the Member on the process for switching ECM Providers, if requested.
    b. MCP must implement any requested ECM Provider change within thirty (30) calendar days.
6. Refer to the Anthem ECM Provider Guide, ECM Core Services, for more details.

VI. ECM Provider Staffing

1. At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned Member consistent with this Provider Standard Terms and Conditions, the DHCS-MCP ECM CS Contract and any other related DHCS guidance.
2. The ECM provider is expected to follow any DHCS provided guidance on staffing.
3. Refer to the Anthem ECM Provider Guide, Staffing, for additional staffing recommendations.

VII. ECM Provider Outreach and Member Engagement

1. ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with Anthem's Policies and Procedures.
2. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.
3. ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the Member's consent.
    a. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences:

i. Mail
ii. Email
iii. Texts
iv. Telephone calls
v. Telehealth

4. ECM Provider shall comply with non-discrimination requirements set forth in State and Federal law and the Contract with Anthem.
5. Refer to the Anthem ECM Provider Guide, Outreach and engagement, for more details.

VIII. Initiating Delivery of ECM

1. ECM Provider shall obtain, document, and manage Member authorization for the sharing of Personally Identifiable Information between Anthem and ECM, CS, and other Providers involved in the provision of Member care to the extent required by federal law.
2. Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law.
3. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to Anthem.
4. ECM Provider shall notify Anthem to discontinue ECM under the following circumstances:
   a. The Member has met their care plan goals for ECM;
   b. The Member is ready to transition to a lower level of care;
   c. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
   d. ECM Provider has not had any contact with the Member despite multiple attempts.
5. When ECM is discontinued, or will be discontinued for the Member, Anthem is responsible for sending a Notice of Action (NOA) notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the NOA. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Care Management, Basic Care Management, etc.).
6. Refer to the Anthem ECM Provider Guide, Initiating delivery of ECM, for more details.

IX. ECM Requirements and Core Service Components of ECM

1. ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members enrolled in managed care. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.
2. ECM Provider shall:
   a. Ensure each Member receiving ECM has a Lead Care Manager;
   b. Coordinate across all sources of care management in the event that a Member is receiving care management from multiple sources;
   c. Alert Anthem to ensure non-duplication of services in the event that a Member is receiving care management or duplication of services from multiple sources; and
   d. Follow Anthem instruction and participate in efforts to ensure ECM and other care management services are not duplicative.
3. ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as CS Providers, as appropriate, to coordinate Member care.
4. ECM Provider shall provide all core service components of ECM to each assigned Member, in compliance with Anthem's Policies and Procedures, as follows:
   a. Outreach and Engagement of Anthem Members into ECM.
   b. Comprehensive Assessment and Care Management Plan, which shall include, but is not limited to:

i. Engaging with each Member authorized to receive ECM primarily through in-person contact; When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
ii. Identify necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care and may be needed to inform the development of an individualized Care Management Plan.
iii. Developing a comprehensive, individualized, person-centered care plan by working with the Member and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
iv. Incorporating into the Member's care plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community- based and social services, and housing;
v. Ensuring the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and
vi. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight

c. Enhanced Coordination of Care, which shall include, but is not limited to:
i. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's Care Management Plan;
ii. Maintaining regular contact with all Providers, that are identified as being a part of the Member's multi-disciplinary care team, who's input is necessary for successful implementation of Member goals and needs;
iii. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
iv. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
v. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
vi. Ensuring regular contact with the Member and their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

d. Health Promotion, which shall adhere to federal care coordination and continuity of care requirements (42 CFR 438.208(b)) and shall include, but is not limited to:
i. Working with Members to identify and build on successes and potential family and/or support networks;
ii. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and
iii. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

e. Comprehensive Transitional Care, which shall include, but is not limited to:
    i. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
    ii. For Members who are experiencing, or who are likely to experience a care transition:
        1. Developing and regularly updating a transition of care plan for the Member;
        2. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;
        3. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;
        4. Coordinating medication review/reconciliation; and
        5. Providing adherence support and referral to appropriate services.

f. Member and Family Supports, which shall include, but are not limited to:
    i. Documenting a Member's designated family member(s), AR, guardian, caregiver, and/or authorized support person(s) and ensuring all appropriate authorizations are in place to ensure effective communication between the ECM Providers, the Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s) and Anthem, as applicable;
    ii. Activities to ensure the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s) with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with Federal, State and local privacy and confidentiality laws;
    iii. Ensuring the Member's ECM Provider serves as the primary point of contact for the Member and/or family member(s), AR, guardian, caregiver, and/or authorized support person(s);
    iv. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;
    v. Providing for appropriate education of the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) about care instructions for the Member; and
    vi. Ensuring that the Member has a copy of their Care Plan and information about how to request updates.

g. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
    i. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by Anthem as CS; and
    ii. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

X. Subcontracting

1. ECM Provider may subcontract with other entities or individuals in order to fulfill the obligations of ECM. Provider shall maintain policies and procedures, approved by Anthem, to ensure that Subcontractors fully comply with all terms and conditions of this Agreement, applicable regulations and DHCS regardless of sub-contracting arrangements, Provider retains overall responsibility for all duties outlined in this agreement.
    a. If the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and the DHCS-MCP ECM CS Contract.

b. If the ECM Provider subcontracts, the Provider shall be responsible for all required reporting and coordination.
c. ECM Provider will disclose its subcontracting relationship to Anthem, and demonstrate subcontractor readiness.
d. Anthem reserves the right to allow or disallow a Provider's subcontractor.

XI. Delegation

1. When determined as necessary and appropriate through the Anthem Provider evaluation process, Anthem may delegate certain responsibilities to other providers, community-based organizations, or internal teams until it is determined that the Provider is ready to take on said responsibility.

XII. Training

1. ECM Providers shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by Anthem, including in-person sessions, webinars, and/or calls, as necessary.
2. Refer to the Anthem ECM Provider Guide, Training and technical assistance, for more details.

XIII. Data Sharing to Support ECM

1. Anthem will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS and Anthem guidance for data sharing where applicable:
    a. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
    b. Encounter and/or claims data;
    c. Physical, behavioral, administrative and SDOH data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members; and
    d. Reports of performance on quality measures and/or metrics, as requested.
2. Refer to the Anthem ECM Provider Guide, Data exchange, for more details.

XIV. Quality and Oversight

1. ECM Provider acknowledges that Anthem will conduct oversight of its participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include site visits, audits and/or corrective actions.
2. ECM Provider shall respond to all Anthem requests for information and documentation to permit ongoing monitoring of ECM.
3. Program (e.g., ECM Director) and organization-level (e.g. CFO) leadership shall, at a minimum, attend bi-annual Performance Review meetings.
4. Provider shall comply with applicable monitoring provisions of the contract between Anthem and DHCS and any monitoring request by DHCS. Further, Provider agrees that Anthem shall revoke the delegation of activities or obligations, or specific other remedies in instances where DHCS or Anthem determine that Provider has not performed satisfactorily.
5. Refer to the Anthem ECM Provider Guide, Quality, monitoring and oversight, for more details.

Street Medicine

I. Service Overview, Background and Definition

I. Background and Definition: Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Typically, street medicine is provided for an individual experiencing unsheltered homelessness in their lived environment, places that are not intended for human habitation. Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed, specified

location does not qualify as street medicine, it is considered mobile medicine, as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location. Please note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine. Although mobile medicine does provide health and social services to individuals experiencing homelessness, DHCS envisions and expects the majority of these services provided to individuals experiencing unsheltered homelessness to be delivered in their lived environment via street medicine.

Street medicine directly aligns with California Advancing and Innovating Medi-Cal's (CalAIM) primary goal to identify and manage comprehensive needs through whole person care approaches and social drivers of health. Street medicine offers an opportunity to provide needed services to individuals who are experiencing unsheltered homelessness by meeting them where they are and utilizing a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address social drivers of health that impede health care access. The Department of Health Care Services (DHCS) considers street medicine to be a harm reduction tool and integral to avoiding an emergency department visit or hospitalization, providing access to Medically Necessary health care services, and connecting MCP Members to Community Supports that they may not otherwise access.

MCPs may cover the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers in the role of the Member's assigned Primary Care Provider (PCP), through a direct contract with the MCP, as an ECM Provider, as a Community Supports Provider, or as a referring or treating contracted Provider.

DHCS does not require a street medicine provider to be affiliated with a brick-and-mortar facility and has outlined various provisions for the different street medicine Provider roles. DHCS does not prescribe any particular contracting type for MCPs and street medicine providers.

- Street Medicine provider is certified as an ECM Provider and has agreed to render services in the manner referenced in Exhibit B. Please identify any limitations or qualifications to accept any member who meets the Street Medicine level of care criteria, e.g. only serve clients fleeing domestic violence.

  a. Inclusion Criteria (if applicable):

  N/A

  b. Exclusion Criteria (if applicable):

  N/A

- Service Capacity

  1. MCP may require Capacity Report information from street medicine providers upon request.

II. Street Medicine Policies and Provider Requirements

Provider Enrollment and Credentialing: MCP Network Providers, including street medicine Providers, are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so (5). The credentialing requirements outlined in APL 22-013 only apply to street medicine providers with a state-level pathway for Medi-Cal enrollment. If there is not a state-level enrollment pathway, the street medicine provider is not required to meet the credentialing requirements in APL 22-013 in order to become an "in-network" Provider. To include street medicine Providers in their Networks when there is no state-level Medi-Cal enrollment pathway,

MCPs are required to vet the qualifications of the street medicine Provider to ensure they can meet the MCP's standards of participation, similar to the credentialing process and requirements mentioned above. MCPs must create and implement their own processes to do this. Criteria that MCPs vetting processes include, but is not limited to:

- Sufficient experience providing similar services within the service area;
- Ability to submit claims or invoices using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;
- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the provider.

- Access Requirements: Anthem Blue Cross Medicaid Plan is not expected to contract with street medicine Providers in order to meet time and distance standards as part of Annual Network Certification requirements.

- Direct Contracting Arrangement: To facilitate direct access, DHCS encourages MCPs to contract directly with street medicine Providers. Even if the MCP delegates the provision of health care services to a Subcontractor, MCPs have an option to directly contract with street medicine Providers. Direct contracts with street medicine Providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and would reduce contracting complexity for street medicine Providers. For example, rather than having to contract with each subcontracted Independent Physician/Provider Association (IPA) in the MCP's Network, the street medicine Provider could directly contract with the MCP. In addition, the street medicine Provider would be subject to the same MCP administrative processes (e.g., billing protocols, credentialing requirements, authorization guidelines, etc.) rather than multiple processes and requirements under each subcontracting entity. The payment arrangement would be between the MCP and the street medicine Provider. Moreover, Prior Authorization to see a street medicine Provider would not be needed if the Member seeks services directly from a street medicine Provider related to the Member's primary care. This means that an MCP-contracted street medicine Provider, that meets all MCP-required administrative processes, could provide services to an MCP Member and receive payment for those services, even if the Member is assigned to a Subcontractor, such as a medical group or IPA. Under a direct contracting arrangement, the street medicine Provider must have the ability to refer Members to Medically Necessary Covered Services within the proper MCP network, and must coordinate care with the MCP, Subcontractor, and/or IPA as appropriate. MCPs would need to ensure Members have access to all Medically Necessary Covered Services and have appropriate referral and authorization mechanisms in place to facilitate access to needed services in the MCP's Network.

