MANAGED CARE PROGRAM SERVICES

AGREEMENT

FOR

Long Term Services and Supports
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This AGREEMENT is effective on , between and Affiliates (hereinafter jointly referred to as "") and (hereinafter referred to as "PROVIDER").

I. RECITALS

1.1 is a California corporation licensed by the Director of the California Department of Managed Health Care to operate a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and the Rules of the Director of the California Department of Managed Health Care promulgated thereunder (California Health & Safety Code, Sections 1340 to 1399.64 and California Code of Regulations, Sections 1300.43 to 1300.99, collectively, the "Knox-Keene Act"), including without limitation to issue benefit agreements covering the provision of health care services and to enter into agreements with PROVIDER.

1.2 has a contract(s) with the California Department of Health Services to provide Medi-Cal benefits to eligible persons through its Medi-Cal Managed Care ("MMC") Program.

1.3 PROVIDER is in the business of providing CoveredServices and /or Supplies and is organized and operating under the laws of the State of California and possesses any and all licenses and/or governmental approvals required in order for it to provide the Medical Services and /or Supplies called for by this Agreement and is qualified to provide such Medical Services and /or Supplies.

1.5 intends by entering into this Agreement to make available quality Medical Services and /or Supplies to persons who are assigned to under the MMC Program by contracting with PROVIDER. PROVIDER intends to provide such quality Medical Services and /or Supplies in a cost-efficient manner.

II. DEFINITIONS

2.1 "Affiliate(s)" means a corporation or other organization owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with 

...
2.2 "Benefit Agreement(s)" means the written agreement entered into by ANTHEM and individuals under which ANTHEM provides, indemnifies, or administers health care benefits to persons enrolled in the MMC Program or a Medicaid Managed Care program maintained by ANTHEM or an Affiliate. When such written agreement is between an individual and an Affiliate, PROVIDER shall owe the obligations of this Agreement to such Affiliate and look to such Affiliate for the performance of obligations owed to PROVIDER under this Agreement.

2.3 "Coordination of Benefits" means the method of determining primary responsibility for payment of covered services under the terms of the applicable MMC Benefit Agreement or insurance policy, and applicable law and regulations, when more than one payor may have liability for payment for services received by Member.

2.4 "Emergency" means a sudden onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including without limitation, severe pain) that the patient may reasonably believe that the absence of immediate medical or psychiatric attention could reasonably result in any of the following:

(1) Placing the patient's health in serious jeopardy,
(2) Serious impairment to bodily functions,
(3) Other serious medical or psychiatric consequences, or
(4) Serious and/or permanent dysfunction of any bodily organ or part.

2.5 "Medically Necessary" means procedures, supplies, equipment or services that ANTHEM determines to be:

(1) Appropriate for the symptoms, diagnosis or treatment of the medical condition, and
(2) Provided for the diagnosis or direct care and treatment of the medical condition, and
(3) Within standards of good medical practice within the organized medical community, and
(4) Not primarily for the convenience of the Member’s physician or another provider, and
(5) The most appropriate procedures, supplies, equipment or service which can safely be provided. The most appropriate procedures, supplies, equipment or service must satisfy the following criteria: (i) there must be valid scientific evidence demonstrating that the expected health benefits from the procedures, supplies, equipment or service are clinically significant and produce a greater likelihood of benefit without a disproportionately greater risk of harm or complications, for the Member with the particular medical condition being treated than other alternatives; and (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 hospital stays acute care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

2.6 "Covered Services" means those services provided by a Participating MMC Program Provider and covered by the MMC Program Benefit Agreement.

2.7 "Member(s)" means an individual who is covered by a MMC Program Benefit Agreement.

2.8 "MMC Program Benefit Agreement" means a Benefit Agreement pursuant to which Members have a financial incentive to use Participating MMC Program Providers.

2.9 "Participating MMC Program Hospital" means a hospital which has entered into an agreement to provide Hospital Services as a Participating MMC Program Provider.

2.10 "Participating MMC Program Physician" means a physician who has entered into an agreement to provide Medical Services as a Participating MMC Program Provider and who is a "licensee" as that term is defined in Business and Professions Code Section 2041.