- Street Medicine Provider as an ECM Provider: ECM is delivered primarily by community-based ECM Providers that enter into contracts with MCPs. MCPs may contract with street medicine Providers to become an ECM Provider. A street medicine Provider can be contracted to provide both PCP and ECM services to a Member. ECM is primarily in-person based, and as such, ECM Providers are poised to build trust and facilitate coordinated care management with individuals experiencing unsheltered homelessness. Street medicine Providers that are also ECM Providers are required to enroll in Medi-Cal if there is a state-level enrollment pathway; fulfill all ECM requirements; have the capacity to provide culturally appropriate and timely in-person care management activities; and have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management(6). MCPs are responsible for ensuring non-duplication of services provided through ECM and any other covered benefit, program, and/or delivery system.

- Anthem Street Medicine Additional Provider Requirements:
    - Street Medicine Provider shall be experienced serving homeless members.
    - Street Medicine Provider shall have experience and expertise with the services it will provide;
    - Street Medicine provider is encouraged to utilize Homeless/Housing Navigation/Coordinated Entry data systems in all areas/counties they serve (e.g., Homeless Management Information System (HMIS data, read/write accounts, etc.)
    - Street Medicine Provider shall comply with all applicable state and federal laws and regulations and all DHCS Street Medicine benefit requirements
    - Street Medicine Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities and services
    - Street Medicine Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways;
    - Street Medicine Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including ECM, CS, and CHW Providers, to coordinate care as appropriate to each Member;
    - Street Medicine Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

  Contracted Street Medicine Providers who are also contracted ECM, CS, CHW, or other Provider types should provide separate and distinct services to authorized members when applicable

III. Medicaid Enrollment/Vetting for Providers

- If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal provider, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 22-013.
    a. If APL 22-013 does not apply to an ECM Provider, the ECM Provider must comply with Anthem's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

IV. Medi-Cal Eligibility

- Street medicine Providers are required to verify the Medi-Cal eligibility of individuals they encounter in the provision of health care services. Medi-Cal eligible individuals will be covered by either the Medi-Cal Fee-for-Service (FFS) or Medi-Cal managed care (with a corresponding MCP) delivery system. For those individuals without Medi-Cal coverage, the Hospital Presumptive Eligibility (HPE) program is one pathway for qualified HPE Providers to determine Medi-Cal eligibility. HPE provides qualified individuals immediate access to temporary Medi-Cal services while individuals apply for permanent Medi-Cal coverage. DHCS allows qualified HPE Providers to determine presumptive eligibility under the HPE program off the premises of hospitals and clinics, such as in mobile clinics, street teams, or other locations. Street medicine Providers are not required to participate in the HPE program but may do so if they meet and fulfill all qualifications and requirements of the HPE program.

V. Billing/Reimbursement:

Street medicine Providers rendering services to Medi-Cal eligible individuals are to bill Medi-Cal FFS, or the MCP if contracted, based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street medicine Providers must comply with the billing provisions for street medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual. For managed care Members, street medicine Providers must comply with the billing provisions for street medicine Providers as applicable to MCP policies and procedures.

If the street medicine Provider is an FQHC, they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located, and are using the correct CMS code. The FQHC would be paid their applicable PPS rate when the street medicine Provider is a billable clinic provider.

Street medicine Providers can also be reimbursed for providing State Plan benefits, including the use of Community Health Worker (CHW) services as defined in 42 CFR 440.130(c) and APL 22-016. MCPs are responsible for ensuring non-duplication of services provided by a CHW and any other covered benefit, program, and/or delivery system.

VI. Subcontracting

- Street Medicine Provider may subcontract with other entities or individuals in order to fulfill the obligations of Street Medicine. Provider shall maintain policies and procedures, approved by Anthem, to ensure that Subcontractors fully comply with all terms and conditions of this Agreement, applicable regulations and DHCS regardless of sub-contracting arrangements, Provider retains overall responsibility for all duties outlined in this agreement.
- If the Street Medicine Provider subcontracts with other entities to administer Street Medicine functions, the Street Medicine Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth here and that its Subcontractors comply with all requirements in these Standardized Terms and Conditions and DHCS APL guidance.
- If the Street Medicine Provider subcontracts, the Provider shall be responsible for all required reporting and coordination.
- Street Medicine Provider will disclose its subcontracting relationship to Anthem and demonstrate subcontractor readiness.
- Anthem reserves the right to allow or disallow a Provider’s subcontractor.

VII. Delegation

- When determined as necessary and appropriate through the Anthem Provider evaluation process, Anthem may delegate certain responsibilities to other providers, community-based organizations, or internal teams until it is determined that the Provider is ready to take on said responsibility.

VIII. Training

- ECM Providers shall participate in all mandatory, Provider-focused training and technical assistance provided by Anthem, including in-person sessions, webinars, and/or calls, as necessary.

Data Sharing, Reporting and Administration Requirements to Support Street Medicine

- Contracted street medicine Providers must comply with all applicable MCP data sharing and reporting requirements in accordance with federal and state laws and the MCP Contract based on provider contracting type. MCPs are to ensure street medicine Providers receive appropriate provider training and manuals and have adequate systems in place to adhere to data sharing and reporting requirements, such as for encounter, claims, and care coordination data. Additionally, street medicine

Providers must comply with all applicable MCP administration requirements in accordance with federal and state laws and the MCP Contract based on provider contracting type. MCPs are to ensure street medicine Providers receive appropriate provider training and manuals and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

- MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

IX. Quality and Oversight

- Street Medicine Provider acknowledges that Anthem will conduct oversight of its participation in Street Medicine to ensure the quality of Street Medicine and ongoing compliance with program requirements, which may include site visits, audits and/or corrective actions.
- Street Medicine Provider shall respond to all Anthem requests for information and documentation to permit ongoing monitoring of Street Medicine.
- Program Director and organization-level (e.g. CFO) leadership shall, at a minimum, attend bi-annual Performance Review meetings as required for ECM Providers.
- Provider shall comply with applicable monitoring provisions of the contract between Anthem and DHCS and any monitoring request by DHCS. Further, Provider agrees that Anthem shall revoke the delegation of activities or obligations, or specific other remedies in instances where DHCS or Anthem determine that Provider has not performed satisfactorily.

Community Supports

I. Service Overview

1. Community Supports are flexible wrap-around services or settings provided by the Anthem and integrated into its population health management programs. The services are provided as a substitute for utilization of other services or settings such as a hospital or skilled nursing facility admission, discharge delays, or emergency department use. CS will be integrated with care management for Members at medium to high levels of risk and fill gaps in state plan benefits to address medical or other needs that may arise from social determinants of health. See Exhibit B for in scope Community Supports.

II. CS Provider Requirements Provider Experience and Qualifications

1. Experience and training in the elected CS.
    a. The CS Provider shall have experience and/or training in the Provision of the CS being offered.
    b. The CS Provider shall have the capacity to provide the CS in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by Anthem.
2. If the CS Provider subcontracts with other entities to administer its functions of CS, the CS Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth here.
3. The CS provider will perform all services as outlined in the Anthem CS Program Guide and in the DHCS CS Policy Guide.
4. Contracted ECM Providers who are also contracted CS Providers should provide separate and distinct ECM and CS services to authorized members

III. Medicaid Enrollment/Vetting for CS Providers

1. CS Providers for whom a State-level enrollment pathway exists, shall enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    a. If APL 19-004 does not apply to an CS Provider, the CS Provider will comply with Anthem's process for vetting the CS Provider, which may extend to individuals employed by or

delivering services on behalf of the CS Provider, to ensure it can meet the capabilities and standards required to be an CS Provider.

IV. Initiating Delivery of Community Supports

1. CS Provider shall deliver contracted CS in accordance with DHCS service definitions and requirements.
2. CS Provider shall maintain staffing that allows for timely, high-quality service delivery of the CS that it is contracted to provide.
3. CS Provider shall:
    a. Accept and act upon member referrals from Anthem for authorized CS, unless the CS Provider is at its pre-determined capacity;
        i. Provider shall be permitted to decline a Member assignment if CS Provider is at its pre-determined capacity.
        ii. Provider shall immediately alert Anthem if it does not have the capacity to accept a Member assignment.
    b. Conduct outreach to the referred Member for authorized CS as soon as possible. Including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;
    c. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;
    d. Coordinate with other Providers in the Member's care team, including ECM Providers, other CS Providers and Anthem;
    e. Comply with cultural competency and linguistic requirements required by federal, State, and local laws, and in contract(s) with Anthem; and
    f. Comply with non-discrimination requirements set forth in State and Federal law and the Contract with Anthem.
    g. CS Provider will be reimbursed only for services that are authorized by Anthem. In the event of a Member requesting services not yet authorized by Anthem, CS Provider shall send prior authorization request(s) to Anthem, unless a different agreement is in place (e.g., if Anthem has given the CS Provider authority to authorize CS directly).
4. When federal law requires authorization for data sharing, CS Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to Anthem.
    a. Member authorization for CS-related data sharing is not required for the CS Provider to initiate delivery of CS unless such authorization is required by federal law.
5. If an CS is discontinued for any reason, CS Provider shall support transition planning for the Member into other programs or services that meet their needs.
6. CS Provider is encouraged to identify additional CS the Member may benefit from and send any additional request(s) for CS to Anthem for authorization.

V. Payment for CS

1. CS Provider shall record, generate, and send a claim or invoice to Anthem for CS rendered.
    a. If CS Provider submits claims, CS Provider shall submit claims to Anthem using specifications based on national standards and codes set to be defined by DHCS.
    b. In the event CS Provider is unable to submit claims to Anthem for CS-related services using specifications based on national standards or DHCS defined standard specifications code sets, CS Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the CS services rendered, and CS Providers' information to support appropriate reimbursement by Anthem, that will allow Anthem to convert CS invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.
2. CS Provider shall not receive payment from Anthem for the provision of any CS not authorized by Anthem.
3. CS Provider must have a system in place to accept payment from Anthem for CS rendered.

    a. Anthem will adjudicate Clean Claims submitted by Provider within thirty (30) working days of the date Anthem receives the claim. For purposes of determining compliance with the stated time frames, the date of receipt is the date that Anthem receives the claim, as

indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

VI. Data Sharing to Support CS

1. As part of the referral process, Anthem will ensure CS Provider has access to:
   a. Demographic and administrative information confirming the referred Member's eligibility for the requested service;
   b. Appropriate administrative, clinical, and social service information the CS Provider might need in order to effectively provide the requested service; and
   c. Billing information necessary to support the CS Provider's ability to submit invoices to Anthem.
2. Refer to the Anthem CS Provider Guide for more details.

VII. Quality and Oversight

1. CS Provider acknowledges Anthem will conduct oversight of its delivery of CS to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both Anthem and the CS Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

VIII. Electronic Visit Verification (EVV)

1. EVV must be implemented for all Medi-Cal Personal Care Services (PCS) and Home Health Care Services (HHCS) for in-home visits by a Provider. This includes, but is not limited to, PCS and HHCS delivered as part of Community Supports – Personal Care and Homemaker Services, Respite Services, Day Habilitation Programs – and all other HHCS programs covered under the contract between DHCS and Anthem. Implementation of EVV is only required for PCS and HHCS delivered in a member's home, including visits that begin in the community and end in the home (or vice versa).
2. Exclusions:
   a. The following services are not subject to EVV requirements:
      1. HHCS or PCS that do not require an in-home visit are not subject to EVV requirements;
      2. HHCS or PCS provided in congregate residential settings where 24-hour service is available are not subject to the EVV requirements;
      3. HHCS or PCS rendered by an individual living in the member's residence does not constitute an "in-home visit" and is not subject to EVV requirements,
      4. Any services rendered through the Program of All-Inclusive Care for the Elderly;
      5. HHCS or PCS that are provided to inpatients or residents of a hospital, nursing facility including skilled nursing facility or residence of nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases;
      6. Durable Medical Equipment is not subject to EVV requirements.
3. State EVV Vendor:
   a. The State of California contracted with Sandata Technologies, LLC (Sandata) to provide a state-sponsored EVV system. Sandata is providing California with an EVV system that includes the ability to capture data elements during the visit, data portals that allow providers to view and report on visit activity, and an EVV Aggregator to provide California with EVV program oversight and analytics. The EVV Aggregator will also receive data from providers that choose to use their existing EVV system, support California's Open EVV model, and provide a meaningful data and analytics dashboard. Additionally, training videos for the Aggregator and the Business Intelligence tool will be available online, which demonstrate functionality and capabilities.
   b. Anthem is not required to use the state-contracted EVV system. However, use of the Sandata EVV system is free to Anthem, and their subcontractors and network providers, to use for capturing and transmitting required EVV data components to the EVV Aggregator. If Anthem chooses to contract with a different EVV vendor, the resulting administrative service agreement must be filed with the Department of Managed Health Care.
4. All Medi-Cal PCS and HHCS providers must capture and transmit the following six mandatory data components:
   a. The type of service performed;

b. The individual receiving the service;
c. The date of the service;
d. The location of service delivery;
e. The individual providing the service; and
f. The time the service begins and ends.

5. All network providers are required to comply with the EVV requirements when rendering PCS and HHCS, subject to federal EVV requirements. Anthem shall monitor provider to ensure compliance with these requirements in accordance with the established guidelines below:
   a. Monitor Provider for compliance with the EVV requirements and CalEVV Information Notice(s), and alert DHCS to any compliance issues.
   b. Supply Provider with technical assistance and training on EVV compliance.
   c. Require Provider to comply with an approved corrective action plan.
   d. Deny payment if the provider is not complying with EVV requirements and arrange for the participants to receive services from a provider who does comply.
6. If Provider is identified as non-compliant with these requirements, Anthem will not authorize the Network Provider to perform services and/or withhold the payment. If non-compliance is committed by the employee of Provider's subcontractor, the specific non-compliant subcontractor employee will not be able to provide Medi-Cal PCS and HHCS services.
7. EVV System – Provider Self-Registration and Training
   a. To the extent that Provider provides Community Supports – Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs, Anthem requires that their Provider and its subcontractors complete the self-registration process immediately to gain access to the state-sponsored EVV system and EVV Aggregator and be trained on how to operate the solution, and capture the six data elements with each in-home visit.
      1. Once registered, Provider and Provider's subcontractors will gain access to extensive training and technical assistance, including self-guided learning modules and EVV system demonstrations, provided by Sandata.
   b. Information on the self-registration portal and the link can be found on the DHCS website at: https://www.dhcs.ca.gov/provgovpart/Pages/EVV.aspx
8. Alternate EVV System:
   a. Anthem and its network have the option to implement EVV requirements using an alternate EVV system.
   b. Any alternate EVV system must comply with all business requirements and technical specifications, including the ability to capture and transmit the required data elements to the EVV Aggregator.
   c. Anthem, its subcontractors, and network providers who choose to use an alternative EVV system are required to register in the EVV self-registration portal and must participate in state-sponsored training provided by Sandata.
9. All claims submitted by Provider for PCS and HHCS services must be submitted with allowable Current Procedural Terminology or Healthcare Common Procedure Coding System codes as outlined in the Medi-Cal Provider Manual. MCPs and/or provider must also indicate proper Place of Service Code or Revenue Code on claims and/or encounters to indicate the rendering of PCS or HHCS in a member's home.
10. DHCS will monitor Anthem's' implementation through existing data reporting mechanisms, including reviewing encounter data and will include EVV implementation and requirements in the scope of the annual medical audit.

EXHIBIT F

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of [5%] or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **Please attach a separate sheet if necessary.**

Answer all questions as of the current date. If additional space is needed, note on the form that the answer is being continued and attach a sheet referencing the relevant item number. Please return the original to us and retain a copy for your files. If a question is not applicable, respond N/A for that question. You should completely answer all applicable questions — No questions should be left blank.

You must provide dates of birth and Social Security numbers (SSNs) for validation purposes as outlined in 42 CFR 455.104 (b)(1)(ii).

Identifying information		
Provider entity name:	Provider DBA name (if different from provider entity name):	Entity NPI:
Entity TIN:	Medicaid ID:	Provider phone #:

Provider address — List all practice locations. Must include at least one street address. Attach a separate sheet if needed.	City	State	ZIP

Owner or control information

An **owner** is a person or business entity that owns [5%] or more of the assets, stock, or profits of the provider entity. This [5%] may be **direct** ownership or **indirect** ownership. (for example, an individual might own [50%] of a company that owns the actual **provider entity**. This means that the indirect ownership is [50%.]) In addition to ownership of stock, an owner also has a legal obligation like a mortgage or loan that is secured by the assets of the provider entity.

A **person with control** is someone who directs the provider entity — this includes directors, trustees and officers of corporations, and partners in a partnership. If the provider entity is a nonprofit entity, respond N/A in the column for percent of ownership

A **managing employee** is someone who makes the day-to-day decisions for the provider entity. These individuals include office or billing managers for smaller providers; for larger provider entities, a managing employee may be the head of a major operating group such as the director of Accounting, director of same- day services or another executive/management position typically listed below the corporate officers on an organizational chart.

An **agent** is an individual who has the legal ability to bind the provider entity (for example, the provider entity may use an agent to obtain contracts on its behalf). Please provide the following information for owners, persons with control interests, managing employees and agents of the provider entity. Attach a separate sheet if needed.

List the name, title, address, date of birth (DOB), and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of [5%] or greater.

List the name, tax identification number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of [5%] or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Master list		
Last name:	First name:	Middle initial:
Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		City:
State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:
Last name:	First name:	Middle initial:
Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		City:
State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:
Last name:	First name:	Middle initial:
Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		City:
State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:

Specific questions:		
1. Is any person on the master list related to another person on the master list (spouse, parent, child or sibling)? Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information:***		
If yes, please provide the following information about the related persons.		**Relationship**
Full name of first related person		
Full name of second related person		
2. Does any person or entity in the master list have an ownership or control interest in any other provider entity? Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information about the other provider entity in which the person on the master list has an interest.***		
Name of other provider entity:	Address:	City:
State:	ZIP:	TIN:
3. Has any person or entity on the **master list** ever been **excluded** from participation in federal healthcare programs (Medicaid, CHIP or TRICARE) in the past? Excluded means that a provider or entity has been told by the Department of Health and Human Services — Office of the Inspector General (HHS OIG) that they may no longer be a provider for any federally funded healthcare program. Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information.***		
Full name of individual or entity:	Beginning date of exclusion or termination:	End date of exclusion or termination:
Reason for exclusion or termination:		
4. Since the inception of Medicaid, CHIP or TRICARE, were any of the individuals or entities on the **master list** convicted of a criminal offense related to that person's involvement in a related program? Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following requested information.***		
Name on court records:	SSN:	DOB:
Matter of the offense:	Date of the conviction:	Exclusion period of the offense if excluded by the HHS OIG:
5. Were any of the individuals or entities on the **master list** ever **debarred** from participation in federal government contracts? **Debarred** means an individual is not allowed to participate in contracts paid for by the federal government whether or not those contracts are in the healthcare area. Yes ☐ No ☐ ***If no, go to the next question. If yes is checked, provide the following information.***		
Date of debarment:	Length of debarment:	
Reason for debarment:		
6. Was any person or entity on the master list ever terminated from a state's Medicaid or CHIP program for reasons having to do with program integrity (fraud or abuse)? Terminated means the provider lost the right to bill a state's Medicaid or CHIP programs for a cause related to fraud or abuse. Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information.***		
Full name of provider:	State of practice when terminated:	
Reason for termination:	Date of termination:	

7. Did any person or entity on the **master list** ever have civil monetary penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a provider by a governmental agency that manages a federal healthcare program. Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information.***			
Full name of the individual or entity:		State of practice when the CMP assessed:	
Reason for CMP:	Amount of CMP:	Date of CMP:	
8. Did anyone on the master list obtain ownership interest? Yes ☐ No ☐			
a. As a result of a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal healthcare program, or was in fact excluded or terminated from participation in a federal healthcare program?			
b. Due to circumstances of the original owner being a member (currently or formerly) of the current owner's immediate family or household at the time of the transfer of ownership?			
9. **Immediate family** is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in- law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Member of household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit. This includes domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of the household. Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information.***			
Full name of original owner:		SSN or TIN of original owner:	
Place of transfer:		Date of transfer:	
10. List any **subcontractor** in which this **provider entity** has a direct or indirect **ownership** interest of at least [5%]. A **subcontractor** is a person or company that this **provider entity** contracted with to do some of the **provider entity's** management functions (for example, a billing agent or medical services provider such as a medical lab).			
Full name of subcontractor:		Address:	
City:	State:	ZIP:	TIN
Full name of subcontractor:		Address:	
City:	State:	ZIP:	TIN
a. For each **subcontractor(s)** listed above, please provide the following information for the individuals with an **ownership** or **control** interest in the **subcontractor(s)**. See the previous sections above for a definition of these terms. **Attach a separate sheet if necessary.**			
Full name:	Address (for individuals, home address; for business entities that might have ownership interest, use business street address and P.O. Box address if any):		

City:	State:	ZIP:	DOB:
Individual (SSN)/ Entity (TIN):	Percentage of ownership:	Title:	

b. Is anybody on the list above related to any person on the **master list**? Yes ☐ No ☐ ***If no, go to the next question. If yes, please provide the following information about the related persons.***

Full name of first related person:	Relationship:
Full name of second related person:	Relationship:

Business transactions

1. Has the **disclosing entity** had any financial transaction/significant business transactions with any **subcontractor** totaling more than [$25,000]? Yes ☐ No ☐ ***If no, go to the next question*** If *yes*, list the ownership of any **subcontractor** with whom this provider had one or more business transactions totaling more than [$25,000] during the previous [12-month period], any significant business transactions between this **provider** and any wholly owned **supplier**, or between the **provider** and any **subcontractor** during the past [five-year period.]

Full name:	Address:	
City:	State:	ZIP:

2. Does the **provider entity wholly own** a **supplier**? **Supplier** means an individual, agency or organization from which the **provider entity purchases goods and services** used in carrying out its responsibilities under Medicaid (for example, a commercial laundry, a manufacturer of hospital beds or a pharmacy). Yes☐ No ☐ ***If no, go to the next question If yes, supply the following information about the supplier.***

Name:	Address:	
City:	State:	ZIP:
NPI:	TIN:	

Signature

The state or federal Medicaid agency may refuse to enter into, renew or terminate an agreement with a provider if it is determined that a provider did not fully, accurately and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. The signature below **must** be the written signature of an individual who can legally bind this **provider entity**.

In compliance with *42 CFR 455.104(c)*, a provider shall provide a *Disclosure of Ownership* (*DOO*) upon application for network participation and/or prior to execution of a provider agreement at the time of recredentialing/reenrollment. A provider must provide the *DOO* within 35 days after any change in ownership of the disclosing entity. In compliance with *42 CFR 455.105(b)*, a provider must submit full and complete ownership information within 35 days of the date on a request by the secretary or the Medicaid agency outlined above in *Section III. Business Transactions*.