2.11 "Participating MMC Program Provider" means a hospital, other health facility, physician or other health professional which has entered into an agreement with ANTHEM to provide health care services for prospectively determined rates.

2.12 "Participating MMC Program Supplier" means a hospital, other health facility, physician or other health professional which has entered into an agreement with ANTHEM to provide Supplies for prospectively determined rates.

2.13 "Subscribers" means individuals who have qualified for and are covered by the provisions of a MMC Program Benefit Agreement.

2.14 "Supplies" means those supplies provided by a Participating MMC Program Provider and covered by the MMC Program Benefit Agreement.

2.15 "Utilization Review" means a function performed by ANTHEM, or entity acting on behalf of ANTHEM that has been approved by the Director of the California Department of Managed Health Care, to review and determine whether Medical Services or Supplies provided, or to be provided, are Medically Necessary.

III. RELATIONSHIP BETWEEN ANTHEM AND PROVIDER

3.1 ANTHEM and PROVIDER are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee or principal.
and agent or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement.

3.2 **ANTHEM** and **PROVIDER** agree that PROVIDER shall maintain a provider/patient relationship with each Member that PROVIDER treats. PROVIDER shall be responsible solely to that Member for the provision of Medical Services and/or Supplies. **ANTHEM** and **PROVIDER** agree that PROVIDER may freely communicate with Members regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

3.3 Nothing in this Agreement is intended to be construed, or be deemed to create any rights or remedies in any third party, including but not limited to a Member or a Participating MMC Program Provider other than PROVIDER.

3.4 PROVIDER consents to the memorializing of its legal obligations with **ANTHEM** and each particular Affiliate in one or more separate written agreements that shall not alter the substance of those obligations.

3.5 PROVIDER hereby acknowledges its understanding that this Agreement constitutes a contract between PROVIDER and **ANTHEM** as an independent corporation, operating under a license with the Anthem and Blue Shield Association, an Association of independent **ANTHEM** and **Shield** Plans (the "Association"), permitting **ANTHEM** to use the **ANTHEM** service mark in the State of California and that **ANTHEM** is not contracting as the agent of the Association. PROVIDER further acknowledges and agrees that PROVIDER has not entered into this Agreement based upon representations by any person other than **ANTHEM** and that no person, entity, or organizations other than **ANTHEM** shall be held accountable or liable to PROVIDER for any of **ANTHEM**' obligations to PROVIDER created under this Agreement. This section shall not create any additional obligations whatsoever on the part of **ANTHEM**, other than those obligations created under other provisions of this Agreement.

3.6 PROVIDER and **ANTHEM** agree to keep the terms of this Agreement confidential.

IV. PROVIDER SERVICES AND RESPONSIBILITIES

4.1 PROVIDER shall provide to Members those Medical Services and/or Supplies set forth in Exhibit A, attached hereto and incorporated by reference herein, at the facility(s) listed in Exhibit A.

4.2 PROVIDER shall, to the extent possible, seek, accept and maintain evidence of assignment for the payment of Medical Services and/or Supplies provided to Members by PROVIDER under the applicable MMC Program Benefit Agreement.

4.3 PROVIDER agrees to refer Members to other Participating MMC Program Providers unless otherwise determined by PROVIDER and agreed to in writing by **ANTHEM**.
4.4 PROVIDER agrees that unless explicitly agrees otherwise, PROVIDER is a Participating MMC Program Provider at all locations and under all tax identification numbers. Furthermore, PROVIDER agrees to notify in writing of each separate tax identification number under which PROVIDER receives compensation.

4.5 PROVIDER agrees to participate in the Utilization Review provided in Article VII, and with such amendments as PROVIDER may be notified of, and to abide by decisions resulting from that review subject to rights of reconsideration, review and arbitration provided in Section 7.3.

4.6 PROVIDER agrees that Medical Services and Supplies must be readily accessible to Members.

4.7 PROVIDER agrees to cooperate with administration of its internal quality of care review and grievance resolution procedures.

4.8 PROVIDER shall comply with all applicable state and federal laws and regulations relating to the delivery of Medical Services and/or Supplies including, but not limited to, the applicable requirements specified in Title 22 California Code of Regulations, Division 3, Subdivision 1, Chapters 3 and 4.

4.9 PROVIDER shall submit all reports required by necessary to comply with MMC Program requirements.

4.10 PROVIDER agrees to comply with all requirements set forth in the State Sponsored Programs California Medi-Cal Managed Care Provider Operations Manual (which is incorporated herein by this reference) to be made available to PROVIDER by .

4.11 PROVIDER shall promptly notify of:

(1) Any change in its business ownership;
(2) Any change in business address or change of the address of locations at which services are provided by PROVIDER;
(3) Any legal or government action initiated against PROVIDER, including but not limited to an action (a) for professional negligence; (b) for violation of the law; or (c) against any license, or if applicable, accreditation by JCAHO or any successor; which, if successful, would materially impair the ability of PROVIDER to carry out the duties and obligations under this Agreement;
(4) Any other problem or situation that will materially impair the ability of PROVIDER to carry out the duties and obligations under this Agreement.

4.12 PROVIDER agrees that the following information shall be provided to the Department of Health Services:

(1) The names of the officers and owners of PROVIDER;
(2) Stockholders owning more than ten percent (10%) of the stock issued by the PROVIDER; and
(3) Major creditors holding more than five percent (5%) of the debt of PROVIDER.

The aforementioned information is attached as Exhibit E and made part of this Agreement.

4.13 PROVIDER agrees to comply with requirements set forth in the Federal Regulations set forth in 42 CFR 455.104-455.106 in reference to the Medicare, Medicaid, or Title XX service programs. 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 during the initial contracting, recontracting and/or recredentialing process or upon request by ANTHEM. The PROVIDER further agrees to notify ANTHEM within fourteen (14) days of any changes to the required disclosures. PROVIDER shall complete a copy of the attached form in Exhibit F and submit it as part of the original contract submission and at other times as required by ANTHEM or Federal Regulations.

4.14 PROVIDER agrees that Members shall not be subject to discrimination regardless of race, creed, color, religion, physical/mental handicap, sexual orientation, marital status or national origin/ancestry.

V. SERVICES AND RESPONSIBILITIES

5.1 agrees to pay PROVIDER compensation pursuant to the provisions of Article VI.

5.2 agrees to grant PROVIDER the status of "Participating Medi-Cal Managed Care Program Provider", to identify PROVIDER as a Participating MMC Program Provider on informational materials to Members, and to facilitate the direction of such Members to PROVIDER.

5.3 agrees to provide appropriate identification cards for Members.

5.4 Notwithstanding any provision herein to the contrary, agrees not to change a material term of this Agreement unless (a) has given PROVIDER at least ninety (90) days prior notice of such 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 and a shorter timeframe is required for compliance), and
(b) such 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) has first been negotiated and agreed to by PROVIDER.

Notwithstanding the foregoing paragraph, with respect to a change to a material term of a manual, policy or procedure document referenced in this Agreement, ANTHEM may make such change after giving PROVIDER at least ninety (90) days prior notice of such 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 and a shorter timeframe is required for compliance) if PROVIDER does not notify ANTHEM within thirty (30) days after receipt of notice that it 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). If PROVIDER does so notify ANTHEM and the parties are unable to agree to such change by the forty-fifth (45th) day prior to the effective date of the change, PROVIDER may terminate this Agreement as of the effective date of the change upon prior written notice given to ANTHEM no later than the forty-second (42nd) day prior to the effective date of the change, notwithstanding the provisions of Article XII of this Agreement. If PROVIDER does not so terminate this Agreement, PROVIDER shall be subject to the change to the manual, policy or procedure document from and after its effective date.

VI. COMPENSATION AND BILLING

6.1 PROVIDER shall seek payment only from ANTHEM for the provision of Medical Services and/or Supplies except as provided in Section 6.2. The payment from ANTHEM shall be limited to the rates referred to in Section 6.7.

6.2 Except as permitted under Section 6.3, PROVIDER may also seek payment for the provision of Medical Services and/or Supplies from other sources only as available pursuant to the coordination of benefits provisions of the applicable MMC Benefit Agreement and Section 6.4.