Name of person (printed):	Signature of person:
Title:	Date:
Name of person completing form:	Phone number of person completing form:

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

BUSINESS ASSOCIATE AGREEMENT

If, during the term of any Agreement between Supplier and Elevance Health and/or any of its affiliates ("Elevance Health"), Supplier requires the use or disclosure of Protected Health Information, including creating, receiving, maintaining, or transmitting Protected Health Information, then Supplier shall be deemed a Business Associate of Elevance Health and the following provisions shall apply:

This agreement ("Agreement") shall be effective on the date of Supplier's signature and is between the Supplier ("Business Associate") identified in this Agreement and Elevance Health on behalf of itself and its affiliates who are Covered Entities or Business Associates and who have a business relationship with Business Associate, if any (hereinafter collectively "Company"). The purpose of this Agreement is to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, the HITECH Act, and their implementing regulations (45 C.F.R. Parts 160-164, including Subpart E of 45 CFR Part164) ("HIPAA"), any applicable state privacy laws, any applicable state security laws, any applicable implementing regulations issued by the Insurance Commissioner or other regulatory authority over data protected herein.

Privacy of Protected Health Information

1. Permitted and Required Uses and Disclosures. Business Associate is permitted or required to Use or disclose Protected Health Information ("PHI") it requests, creates, or receives for or from Company (or another business associate of Company) only as follows:

   a) Functions and Activities on Company's Behalf. Business Associate is permitted to request, Use, or disclose PHI it creates or receives for or from Company (or another business associate of Company), consistent with HIPAA, only as described in this Agreement, or other agreements during their term that may exist between Company and Business Associate.

   b) Business Associate's Operations. Business Associate may Use PHI it creates or receives for or from Company as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may disclose such PHI as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

   (i) The Disclosure is Required by Law; or

   (ii) Business Associate obtains reasonable assurance evidenced by written contract, from any person or organization to which Business Associate will disclose such PHI that the person or organization will:

   a. Hold such PHI in confidence and Use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or Required by Law; and

   b. Notify Business Associate (who will in turn promptly notify Company) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

   c) Data Aggregation Services. Business Associate may provide Data Aggregation services relating to the Health Care Operations of the Company the extent required to provide services to Company or as otherwise expressly permitted by Company.

d) Minimum Necessary and Limited Data Set. In any instance when Business Associate requests, Uses, or discloses PHI under this Agreement or in accordance with other agreements that exist between Company and Business Associate, Business Associate may request, Use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose. Business Association will Use a Limited Data Set, if applicable. Business Associate will not be obligated to comply with this minimum necessary limitation with respect to requests, Uses, or discloses as outlined in 45 C.F.R. § 164.502(b)(2).

e) Use by Workforce. Business Associate shall advise members of its workforce of their obligations to protect and safeguard PHI. Business Associate shall take appropriate disciplinary action against any member of its workforce who Uses or discloses PHI in contravention of this Agreement.

f) Disclosure to U.S. Department of Health and Human Services. Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of PHI received from Company (or created or received by Business Associate on behalf of Company) available to the Secretary of the United States Department of Health and Human Services, for purposes of determining Company's compliance with 45 C.F.R. Parts 160-164. Unless the Secretary directs otherwise, Business Associate shall promptly notify Company of Business Associate's receipt of such request, so that Company can assist in compliance with that request.

g) Substance Use Disorder Records. To the extent that PHI exchanged between the parties includes information on an individual's Substance Use Disorder, the parties agree to comply with the applicable requirements of 42 C.F.R. Part 2 ("Confidentiality of Substance Use Disorder Patient Records") including its provisions on disclosure and re-disclosure of said information.

2. Prohibitions on Unauthorized Requests, Use or Disclosure. Business Associate will neither Use nor disclose Company's PHI it creates or receives from Company or from another Business Associate of Company, except as permitted or required by this Agreement or as Required by Law or as otherwise permitted in writing by Company. This Agreement does not authorize Business Associate to request, Use, disclose, maintain or transmit PHI in a manner that will violate 45 C.F.R. Parts 160-164.

3. Sub-Contractors and Agents. Business Associate will require any of its Subcontractors and/or agents that create, receive, maintain, or transmit such PHI to provide reasonable assurance, evidenced by written contract, that Subcontractor or agent will comply with the same privacy and security commitments that are substantively equivalent to those in this Agreement with respect to such PHI, including the obligations described in Section 4 herein.

4. Information Safeguards. Business Associate must use appropriate safeguards to comply with Subpart C of 45 CFR Part 164 and must implement, maintain and use a written information security program that contains the necessary administrative, technical and physical safeguards that are appropriate in light of the Business Associate's size and complexity in order to achieve the safeguarding objectives as detailed in Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 C.F.R. Part 164.530(c), the HITECH Act and any other implementing regulations issued by the U.S. Department of Health and Human Services, as such may be amended from time to time and as required by the Required Information Security Controls exhibit attached to this agreement. Further, Business Associate shall comply with any applicable state data privacy or security law. Business Associate shall notify Company should Business Associate determine it is unable to comply with any such law or regulation.

5. Audits and Surveys. Company shall have the right to audit and monitor all applicable activities and records of Business Associate to determine Business Associate's compliance with the requirements relating to the maintenance, Use, Disclosure, and creation of PHI [and De-Identified Data (DID), if applicable]. At Company's request in lieu of a formal audit, the Business Associate shall provide Company with information concerning its information safeguards and privacy practices as they pertain to PHI.

   During the term of this Agreement, Business Associate may be asked to complete a privacy and security survey and/or attestation document designed to assist Covered Entity in understanding and documenting Business Associate's security procedures and compliance with the requirements contained herein. Business Associate's failure to complete either of these documents within the reasonable timeframe specified by Covered Entity shall constitute a material breach of this Agreement.

   Upon reasonable advance request, Business Associate shall provide Company access to Business Associate's facilities used for the maintenance or processing of PHI, and to its books, records, practices, policies and procedures concerning the Use and Disclosure of PHI, in order to determine Business Associate's compliance with this Agreement. Any such access to Business Associate facilities may be limited to the extent required to protect other entities' PHI or confidential information.

Individual Rights

6. Access. Business Associate will promptly upon Company's request make available to Company or, at Company's direction, to the Individual (or the Individual's Personal Representative) for inspection and obtaining copies any PHI about the Individual which Business Associate created or received for or from Company and that is in Business Associate's custody or control, so that Company may meet its access obligations pursuant to and required by applicable law, including but not limited to 45 C.F.R. 164.524, and where applicable, the HITECH Act. Business Associate shall make such information available in electronic format where directed by the Company.

7. Amendment. Business Associate will, upon receipt of notice from Company, promptly amend or permit Company access to amend any portion of the PHI which Business Associate created or received for or from Company, pursuant to and required by applicable law, including but not limited to 45 C.F.R. Part 164.526.

   Business Associate will not respond directly to an Individual's request for an amendment of their PHI held in the Business Associate's Designated Record Set. Business Associate will refer the Individual to Company so that Company can coordinate and prepare a timely response to the Individual.

8. Disclosure Accounting. So that Company may meet its Disclosure accounting obligations pursuant to and required by applicable law, including but not limited to 45 C.F.R. Part 164.528 Business Associate will promptly, but no later than within seven (7) days of the Disclosure, report to Company for each Disclosure Business Associate makes of Company PHI not expressly excepted from the right to an accounting as described in 45 CFR 164.528(a)(1)(i)-(ix). For each Disclosure for which a report is required by this section, Business Associate will provide the following information as described in 45 CFR 164.528(b).

   Except as provided below, Business Associate will not respond directly to an Individual's request for an accounting of Disclosures. Business Associate will refer the Individual to Company so that

Company can coordinate and prepare a timely accounting to the Individual. However, when Business Associate is contacted directly by an individual based on information provided to the individual by Company, Business Associate shall make the accounting of disclosures available directly to the individual, but only if required by the HITECH Act or any related regulations.

9. Confidential Communications and Restriction Agreements. Business Associate will promptly, upon receipt of notice from Company, send an Individual's communications to the identified alternate address. Business Associate will comply with any agreement Company makes that restricts Use or Disclosure of Company's PHI pursuant to 45 C.F.R. §164.522(a), provided that Company notifies Business associate in writing of the restriction obligations that Business Associate must follow. Company will promptly notify Business associate in writing of the termination or modification of any confidential communication requirement or restriction agreement.

Breach of Privacy and Security Obligations

10. Reporting. Business Associate will report to Company: (i) any Use or Disclosure of PHI not permitted by this Agreement or in writing by Company; (ii) any Security Incident; (iii) any Breach, as defined in the HITECH Act; or (iv) any other breach of a secure system, or the like, as such may be defined under applicable state law (collectively a "Breach"). Except as described in subparagraph "c)" below, Business Associate will, without unreasonable delay, but nolater than within one (1) business day after Business Associate's discovery of a Breach, make the report by sending a report to Company by such reasonable means of reporting as may be communicated to Business Associate by Company. Business Associate shall cooperate with Company in investigating the Breach and in meeting Company's obligations under the HITECH Act, and any other applicable security breach notification laws or regulatory obligations.

a) Report Contents. To the extent such information is available Business Associate's report will at least:

(i) Identify the nature of the non-permitted or prohibited access, Use or Disclosure, including the date of the Breach and the date of discovery of the Breach;

(ii) Identify the PHI accessed, used or disclosed, and provide an exact copy or replication of the PHI, as appropriate, in a format reasonably requested by Company, and to the extent available;

(iii) Identify the entity that and if applicable, the role of the individual, who caused the Breach and who received the PHI;

(iv) Identify what corrective action Business Associate took or will take to prevent further Breaches;

(v) Identify what Business Associate did or will do to mitigate any deleterious effect of the Breach; and

(vi) Provide such other information, including a written report, as Company may reasonably request.

b) Unsuccessful Security Incidents. Except as noted in paragraph 10 (c) below, the parties acknowledge and agree that this section constitutes notice by Business Associate to Company of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined

below) for which no additional notice to Company shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, Use or disclosure of PHI.

c) Medicare Vendor Reporting Requirements –To the extent that Business Associate is subject to any Center for Medicare and Medicaid ("CMS") incident reporting requirements (including applicable timeframes for such reporting) as detailed in the services agreement between Company and Business Associate (including any amendments, exhibits or addenda), Business Associate shall comply with all such reporting requirements, in addition to those imposed hereby.

11. Mitigation. Business Associate agrees to mitigate to the extent practicable, any harmful effect that is known to Business Associate of any security incident related to PHI or any Use or Disclosure of PHI by Business Associate in violation of the requirements of this BA Agreement. To the extent Company incurs any expense Company reasonably determines to be necessary to mitigate any Breach or any other non-permitted Use or Disclosure of Individually Identifiable Information, including without limitation transition costs, Business Associate shall reimburse Company for such expense. Business Associate shall be liable for any costs or expense incurred by Company related to the investigation, remediation, mitigation, incident response, and reporting of Breaches of this Agreement and/or any non-permitted or prohibited Use or Disclosure of PHI by Business Associates, its officers, employees, agents, and/or subcontractors, including without limitation, services for credit monitoring and/or a call center, costs associated with notifying members of a Breach, data recovery costs, system remediation, forensic investigation costs or any other breach response requirements that are imposed on Company. If requested by Company, Business Associate will reimburse Company for any cost or expense associated with the resources and employee time spent by Company investigating or managing Business Associate's security incident or Breach.