6.3 PROVIDER agrees that the only charges for which a Member may be liable and be billed by PROVIDER shall be for Medical Services and/or Supplies not covered by the applicable MMC Benefit Agreement and as provided in Section 6.8. PROVIDER agrees to hold harmless the State of California and Members in the event ANTHEM cannot or will not pay for Medical Services and/or Supplies performed by PROVIDER. If PROVIDER receives any additional surcharge from a Member, ANTHEM shall require that PROVIDER promptly refund the amount thereof to the Member.

6.4 In a case in which, under the applicable MMC Benefit Agreement, is primary under applicable coordination of benefit rules provided in Title 10 of the California Code of Regulations Section 1300.67.13, ANTHEM shall pay the amounts due under this Agreement. In a case in which, under the applicable MMC Benefit Agreement, is other than primary under the coordination of benefit rules referred to above, the Provider is a skilled nursing facility and Medicare Part A is primary,
shall pay an amount equal to the Medicare coinsurance amount for Part A services, not to exceed one hundred percent (100%) of the amount required by this Agreement in Section 6.7. In instances where the patient is not covered by Medicare Part A, will pay the amount required by this Agreement in Section 6.7 minus the Medicare Part B payment. In other cases in which, under the applicable MMC Benefit Agreement, is other than primary under the coordination of benefit rules referred to above, shall pay the lesser of the amounts which when added to the amounts received by PROVIDER from other sources, pursuant to the applicable coordination of benefits rules, equals one hundred percent (100%) of the amount required by this Agreement in Section 6.7.

6.5 PROVIDER shall bill within twelve (12) months of providing the Medical Services and/or Supplies or may refuse payment. PROVIDER shall bill on forms and in a manner acceptable to . PROVIDER shall furnish, on request, all information reasonably required by to verify and substantiate the provision of Medical Services and/or Supplies and the charges for such Medical Services and/or Supplies. reserves the right to review all statements submitted by PROVIDER when necessary.

6.6 shall pay PROVIDER within thirty (30) Working Days of receipt of statements which are accurate, complete and otherwise in accordance with Section 6.5, unless the claim, or portion thereof, is contested by , in which case PROVIDER shall be notified in writing within thirty (30) Working Days. The term "contested" in this paragraph has the same meaning as in the California Health and Safety Code, Section 1371.

6.7 PROVIDER agrees to accept the fee schedule as provided in Exhibit B, attached to and made part of this Agreement, or PROVIDER's covered billed charges, whichever is less, as payment in full for all Medical Services and/or Supplies provided to Members. Such payment shall be for Medical Services and/or Supplies provided on or after the effective date of this Agreement.

6.8 PROVIDER shall not charge Members for Medical Services and/or Supplies denied as not being Medically Necessary under Article VII, unless PROVIDER has obtained a written waiver from that Member or an individual legally responsible for Member. The waiver, except in Emergency situations, must be obtained in advance of rendering services and shall specify those services which has denied as not being Medically Necessary and shall clearly state that the Member, or individual legally responsible for the Member, shall be responsible for payment of Medical Services and/or Supplies denied by .

6.9 Any amount paid by to PROVIDER under this Agreement determined subsequently by to have been an overpayment will be considered indebtedness of PROVIDER to . shall have a first lien in the amount of such indebtedness and may, at its sole option, recover such indebtedness by: (i) deducting from and setting off any amount or amounts due and payable from to
VII. UTILIZATION REVIEW

7.1 PROVIDER may establish a Utilization Review ("UR") program which shall seek to assure that Medical Services or Supplies provided to Members are or were Medically Necessary. The Utilization Review shall follow the procedures described on Exhibit C, attached to and made part of this Agreement. PROVIDER may change UR procedures by delivering amendments to, or a replacement for, Exhibit C at least thirty (30) days prior to implementation.

7.2 Utilization Review for Medical Services and/or Supplies may include, but is not limited to, the following:

(1) "Pre-service/supply review" to determine whether Medical Services or Supplies are Medically Necessary; and
(2) "Concurrent review" to determine whether continuing Medical Services or Supplies are Medically Necessary; and
(3) "Retrospective review" to determine whether Medical Services or Supplies were Medically Necessary; and
(4) "Case Management" to determine, in conjunction with Attending Physician or Participating Medical Group, appropriate alternative treatment plans.