12. Breach of Agreement. Without limiting the rights of the parties elsewhere set forth in the Agreement or available under applicable law, if Business Associate breaches its obligations under this Agreement, Company may, at its option:

a) Exercise any of its rights of access and inspection under paragraph 5 of this Agreement;

b) Require Business Associate to submit to a plan of monitoring and reporting, as Company may determine appropriate to maintain compliance with this Agreement and Company shall retain the right to report to the Secretary of HHS any failure by Business Associate to comply with such monitoring and reporting; or

c) Immediately and unilaterally, terminate this Agreement and/or any other agreements between the parties, without penalty to Company, and with or without an opportunity to cure the breach. Company's remedies under this Section and set forth elsewhere in this Agreement or in any other agreement between the parties shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other. If for any reason Company determines that Business Associate has breached the terms of this Agreement and such breach is not curable or if curable, has not been cured, but Company determines that termination of this Agreement and/or any other agreements between the parties is not feasible, Company may report such breach to the U.S. Department of Health and Human Services.

Compliance with Standard Transactions

Sections 13 through 17 of this Agreement are only applicable to those Business Associates that conduct, in whole or in part Standard Transactions, for or on behalf of Company.

Business Associate will comply, and will require any Subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162 for which HHS has established Standards. Business Associate will comply by a mutually agreed date, but no later than the date for compliance with all applicable final regulations, and will require any Subcontractor or agent involved with the conduct of such Standard Transactions, to comply, with each applicable requirement of the Transaction Rule 45 C.F. R. Part 162.

13. Business Associate agrees to demonstrate compliance with the Transactions by allowing Company to test the Transactions and content requirements upon a mutually agreeable date. Business Associate will not enter into, or permit its Subcontractors or agents to enter into, any trading partner agreementin connection with the conduct of Standard Transactions for or on behalf of Company that:

    a) Changes the definition, data condition or use of a data element or segment in a Standard Transaction.

    b) Adds any data elements or segments to the maximum defined data set;

    c) Uses any code or data element that is marked “not used” in the Standard Transaction’s Implementation Specification or is not in the Standard Transaction’s Implementation Specification;or

    d) Changes the meaning or intent of the Standard Transaction’s Implementation Specification.

14. Concurrence for Test Modification to Standard Transactions. Business Associate agrees and understands that there exists the possibility that Company or others may request from HHS an exception from the Uses of a Standard in the HHS Transaction Standards. If this request is granted by HHS, Business Associate agrees that it will participate in such test modification.

15. Incorporation of Modifications to Standard Transactions Business Associate agrees and understands that from time-to-time, HHS may modify and set compliance dates for the Transaction Standards. Business Associate agrees to incorporate by reference into this Agreement any such modifications or changes.

16. Code Set Retention (Only for Plans). Both parties understand and agree to keep open code sets being processed or used in the Agreement for at least the current billing period or any appeal period, whichever is longer.

17. Guidelines and Requirements**.** Business Associate further agrees to comply with any guidelines or requirements adopted by Company consistent with the requirements of HIPAA and any regulations promulgated thereunder, governing the exchange of information between Business Associate and the Company.

Obligations upon Termination

18. Return or Destruction**.** Upon termination, cancellation, expiration or other conclusion of the Agreement, Business Associate will if feasible return to Company or destroy all PHI, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Company, including all copies of and any data or compilations derived from and allowing identification of any Individual who is a subject of the PHI. Business Associate will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of Agreement. Business Associate shall destroy all PHI in accordance with any guidance set forth by the Secretary of HHS and/or any other government agency or other entity to whom HHS delegates such authority Business Associate will identify any PHI that Business Associate created or received for or from Company that cannot feasibly be returned to Company or destroyed, and will limit its further Use or Disclosure of that PHI to those purposes that make return or destruction of that PHI infeasible and will otherwise continue to protect the security any PHI that is maintained pursuant to the security provisions of this Agreement for so long as the PHI is maintained. Upon request, Business Associate will certify in writing to Company that such return or destruction has been completed, will deliver to Company the identification of any PHI for which return or destruction is infeasible and, for that PHI, will certify that it will only Use or disclosesuch PHI for those purposes that make return or destruction infeasible.

19. Continuing Privacy and Security Obligation**.** Business Associate's obligation to protect the privacy and security of the PHI it created or received for or from Company will be continuous andsurvive termination, cancellation, expiration or other conclusion of this Agreement, so long as the data is maintained.

General Provisions

20. Definitions**.** Except as otherwise provided, the capitalized terms in this Agreement have the meanings set out in 45 C.F.R. Parts 160-164, as may be amended from time to time. The term Protected Health Information ("PHI") includes any information without regard to its form or medium, gathered by Business Associate in connection with Business Associate's relationship with Covered Entity that identifies an individual or that otherwise would be defined as Protected Health Information under HIPAA. The term "business associate" in lower case shall have the meaning set out in 45 CFR 160.103.

21. Amendment. From time to time local, state or federal legislative bodies, boards, departments or agencies may enact or issue laws, rules, or regulations pertinent this Agreement. In such event, Business Associate agrees to immediately abide by all said pertinent laws, rules, or regulations and to cooperate with Company to carry out any responsibilities placed upon Company or Business Associate by said laws, rules, or regulations.

22. Conflicts. The terms and conditions of this Agreement will override and control any conflicting term or condition of any other agreement between the parties with respect to the subject matter herein. All non-conflicting terms and conditions of the said other agreement(s) remain in full force and effect.

23. Owner of PHI. As between the parties, Company is the exclusive owner of PHI generated or used under the terms of the Agreement.

24. Subpoenas. Business Associate will promptly inform Company of any subpoena Business Associate receives with regard to PHI belonging to Company and cooperate with any Company request or effort to limit Disclosure pursuant to such subpoena.

25. Disclosure of De-identified Data. The process of converting PHI to De-identified Data (DID) is set forth in 45 C.F.R Part 164.514. In the event that Company provides Business Associate with DID, Business Associate shall not be given access to, nor shall Business Associate attempt to develop on its own, any keys or codes that can be used to re-identify the data. Business Associate shall only Use DID as directed by Company.

26. Creation of De-identified Data. In the event Business Associate wishes to convert PHI to DID, it must first subject its proposed plan for accomplishing the conversion to Company for Company's approval, which shall not be unreasonably withheld provided such conversion meets the requirements of 45 C.F.R. Part 164.514. Business Associate may only Use DID as directed or otherwise agreed to by Company.

27. Assignment/Subcontract. Company shall have the right to review and approve any proposed assignment or subcontracting of Business Associate's duties and responsibilities arising under the Agreement, as it relates to the Use or creation of PHI (or DID if applicable].

28. Intent. The parties agree that there are no intended third party beneficiaries under this Agreement.

29. Indemnity. Business Associate will indemnify and hold harmless Company and any Company affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or prohibited Use or Disclosure of PHI or other breach of this Agreement by Business Associate or any Subcontractor, agent, person or entity under Business Associate's control.

IN WITNESS WHEREOF, Company and Business Associate execute this Agreement in multiple originals to be effective on the date of Business Associate's Signature below:

County of Fresno	**ANTHEM**
Name of Business Associate	*Name of Company*
By: _____	By: _____
Signature	*Signature*
Ernest Buddy Mendes	Michael Piellucci
Printed Name	*Printed Name*
Chairman, County of Fresno Board of Supervisors	Regional Vice-President
Title	*Title*
12/9/25	12/03/2025
Date	*Date*

ATTEST:
BERNICE E. SEIDEL
Clerk of the Board of Supervisors
County of Fresno, State of California
By _____ Deputy

Required Information Security Controls

This Required Information Security Controls Exhibit ("Exhibit") to the attached agreement ("Agreement") establishes the minimum standards for physical, technical, and administrative controls affecting Data received, maintained, transmitted, accessed, or processed by the supplier of the services Elevance Health has retained (respectively, "Supplier and "Services").

Data. As used in this Exhibit, means Elevance Health Confidential Information.

Security Incident. For the purposes of this Exhibit, Security Incident means an occurrence that results, or is reasonably likely to result, in the unauthorized access, use, or disclosure, of security, confidentiality, integrity, or availability of Data, or the systems that store, processes and/or transmit Data. In addition to, and not in lieu of the definition of Security Incident elsewhere in the Agreement, for the purposes of this Exhibit, a Security Incident shall be deemed to include without limitation, a failure to comply with this Exhibit or any security or confidentiality obligations in the Agreement, or any event defined as a Security Incident by Applicable law, or a use or disclosure of Data contrary to the Agreement shall be deemed a Security Incident.

1. **Compliance**

1.1. Supplier must comply with all applicable state and federal data security laws, regulations, and guidance ("Applicable Law"), and shall abide by all required security controls as stated in the Agreement, including this Exhibit.

1.2. In the event Supplier is permitted under the Agreement to utilize vendors, agents and/or subcontractors to collect, transmit, share, store, control, process, manage and access or otherwise handle Data, Supplier must:

1.2.1. Maintain contractual obligations binding upon each vendor, agent and/or subcontractor that meet or exceed the responsibilities, obligations and controls established in the Agreement, including this Exhibit.

1.2.2. Regularly assess and monitor said vendors, agents, and subcontractors control environments for compliance with the Agreement, including this Exhibit.

1.2.3. Require said vendors, agents, and subcontractors to remediate of any non-compliance with the Agreement, including this Exhibit, within five (5) business days.

1.2.4. Immediately notify Elevance Health if its vendor, agent, or subcontractor's non-compliance could reasonably be expected to lead to a Security Incident if not corrected or if the non-compliance if not corrected as outlined in Section 1.2.3.

2. Information Security Program

2.1. Supplier must maintain a written information security program including documented policies, standards, and operational practices ("Supplier's Information Security Program") that:

2.1.1. Meets or exceeds industry standards for the nature of the services provided and the requirements and controls set forth in this Exhibit and Applicable Law; and

2.1.2. Identify a security official within the organization responsible for enforcement of the program; and

2.1.3. Are reviewed by Supplier's security official, or its designee, at least annually and shall be updated periodically with changes to organization, technology, or Services.

2.2. Supplier shall notify Elevance Health of any material changes to systems, facilities, architecture, technology or written information security program controls affecting the security, confidentiality, integrity, and availability of Data. This notification should set forth in detail how such changes will impact Data. Supplier will conduct a risk assessment consistent with Section 2.6 herein.

2.3. Supplier shall apply appropriate sanctions against workforce members who fail to comply with its written information security program.

2.4. Within its information security program, Supplier shall maintain an Incident Response Program includes a written plan outlining the processes and procedures in place so that information security events and Security Incidents will be reported, investigated, mitigated, and resolved promptly and without unreasonable delay. Such processes and procedures for Event reports must be tested, reviewed, and updated, by Supplier periodically. All personnel, vendors, agents, and subcontractors of Supplier shall be contractually obligated to report all information security Events and Security Incidents prior to being granted access to any Data. If at any time Supplier becomes aware of a Security Incident, Supplier will promptly, and in no event later than 24 hours, notify the Elevance Health Cybersecurity Incident Response Team at csirt@ElevanceHealth.com.

2.5. Supplier shall promptly respond to all reasonable requests of Elevance Health to meet its vendor oversight and incident response obligations including but not limited to an attestation required in support of network and operational reinstatement post Incident. For Incidents involving a cyber-attack, the attestation will contain confirmation that the known threat has been eradicated from the Supplier environment and recommended mitigation is in place or a roadmap to implementation is in place and underway. Supplier will eradicate the known threat and remediate the effect of any Security Incidents caused by Supplier or through the Services at no additional cost to Elevance Health.