7.3 PROVIDER may appeal a Utilization Review decision. The appeal shall be commenced by requesting reconsideration by the organization or entity making the initial decision. If PROVIDER is not satisfied with that result, a review by PROVIDER shall be requested. If PROVIDER continues not to be satisfied, PROVIDER's remedy shall be arbitration as provided in Exhibit D, attached to and made part of this Agreement.

7.4 PROVIDER shall not retrospectively deny any Medical Services and/or Supplies previously approved under Section 7.2 (1) or (2) hereof, provided that the information given by PROVIDER to PROVIDER was substantially true and accurate regarding the medical condition of the Member. If PROVIDER approves a specific type of Medical Service and/or Supply, PROVIDER shall not rescind or modify such approval after PROVIDER renders such service and/or supply in good faith and pursuant to the approval.

VIII. RECORDS MAINTENANCE, AVAILABILITY, INSPECTION AND AUDIT

8.1 PROVIDER shall prepare and maintain all appropriate records on Members receiving Medical Services and/or Supplies from PROVIDER. The records shall be maintained in
accordance with applicable general standards, prudent record-keeping procedures and as required by law.

8.2 ANTHEM, the Department of Health Services ("Department"), Department of Health and Human Services ("DHHS") and the Director of the California Department of Managed Health Care shall have access (which includes inspection, examination and copying) at reasonable times upon demand to the books, records and papers of PROVIDER at PROVIDER’s office or such other mutually agreeable location in California relating to the Medical Services and Supplies PROVIDER provides to Members, to the cost thereof, and to payments PROVIDER receives from Members or others on their behalf. PROVIDER shall maintain such records and provide such information to the Department, DHHS and the Director of the California Department of Managed Health Care as may be necessary for compliance with the requirements of this Agreement and the Knox-Keene Act. PROVIDER shall maintain such records in accordance with applicable general standards for at least five (5) years from the close of the Department's fiscal year in which this Agreement is in effect, and such obligations shall not be terminated upon a termination of this Agreement, whether by rescission or otherwise.

8.3 Ownership and access to records of Members shall be controlled by applicable law.

8.4 All records must be maintained in a system that permits prompt retrieval of information. Medical records are to be legible, documented accurately in a timely manner and readily accessible.

8.5 PROVIDER agrees to maintain and make available to the Department, upon request, copies of all subcontracts and to ensure that all subcontracts are in writing and require the subcontractor to comply with the requirements set forth at Section 8.2 herein.

8.6 Subject to all applicable laws relating to privacy, confidentiality, and privileged documents and communications, PROVIDER shall only make a Member’s information, including but not limited to medical records, available as follows: (1) upon reasonable request to each physician or practitioner treating the Member, (2) for Utilization Review purposes, and (3) to ANTHEM; or otherwise as consented by the Member or an authorized representative of the Member.

IX. LIABILITY, INDEMNITY AND INSURANCE

9.1 Neither ANTHEM nor PROVIDER nor any of their respective agents or employees shall be liable to third parties for any act or omission of the other party.

9.2 PROVIDER, at its sole expense, agrees to maintain adequate insurance for professional liability and comprehensive general liability.

9.3 Upon request by ANTHEM, PROVIDER shall provide insurance policies required under Section 9.2.
9.4 PROVIDER agrees to notify ANTHEM no less than thirty (30) days prior to the termination, cancellation, or lapse of all or any portion of PROVIDER's insurance coverage.

X. MARKETING, ADVERTISING AND PUBLICITY

10.1 PROVIDER shall have the right to use the name of PROVIDER for purposes of informing Members, prospective Members, and Participating MMC Program Providers of the identity of Participating MMC Program Providers.

10.2 Except as provided in Section 10.1, PROVIDER and PROVIDER each reserve the right to and the control of the use of its name and all symbols, trademarks or service marks presently existing or later established. In addition, except as provided in Section 10.1, neither PROVIDER nor PROVIDER shall use the other party's name, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of that party and shall cease any such usage immediately upon written notice of the party or on termination of this Agreement, whichever is sooner.