2.6. Supplier shall periodically, but in any event no longer than once every three (3) years, conduct an accurate and thorough risk assessment of the potential threats and vulnerabilities to the confidentiality, integrity, and availability of data and its network, systems, and infrastructure, including on premises, cloud, remote and virtual operations supporting the Services. The risk assessment must be reviewed by Supplier's security official and used to inform the Supplier's information security program.

3. Assessment, Audit and Certification

3.1. Assessment

3.1.1. Upon request, Supplier shall complete a questionnaire or security controls assessment reasonably related to confirming compliance with this Exhibit conducted by Elevance Health or its designated subcontractor ("Security Assessment"). Elevance Health may require additional Security Assessments in connection with contemplated Statements of Work for new or additional Services. To the extent that the Security Assessment identifies any risks or deficiencies for which remediation is required, such remediation requirements or compensating controls (and the timeframes within which they must be successfully implemented) will be set forth in a corrective action plan. Supplier's failure to complete any remediation requirements set forth in a corrective action plan within the required timeframe

shall be deemed to be a material breach of the Agreement. Supplier will provide the applicable auditor's report or validated assessment report to Elevance Health upon request.

3.2. One of the following independent third-party audits of information security controls is required HITRUST r2 certification, ISO27001 or ISO27018 certification, SOC 2 Type 2 report including, unless otherwise agreed upon in the Agreement, a review of controls relevant to the Security, Availability, Processing Integrity, Confidentiality and Privacy Trust Service Principles, or FedRAMP Moderate or High Authorization.

3.3. The report(s) of the third-party auditors will be solely for the use of Supplier and Elevance Health, its regulators and its independent accountants and will not be distributed or used by any other parties unless approved by Supplier, such approval not to be unreasonably withheld.

3.3.1. If Supplier is providing a SOC 2 audit report to satisfy this requirement, and if such report(s) include(s) any findings that Supplier fails to comply with the SOC 2 requirements, or audit tests result in exceptions, Supplier agrees to remedy such noncompliance, and

3.3.2. Upon request, and at Supplier's expense, Supplier will provide bridge letters for SOC 2 audit reports covering the period from the end of the audit period through the end of Elevance Health's financial reporting period. Supplier will comply with future guidance relating to SOC 2 (AT section 101) (or its successors) as issued by the AICPA.

3.4. Supplier shall promptly (and in any event with 30 days of identification) report to Elevance Health Information Security at vsrm@elevancehealth.com any findings through Supplier's independent third-party audit as required by Section 3.2 that materially impact Data and associated corrective action plans identified during a self-assessment or any third-party assessment, including any assessment related to Supplier's independent certification / attestation. Supplier will provide Elevance Health with any further information associated with such findings, as reasonably requested by Elevance Health. Supplier will eradicate the known threat and remediate the effect of any Security Incidents caused by Supplier or through the Services at no additional cost to Elevance Health.

3.5. If at any time during the engagement, the Supplier's independent third party audit as required by Section 3.2 is withdrawn or qualified, for any reason, Supplier will contact vsrm@elevancehealth.com within 24 hours of learning of the issue to provide information and remediation plans regarding the withdrawal.

3.6. From time to time, Supplier may be requested to respond to, inform and provide updates regarding specific high risk security gaps or exposures that exist for new or emerging security vulnerabilities that are made publicly known for systems, applications, hardware devices, etc. In all instances Supplier will provide a response to any inquiry within 5 business days and will provide specific details as to the questions asked to ensure that Elevance Health can appropriately evaluate the risk or exposure to Data.

4. Cryptographic Controls

4.1. Data must be encrypted while in transit and at rest. The manner of encryption must conform to existing industry standard as defined under Federal Information Processing Standards.

4.2. At a minimum, Data will be encrypted on the following:

4.2.1. Public shared networks

4.2.2. Non-wired networks

4.2.3. Cloud services

4.2.4. Desktop and portable computing devices

4.2.5. Mobile devices

4.2.6. Portable media

4.2.7. Back-ups

4.2.8. Application or network servers

4.2.9. "Plug & play" storage devices.

4.3. Cryptographic key management procedures must be documented and include references to key lifecycle management (including provisioning, distribution, and revocation) and key expiration dates.

4.4. Access to encryption keys must be restricted to named administrators. Encryption keys must be protected in storage. Example methods of acceptable key storage include encrypting keys or storing keys within a hardware security module (HSM). Data-encrypting keys should not be stored on the same systems that perform encryption/decryption operations.

4.5. Elevance Health will manage encryption keys for Elevance Health Protected Health Information (PHI) or Personally Identifiable Information (PII) on Supplier systems or application in public cloud environments.

4.6. If a previously acceptable encryption standard becomes known to be compromised, Supplier will move to a secure standard as quickly as commercially feasible.

4.7. Commercially reasonable efforts must be made to apply cryptographic controls to PHI/PII at the file or database level.

5. Network and Systems Security

5.1. Supplier shall utilize and maintain a commercially available, industry standard malware detection program which includes an automatic update function to ensure detection of new malware threats.

5.2. An intrusion detection or prevention system which detects and/or prevents unauthorized activity traversing the network will be maintained.

5.3. Supplier shall have technical controls to detect, alert, and prevent the unauthorized movement of Data from Supplier's control (commonly referred to as Data Loss Prevention).

5.4. Networks or applications that contain Data must be separated from public networks by a firewall to prevent unauthorized access from the public network.

5.5. At managed interfaces, network traffic is denied by default and allowed by exception (i.e., deny all, permit by exception).

5.6. Supplier shall establish security and hardening standards for network devices, including Firewalls, Switches, Routers, Servers, and Wireless Access Points (baseline configuration, patching, passwords, access control).

5.7. Technical controls must be in place to restrict external webmail, instant messaging, file sharing and other data leak vectors for any Supplier Personnel with access to Data.

5.8. Quarterly vulnerability scans must be performed, and intrusion detection and identity management systems must be installed and monitored on all systems and components that handle, process, or store Data. Upon request, report summaries, including confirmation of remediation for vulnerabilities identified as high- or medium-risk, must be provided to Elevance Health.

5.9. At a minimum, Supplier shall engage a qualified third party to perform annual penetration testing of Supplier's networks containing Data. The scope of the penetration testing must, at a minimum, include all internal/external systems, devices and applications that are used to process, store, or transmit Data, physical security controls for all applicable facilities, and social engineering tests. Supplier must provide Elevance Health with summary results and a remediation plan at Elevance Health's request.

5.10. Supplier shall ensure that no unencrypted Data is stored on any system that is internet facing.

6. Email Security

6.1. Supplier email systems used in the exchange of information must:

6.1.1. Use of security features, including anti-virus, file inspection, and filtering of know bad IP addresses,

6.1.2. Be configured to protect against common email exploits, including spoofing, anonymous relay functionality, directory harvesting and denial of service attacks,

6.1.3. Use an encryption method for web client connectivity to email systems, and

6.1.4. Use an encryption method for Data in transit and at rest.

7. Mobile Device Security Controls

7.1. Supplier must have a documented mobile device policy that includes a documented definition for mobile devices and the acceptable usage and security requirements for all mobile devices.

7.2. Where Supplier permits Bring Your Own Device (BYOD), Supplier must have a BYOD policy that requires encryption of such devices and defines the device and eligibility requirements for BYOD usage when Data will be viewed or stored on devices that are not Supplier-issued mobile devices.

7.3. Supplier must post and communicate the mobile device policy and requirements through Supplier's security awareness and training program.

7.4. Supplier must have a centralized mobile device management solution (MDM) deployed to all mobile devices that are permitted to store, transmit, or process Data, including devices permitted under the Supplier's BYOD policy.

7.5. Supplier's Information Technology department must provide remote wipe or corporate data wipe for all mobile devices, including BYOD.

7.6. Supplier's mobile device policy must require the use of industry standard encryption for either the entire device or for Data and must be enforceable through Supplier's MDM solution or another equivalent technical controls.

7.7. Supplier must enforce password policies for enterprise-issued mobile devices and/or BYOD mobile devices using Supplier's MDM solution or another equivalent technical controls.

8. System and Application Controls

8.1. All systems and applications must meet or exceed industry standards for the prevention of unauthorized access, use or disclosure.

8.2. Laptop and workstation systems that could access Data remotely must utilize endpoint protection which includes a personal firewall and anti-malware protection. Endpoint protection must be regularly updated.

8.3. Operating systems and application software used must be currently supported by the manufacture.

8.4. Current versions of operating system and application software must be maintained, and patches applied in a timely manner for all systems and applications that receive, maintain, process, transmit or otherwise access Data.

8.5. Data must not be used in any non-production environment such as testing or quality assurance unless de-identification in a manner consistent with HIPAA's de-identification standards has been performed. If de-identification is not practical or feasible, compensating controls must be in place protecting the data to the same level of protection as afforded to the production environment. Data must not be placed into a non-production cloud computing environment. For clarification, cloud test environments may only contain or use synthetic data or data that has been de-identified in a manner consistent with HIPAA's de-identification standards. Cloud pre-production staging environments containing production data must be afforded the same security controls as the production environment.

8.6. Data must be segmented from non-Elevance Health Data so that appropriate controls are in place to identify the Data as Elevance Health's in all instances, including backup and removable media, and to appropriately restrict access only to users authorized to view the data. Logical separation must allow Data to be deleted when it is no longer required.

8.7. Logical controls, virtual machine zoning, virtualization security and segregation must be in place to help prevent attacks and exposure in multi-tenancy environments. This may be accomplished with tenant isolation, data isolation patterns, database per tenant, or application instances.

8.8. Supplier has and will maintain asset management system which records the inventory, assignment and movement of hardware and electronic media and any persons responsible, therefore.

9. Software Development Lifecycle

9.1. Supplier must use industry standards such as BSIMM, NIST, OWASP, etc. to build in security for its Systems Development Lifecycle (SDLC).

9.2. Supplier must use an automated source code analysis tool to detect and remediate security defects in code prior to production deployment.

9.3. At least annual manual penetration testing for applications which are internet-facing or provided to Elevance Health members through Elevance Health portals or mobile applications on behalf of

Elevance Health must be performed by qualified testers which may be third party or internal workforce with appropriate credentials.

9.4. Supplier must have policies and procedures in place to triage and remedy reported bugs and security vulnerabilities for the products/Services it provides to Elevance Health.

9.5. Supplier must have controls in place to prevent unauthorized access to its or Elevance Health's application, program, or object source code and ensure that access is restricted to authorized Personnel only.

9.6. Supplier will not use national identifiers or Social Security Numbers as User IDs for logon to applications.

9.7. Supplier will participate in Elevance Health Information Security's Vendor Application Security Program by providing evidence of scanning and penetration testing including scope, methodology and confirmation of remediation. Supplier agrees to remediate vulnerabilities identified during this process in a manner and timeline acceptable to Elevance Health and consistent with healthcare industry standards. If evidence of scanning and penetration testing is not provided or Elevance Health determines such evidence does not meet healthcare industry standards, then Elevance Health reserves the right, at Supplier's expense, to have vendor engage a third-party penetration test necessary to gain evidence that Supplier's vulnerability management processes and procedures meet the requirements of this Exhibit.

10. Data Destruction

10.1. When no longer needed for the provision of Services or when directed by Elevance Health, Supplier must delete Data on its systems using security techniques consistent with industry standards such as NIST 800-88 Guidelines for Media Sanitization so that deleted Data is rendered unrecoverable. If media containing Data is to be re-used, then that device shall be sanitized according to industry standards such as NIST SP 800-88 Guidelines for Media Sanitization before it may be used by Supplier for any purpose.