XI. DISPUTE RESOLUTION

11.1 ANTHEM and PROVIDER agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement.

11.2 In the event that any problem or dispute concerning the terms of this Agreement, other than a Utilization Review decision as provided for in Article VII, is not satisfactorily resolved, ANTHEM and PROVIDER agree to arbitrate such problem or dispute. Such arbitration shall be initiated by either party making a written demand for arbitration on the other party. The arbitration will be conducted under the Commercial Rules of the American Arbitration Association, unless otherwise mutually agreed in writing by ANTHEM and PROVIDER. PROVIDER and ANTHEM agree that the arbitration results shall be binding on both parties in any subsequent litigation or other dispute. The initiation of the arbitration by written demand must be made within two (2) years of the date upon which the problem or dispute arose.

XII. TERM AND TERMINATION

12.1 When executed by both parties, this Agreement shall become effective as of the date noted on page one and shall continue in effect until terminated pursuant to this Agreement. Notwithstanding the aforementioned, this Agreement shall only become effective upon approval by the Department in writing or by operation of law. The parties agree the Department shall be notified in accordance with Section 13.3 herein in the event this Agreement is terminated.
12.2 Either party may terminate this Agreement by giving at least ninety (90) days prior written notice. Nothing contained herein shall be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

12.3 After the effective date of termination, this Agreement shall remain in effect for the resolution of all matters subject to this Agreement but unresolved at that date.

12.4 In the event this Agreement is terminated, PROVIDER agrees to assist [Redacted] in the transfer of Member medical care including making available to the Department and [Redacted] 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 Services. The parties acknowledge that the cost of reproduction required by this provision will not be billed to Members, but will be borne by the Department.

12.5 The obligations set forth in Sections 6.1, 6.3 and 12.3 hereof shall survive the termination of this Agreement regardless of the cause giving rise to such termination, including insolvency of [Redacted], and shall be construed for the benefit of Members and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between PROVIDER and any Member or any persons action on their behalf.

XIII. GENERAL PROVISIONS

13.1 Assignment

No assignment of the rights, duties, or obligations of this Agreement shall be made by PROVIDER without the express written approval of a duly authorized representative of ANTHEM. Any attempted assignment in violation of this provision shall be void as to ANTHEM. Notwithstanding the aforementioned, PROVIDER agrees that any assignment or delegation of this Agreement shall be void unless prior approval is obtained from the Department.

13.2 Binding on Successors in Interest

Subject to Section 13.1, the provisions of this Agreement and obligations arising hereunder shall extend to and be binding upon the parties hereto and their respective successors and assigns and shall inure to the benefit of the parties hereto and their respective successors and assigns.

13.3 Waiver of Breach

Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision.

13.4 Notices
Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing, postage prepaid, and shall be sent by certified mail, return receipt requested, to ANTHEM, PROVIDER or the Department at the addresses below. The notice shall be effective on the date indicated on the return receipt.

To ANTHEM at: Anthem Blue Cross Network Development & Management 21555 Oxnard Street Woodland Hills, CA 91367

To PROVIDER at: Silicon Valley Independent Living Center 2202 North First Street San Jose, CA 95131-2007 Attn: Nayana Shah

And to at: California Department of Health Services Medi-Cal Managed Care Division MS # 4408/4409 1501 Capitol Ave., 4th Fl. Sacramento, CA 95814

13.5 Severability

In the event any provision of this Agreement is rendered invalid or unenforceable by an Act of Congress or of the California Legislature or by any regulation duly promulgated by officers of the United States or of the State of California acting in accordance with law, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of this Agreement shall, subject to Section 13.5, remain in full force and effect.

13.6 Effect of Severable Provision

In the event that a provision of this Agreement is rendered invalid or unenforceable or declared null and void as provided in Section 13.4 and its removal has the effect of materially altering the obligations of either party in such manner as, in the judgment of the party affected, (a) will cause serious financial hardship to such party; or (b) will cause such party to act in violation of its corporate Articles or Bylaws, the party so affected shall have the right to terminate this Agreement upon thirty (30) days prior written notice to the other party. The applicable provisions of Article XII shall apply to such termination.