11. Physical Controls for the Protection of Data

11.1. Facilities Processing Data

11.1.1. General Requirements

11.1.1.1. All Data received or created in paper form must be physically secured and protected from viewing by unauthorized persons.

11.1.1.2. A clean desk policy will be enforced to ensure proper safeguarding of all hard copy Data.

11.1.1.3. The facility must have formal documentation that outlines the physical security control requirements for the site.

11.1.2. Access Control for facilities with personnel accessing Covered Information

11.1.2.1. All access doors to work areas containing Data shall be controlled by an electronic access control system with individually assigned Photo ID access badges. Badges must always remain visible.

11.1.2.2. Visitors must be logged, and escorted while in work areas where PHI is accessible. Visitors must wear a badge clearly describing them as a 'visitor' while on premises.

11.1.2.3. Closed-Circuit Television (CCTV)

11.1.2.3.1. Where local policies permit, a closed-circuit television system shall be installed. The cameras and monitors shall provide sufficient resolution and clarity to positively identify people and situations.

11.1.2.3.2. The cameras shall cover all exit and entry points to the work area to include badge-controlled access points and emergency exits. A digital video recording shall be made of all personnel entering or exiting the work area. The recordings must be of a quality that ensures the positive identification of persons entering/exiting the area.

11.1.2.3.3. The activity shall be always recorded that the door is open with pre and post event recording as appropriate. The production area itself may be monitored only if operationally necessary.

11.2. Data Centers Hosting/Processing Data

11.2.1. In addition to the requirements listed in section 11.1, all designated areas that store/house Data shall comply with the following additional controls:

- 24-hour on-site security officers or an intrusion detection system monitored by a central station.
- No doors to the data center/processing area are public facing.
- Perimeter walls must have slab to slab access restriction barriers.
- The number of doors will be kept to an absolute minimum to consist with operational necessity and fire codes.
- Access by personnel into a data center containing Data requires multi-factor authentication – biometric factor must be one factor.
- All access control and visitor management database records shall be retained for a period no less than 60 months.
- A fixed CCTV camera shall be installed at every entry, fire exit, and freight door leading to these areas. The camera will view all individuals that enter or exit through the door. This camera must be positioned, and the lens chosen so that facial recognition can be assured. In certain cases, dual cameras may be required to achieve coverage of both exit and entry events.
- Video recordings shall be retained for a period of no less than 180 days.

11.2.2 Suppliers that subcontract data centers will ensure physical environment and security controls are in place through contracts that require them to meet or exceed industry standards that are validated through the subcontracted data center's SOC2 Type 2, HITRUST certification, FedRAMP or equivalent independent third-party audit or certification.

12. Physical and Logical Access Controls

12.1. Prior to gaining access to Data, workforce members will have appropriate background checks completed in compliance with state and federal law.

12.2. Security awareness training will be completed prior to access being granted to Data, and then completed on an annual basis going forward so long as access to Data continues. This training should include, at a minimum, guidance on defending against malware, protecting passwords, monitoring, and reporting system notifications, social engineering, and handling sensitive data.

12.3. Physical and logical access will be granted to the minimum necessary Data necessary to meet the requirements of the user's scope of responsibilities in accordance with the principle of Least Privilege.

12.4. Separation of duties, role-based or attribute-based access controls will be in place to ensure that a single user will not introduce fraudulent or malicious code or Data without detection.

12.5. Physical and logical access reviews will be performed at least quarterly for privileged user accounts and twice annually for non-privileged user accounts.

12.6. Only those individuals providing Services to Elevance Health, or those who are responsible for administering or managing systems that contain Data, shall be authorized to access systems containing Data.

12.7. All users that are no longer required or authorized to access Data or systems that contain Data must have access promptly disabled.

12.8. Access to Data and systems that contain Data must be access controlled using individual user IDs and passwords that meet healthcare industry standard complexity rules and password lifetimes.

12.9. If it is suspected a password has been compromised, the password must be immediately changed or reset.

12.10. Processes must be in place to create the audit trails or logs capable of determining who has accessed Data and/or systems and the facilities that contain Data. Logging and/or audit trails must include all identity credentialing, authentication, and access control events (including all success and failure events). Logs and/or audit trails are subject to periodic audit by Supplier's internal and/or external auditors. These logs and/or audit trails must then be archived for at least twelve (12) months. These archived logs and/or audit trails must be searchable and or discoverable by Supplier.

12.11. Remote access to systems or networks that contain Data, including but not limited to email, must use multi-factor authentication and a connection with Approved Encryption as defined in Section 4 of this Exhibit.

12.12. Wireless access will be secured using best practices including encryption, and segregation from other networks, and encryption.

12.13. Account management capabilities, such as account lockouts for unsuccessful logon attempts, defined inactivity times, remote access allowances, specific success and failure events, and management of elevated privilege accounts must be enforced.

12.14. Supplier will offer web access management mechanism such as the CA Single Sign On product, the SecureAuth product, or OpenID Connect protocol for internet visible and cloud-based web applications.

13. Data Location and access from outside the United States

13.1. Data, or backups thereof, is not permitted to be hosted or stored, outside the United States. Locations outside the United States may be accessed in a view-only mode for the processing of Data. However, all Data must reside on servers located in the United States for duration of the processing.

13.2. Supplier will follow industry standard practices for securing workstations located outside the United States, including but not limited to:

13.2.1. Technical controls in place to prevent the storage or copying of Data on workstations; and

13.2.2. Scanning to detect Data on workstations; and

13.2.3. Filtering and blocking email and instant messaging containing Data; and

13.2.4. Disabling ports for removable media and printing unless explicitly authorized in an exception.

13.2.4.1. A Clean Room is required whenever greater than incidental access to regulated data such as Protected Health Information, Personally Identifiable Information, or cardholder data as defined by Payment Card Industry-Data Security Standard is required to provide services.

13.2.4.2. Clean Room is a work environment where devices that may capture information by visual (e. g. camera or smart phone), audio (e.g. recorder, cell phone or smart phone [unless otherwise expressly required by Elevance Health to receive security token for the purpose of multi-factor authentication only]), data transfer (e.g. memory stick, laptop, smart phone, tablet, etc.) or any other method and physically or electronically transport the information out of the work environment by unapproved methods are prohibited from entering the work environment. Devices that may capture data but are not capable of transporting the information out of the work environment other than by IT approved electronic methods, such as resident data processing devices, are permitted if approved by Elevance Health Information Technology. This standard is implemented through physical security controls on the work environment and guard force procedures.

13.2.4.2.1. If Elevance Health requests that cell phones or smart phones be utilized for Multifactor Authentication (MFA), then cell phones or smart phones will be allowed into the environment strictly for purposes of MFA. Cell phones must be stowed away and only visible when utilized for purposes of MFA.

13.3. All work from locations outside the United States must be performed in facilities approved in writing by Elevance Health.

14. Contingency Planning

14.1. Supplier will have a documented Business Continuity and Disaster Recovery plans in place that include information security controls. Such plans will be tested at least annually.

14.2. Supplier's Business Continuity and Disaster Recovery plans will address critical physical and information security systems to ensure ongoing security during Incidents and power outages.

15. Payment Card Industry Data Security Standard

15.1. If, in performing Services to or on behalf of Elevance Health, Supplier acts as a Merchant or Payment Processor as defined by the Payment Card Industry Data Security Standard (PCI DSS) then Supplier agrees to comply with the applicable PCI DSS requirements.

16. No Data Commercialization

16.1. The sale or commercialization in any form of Data, or derivatives thereof, including Elevance Health member data (such as PHI, PII, or PCI data) is strictly prohibited. For clarification, this prohibition applies regardless of whether or not the data has been aggregated and/or de-identified.

17. Suspension of Access

17.1. Elevance Health may suspend access to Elevance Health systems at any time if Elevance Health reasonably suspects that Supplier has failed to comply with any aspect of this Exhibit or if Elevance Health otherwise determines such suspension is necessary to protect the confidentiality, integrity, or availability of Data.

18. Conflicts

18.1. To the extent that any information security control in this Exhibit conflicts with the Agreement or any other writing between the parties, the most restrictive control applies.

Enhanced Care Management (ECM) and Community Supports (CS) Background Check Attestation

I, _____ attest that all officers, employees, volunteers, representatives, and agents of County of Fresno who are providing ECM and/or CS services have undergone a criminal activity background check.

I understand I am required to offer upon request proof of such background checks for any applicant upon an audit.

By signing below, I confirm background checks will be conducted as required.

_____
Signature

_____
Print name

_____
Title

_____
Tax ID

_____
Date

Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

How to enroll in the state's Medi-Cal program

Step 1: Go to the Department of Health Care Services' (DHCS) Provider Application and Validation for Enrollment (PAVE) Portal by visiting **https://pave.dhcs.ca.gov/sso/login.do**.
Step 2: If you do not have a PAVE user profile, select **Sign Up**.
Step 3: Complete the registration process (if applicable) and online application.
Step 4: Once your application has been successfully submitted, include a screen shot of the PAVE *Application Dashboard* with your Anthem Blue Cross (Anthem) application.

Important: When applying as a group provider, in addition to the DHCS group provider application, a complete rendering provider application must be submitted for each individual provider that belongs to the group.

Frequently asked questions

Q: Whom do I contact if I need help filling out the application or if I'm not sure what application to use?
A: In addition to the Message Center within the PAVE Portal, the following resources are available:

- PED Message Center **916-323-1945** or the *Online Inquiry Form* under the **Contact Us** section at **https://files.medi-cal.ca.gov/pubsdoco/prov_enroll.aspx**
- PAVE Technical Support **866-252-1949**

Q: If I enroll with Medi-Cal Managed Care (Medi-Cal) for Fee-for-Service (FFS) through DHCS, do I have to see Medi-Cal FFS members?
A: No, enrollment in Medi-Cal for FFS does not obligate you to accept Medi-Cal for FFS members.
Q: What if none of the DHCS application packets apply to me?
A: If you feel you do not need to apply, cannot apply, or if your application has been denied by DHCS, please email us (as indicated in **Step 4** above) to address your concern. Attach a copy of your denial letter if applicable.
Q: If I am already an Anthem-contracted provider serving Medi-Cal members, do I need to do anything?
A: Yes, this enrollment requirement applies to both existing and new Medi-Cal network providers.

https://providers.anthem.com/ca

ACAPEC-3240-21 October 2021

Anthem BlueCross

Medi-Cal Managed Care

Provider Bulletin
March 2022

Enhanced Care Management and Community Supports taxonomy requirement

California requires all Community Supports (CS) and Enhanced Care Management (ECM) providers to add taxonomies to their location national provider identifier (NPI) (for example, Type 2 or Group NPI) that indicates which services (CS/ECM – see below) the provider will offer at that location. This is a State of California requirement; as such, failure to add the taxonomy will result in inability for Anthem Blue Cross (Anthem) to execute an agreement. We apologize for the inconvenience and appreciate your efforts to ensure this request is complete.

Please follow the instruction below to add the California state-suggested taxonomy to each location's NPI that will offer the service.

Step 1

Determine which services your organization will provide from the list below.

Service	Taxonomy
ECM	171M00000X – Case manager/Care coordinator
Housing transition services	251X00000X – Supports brokerage
Housing deposits	251X00000X – Supports brokerage
Housing tenancy and sustaining services	251X00000X – Supports brokerage
Short-term post-hospital housing	385H00000X – Respite care
Recuperative care (medical respite)	385H00000X – Respite care
Respite services	385H00000X – Respite care
Day habilitation programs	251C00000X – Day training
Adult nursing facility (NF) transition to assisted living facilities	171M00000X – Case manager/Care coordinator
Community/NF transition services to home	171M00000X – Case manager/Care coordinator
Personal care and homemaker services	3747P1801X – Personal care attendant
Environmental accessibility adaptations	171W00000X – Contractor
Medically supportive food/meals	332U00000X – Home delivered meals
Sobering centers	261QR0405X – Rehabilitation, substance use disorder
Asthma remediation	171W00000X – Contractor

Step 2

Determine which business locations will offer the services.

Step 3

Visit the National Plan and Provider Enumeration System (NPPES) site at **https://nppes.cms.hhs.gov** to update your location NPI by adding the appropriate taxonomy code above depending on which services you plan to offer at that location.

ACAPEC-3449-22 March 2022

Example: Provider will offer asthma remediation, medically supportive food/meals, and day habilitation at 2020 Fake Street. That location NPI should be updated to include the following taxonomies (in addition to any other taxonomies already registered):

- 171W00000X
- 332U00000X
- 251C00000X

Step 4

Once the taxonomies have been added to the appropriate location NPI, please notify Anthem (if your roster was already submitted) via email at CalAIMCertification@anthem.com.

If you have not yet submitted your roster, please do so via email at ecm_cs_contracting@anthem.com.

If additional direction is required, please visit the CMS NPPES FAQ at https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html.

Email is the quickest and most direct way to receive important information from Anthem Blue Cross.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (**https://bit.ly/3lLgko8**).

Health Care Delivery Organization and Ancillary Application

Please submit all applicable documents from the list below with your completed and signed application. Failure to submit a complete application and all applicable documents will result in the application being returned and will prohibit Anthem Incorporated from completing the credentialing and/or contracting process.

Note: Submission of a completed application does not guarantee approval as a participating provider as additional information and/or documentation may be required by Anthem Incorporated.

Required attachments:

- Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- Copy of Accreditation Certificate/letters OR
- Copy of most recent CMS or state survey (with deficiencies) including cover letter from CMS or state agency stating facility is in substantial compliance or Corrective Action Plan if deficiencies were cited
- Copy of Medicaid and Medicare Certification(s) or Certificate numbers on the application
- *W-9*
- Current copy of professional liability insurance and general liability insurance (must indicate coverage limits, policy number, effective date and expiration date)
- Proof of established Quality Improvement Program
- Current copy of Pharmacy License in state where contracting (for ambulatory and home infusion therapy providers)
- Clinical Laboratory Improvement Act Certificate(s) for each location (for dialysis and laboratory providers)

As requested by our Network Provider Solutions additional paperwork or addendums to this application may need to be completed.

Instructions: Complete the following pages and return to Anthem Incorporated with the required attachments.

Provider type		
☐ Ambulatory surgery center	☐ Home health agency	☐ Outpatient rehab center/hospital
☐ Birthing center	☐ Home infusion therapy	☐ Portable X-Ray supplier
☐ Clinical laboratories	☐ Hospice facility	☐ Rural health clinic (RHC)
☐ Dialysis center/ESRD	☐ Hospital	☐ Skilled nursing facility
☐ Federally qualified health center (FQHC)	☐ Inpatient rehab hospital	

Behavioral health	
☐ Ambulatory detox	☐ Partial hospitalization — psychiatric
☐ Community mental health center	☐ Partial hospitalization — substance abuse
☐ Crisis stabilization unit	☐ Psychiatric inpatient rehabilitation
☐ Hospital — inpatient detox	☐ Psychiatric residential treatment facility
☐ Hospital — psychiatric	☐ Residential treatment center — substance abuse
☐ Intensive outpatient — psychiatric	☐ Substance abuse — inpatient rehabilitation
☐ Intensive outpatient — substance abuse	☐ Substance abuse clinic — outpatient services
☐ Mental health clinic — outpatient services	
☐ Methadone maintenance clinic	

Provider identification		
Legal business name:		
Doing business as (if applicable):		
Primary contact person:		
Title:		
Email:		
Primary contact address:		
City:	State:	ZIP code:
Phone:	Fax:	

Credentialing information		
Credentialing contact name:		
Title:		
Email:		
Credentialing address:		
City:	State:	ZIP code:
Phone:	Fax:	

Primary office/service address		
Does the facility have multiple locations? ☐ Yes ☐ No (If yes, attach a separate sheet for other locations.)		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
County:		
Phone:	Fax:	
Primary contact:		
Primary contact email:		
Phone:	Website:	
Administrator (full name):		

Medicaid #:		Medicare #:	
TIN/EIN:		NPI #:	
Taxonomy code(s):			
Does provider bill from this address? ☐ Yes ☒ No			
Does this office meet *ADA* accessibility requirements? ☐ Yes ☐ No			
Check all that apply:			
Handicap accessible:	☐ Building ☐ Parking ☐ Restroom		
Services for disabled:	☐ TTY ☐ American Sign Language ☐ Mental/physical impairment		
Accessible by public transportation:	☐ Bus ☐ Subway ☐ Regional train		
Billing information			
Contact name (billing contact):			
Title:			
Address line 1:			
Address line 2:			
City:	State:	ZIP code:	
Phone:	Fax:		
Email:			
Website:			
Preferred method of communication: ☐ Email ☐ Fax ☐ Mail			
Licensure/operating certificate			
State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:
CLIA certificate #:			
Accreditation/certification (Attach a copy of current accreditation certificate or survey)			
A.			
☐ AAAASF ☐ AAAHC ☐ AAPSF ☐ ACHC ☐ ACR ☐ BOC INTL	☐ CABC ☐ CAHC ☐ CCAC ☐ CHAP ☐ CIHQ ☐ COA	☐ COLA ☐ CTEAM ☐ DNV/NIAHO ☐ HFAP ☐ HQAA ☐ IMQ	☐ TJC ☐ AIUM ☐ FDA CERT ☐ _____ ☐ Not accredited (if not accredited, please complete Section B below)
Date of initial accreditation:		Date of next survey:	
Date of last survey:			

B.

Has provider had an onsite survey by CMS or state? ☐ Yes ☐ No*

Date of last recertification/annual state survey program review report:

* If no, successful completion of an onsite visit is required to complete credentialing. You will be contacted to schedule the visit.

Non-accredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with the Corrective Action Plan (if deficiencies were cited) or attach the letter from the government agency stating facility is in substantial compliance with most recent survey standards. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

General and professional liability insurance

General liability coverage (Attach copy of current insurance face sheet/declaration page)

Carrier name:	
Policy #:	
Effective date:	Expiration date:
Coverage per incident: $	Coverage aggregate: $

Professional liability insurance

Carrier name:	
Policy #:	
Effective date:	Expiration date:
Coverage per incident: $	Coverage aggregate: $

Provider directory

The following information will be used for your provider directory listing.

Office hours

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Close:							

About the facility

1. Does the facility have experiences and skills in treating persons with:
   - A. Physical disabilities? ☐ Yes ☐ No ☐ N/A
   - B. Chronic illness? ☐ Yes ☐ No ☐ N/A
   - C. HIV/AIDS? ☐ Yes ☐ No ☐ N/A
   - D. Serious mental illness? ☐ Yes ☐ No ☐ N/A
2. Do you have experience and skills in treating individuals who are:
   1. Homeless? ☐ Yes ☐ No ☐ N/A
   2. Deaf or hard of hearing? ☐ Yes ☐ No ☐ N/A
   3. Blind or visually impaired? ☐ Yes ☐ No ☐ N/A

What languages (other than English) are spoken by you/facility staff fluently enough to treat patients who only speak that language?

_____

_____

Disclosure questions		
• **If you answer yes to any of the following questions, attach a detailed explanation.** • **If any question does not apply, please answer no.** • Failure to answer or provide an explanation may result in a delay in processing the application. • Do not use whiteout to correct/change answers; if you need to correct/change an answer, cross out the incorrect answer, initial it and then mark the correct answer.		
1. Does the business have evidence of:		
	A. Professional liability claims history for each subcontractor?	☐ Yes ☐ No
	B. Disciplinary action taken against any business or professional license held in this or any other state or surrender of a license in this or any state?	☐ Yes ☐ No
	C. Any history of loss or limitation of privileges or disciplinary activity?	☐ Yes ☐ No
2.	Has the business' general or professional liability insurance ever been denied, cancelled, non-renewed or refused upon application for any reason other than by the facility's request?	☐ Yes ☐ No
3.	Has the business, under any current or former name or business entity, ever:	
	A. Had licensure to do business in any applicable jurisdiction ever been denied, revoked, reduced, suspended or not renewed?	☐ Yes ☐ No
	B. Been suspended or excluded from receiving payment under Medicare or Medicaid?	☐ Yes ☐ No
	C. Had accreditation status reduced, terminated, suspended or revoked?	☐ Yes ☐ No
	D. Been under investigation by any government agency?	☐ Yes ☐ No
4.	Is the business' professional liability insurance provided through a self-insurance trust or program?**	☐ Yes ☐ No

****** If yes, an officer of the company (e.g. president, vice president, chief financial officer or chief operating officer) must sign the following attestation.

On behalf of the applicant, I represent and warrant the following with respect to the self-insurance program maintained by the applicant or which provides professional liability insurance for the applicant:

1. The self-insurance program is adequately funded to provide the minimum required limits of liability as required by plan.
2. The self-insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims and future claims based on past experience.
3. The self-insurance program has a designated third-party administrator or other appropriately licensed claims professional or attorney serving the program.
4. The self-insurance program has a designated medical malpractice defense firm or more than one designated medical malpractice defense firm.
5. The self-insurance program maintains excess insurance/reinsurance above the self-funded level if the self-insured level alone is insufficient to meet required limits of the plan.
6. The self-insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit or a captive, self-management of a large retention through a trust.
7. The self-insurance program maintains a total value of the program that at a minimum meets the required limit of liability as set forth by plan.
8. I have confirmed the foregoing with my auditor or the actuary for the self-insurance fund.

Attestation signature:	Date:
Printed name:	Title:

Note: Anthem Incorporated reserves the right to request documentation from the applicant to confirm the information disclosed in this attestation.

Attestation	
I, the undersigned authorized agent, hereby attest that the information submitted in, or in support of this application is true, accurate and complete to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of the application and/or participating agreement. A photocopy of this document shall be as effective as the original.	
Preparer's name:	Title:
Signature:	Date:

Community Support Type	Description	Procedure Code	Modifier	Billing Unit	Reporting Unit	Unit Per Code Description	Anthem Payment Method	Auth Required Yes/No	Fresno
Transitional Rent - Permanent Setting	Supportive Housing	H0044	U6	Actual Cost	Per Month	Actual cost up to DHCS set reimbursable ceilings	Actual cost up to DHCS set reimbursable ceilings	Yes	Actual cost up to DHCS set reimbursable ceilings
Transitional Rent - Interim Setting	Supportive Housing	H0043	U2	Actual Cost	Per Month	Actual cost up to DHCS set reimbursable ceilings	Actual cost up to DHCS set reimbursable ceilings	Yes	Actual cost up to DHCS set reimbursable ceilings
Transiting Rent - Administrative Fee	Supportive Housing - First Months Permanent Housing	N/A	N/A	Flat Rate	Per Month	Monthly	Set Rate	Yes	$1,127.65
Transiting Rent - Administrative Fee	Supportive Housing - Interim housing and post-first month permanent housing	N/A	N/A	Flat Rate	Per Month	Monthly	Set Rate	Yes	$161.29