13.7 Entire Agreement
This Agreement, together with exhibits, contains the entire Agreement between ANTHEM and PROVIDER relating to the rights granted and the obligations assumed by this Agreement. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

13.8 Amendment

This Agreement or any article or section of it may be amended at any time during the term of the Agreement by mutual written consent of duly authorized representatives of the parties. An amendment to this Agreement shall be submitted to the Department for prior approval at least thirty (30) days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor disapproved by the Department shall become effective by operation of law thirty (30) days after the Department has acknowledged receipt or upon the date specified in the amendment, whichever is later.

13.9 Attorney's Fees

In the event that either ANTHEM or PROVIDER institutes any action, suit, or arbitration proceeding to enforce the provisions of the Agreement, each party shall pay one half of the arbitration costs and otherwise pay its own attorneys' fees and other costs.

13.10 Headings

The headings of articles and sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

13.11 Governing Law

This Agreement shall be construed and enforced in accordance with the laws of the State of California and all other laws, regulations and contractual obligations of ANTHEM. Without limiting the foregoing, ANTHEM is subject to the requirements of the Knox-Keene Act and any provision required to be in this Agreement thereunder shall bind ANTHEM and PROVIDER, whether or not expressly provided in this Agreement.
(SIGNATURE) (SIGNATURE)

________________ NAYANA SHAH
NAME (NAME OF OFFICER - TYPE OR PRINT)

_________________________________ Interim Executive Director / COO
TITLE (TITLE)

7/18/13 (DATE) (DATE)
EXHIBIT A DESCRIPTION OF SERVICES AND LOCATION OF FACILITIES Please include all facilities providing services:

Business Name: Silicon Valley Independent Living Center
Practice Address: 2202 North First Street, San Jose, CA 95131-2007
Phone: (408) 894-9041
Billing Agency: if applicable N/A
Billing Contact: Firdosh Agarwal
Payment Address: Same as above
Tax ID: 94-2332246
Medi-Cal Provider #: 1861722456
Counties Served: Santa Clara County

Billing Agency: if applicable N/A
Billing Contact: 
Payment Address: 

Medi-Cal Provider #: 
Counties Served: 

Business Name: 
Practice Address: 
Phone: 

B-1
ATTACHMENT B

Long Term Support Services Reimbursement

ANTHEM shall compensate Provider for Covered Services provided to Covered Persons, subject to all terms and conditions of this Agreement, benefit design, coordination of benefits (COB), applicable authorization requirements, applicable coinsurance, program eligibility and the Provider Manual, in an amount equal to the lesser of Eligible Charges or the amounts shown below.

Section I: Reimbursement

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Billing Code</th>
<th>Rate</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Support Services – Non Facility Type Provider</td>
<td>Applicable CPT/HCPCS code</td>
<td>100% of the California State Medi-Cal Fee Schedule</td>
<td>Per Service</td>
</tr>
<tr>
<td>Long Term Support Service – Facility Type Provider</td>
<td>Applicable Revenue Code</td>
<td>100% of the California State Medi-Cal Fee Schedule</td>
<td>Per Diem</td>
</tr>
</tbody>
</table>

Payments specified as California State Medi-Cal Fee Schedule refer to the applicable California State Medi-Cal Fee Schedule for the market(s) and program(s) covered by the Agreement. ANTHEM will update the Fee Schedule no more than sixty (60) days from the date of receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a prospective basis.

1 All applicable modifiers must be used in accordance with standard billing guidelines.

2 Per Diem payments are all inclusive for all services provided on a specific date of service.

Section II: Notes

1 All services billed by Provider will be submitted on either a UB-04 (or its successor) when billing a Revenue Code or a CMS-1500 (or its successor) when billing a CPT/HCPCS code or corresponding electronic format.

2 Eligible Charges are those charges billed by the Provider subject to conditions and requirements which make the service eligible for reimbursement. Eligibility for reimbursement of the service is dependent upon application of the following conditions and requirements: member program eligibility, provider program eligibility, benefit coverage, authorization requirements, Provider Manual guidelines, administrative, clinical, and reimbursement policies, and code editing logic. The allowed amount reimbursed for the eligible charge is based on the applicable fee schedule or contracted/negotiated rate after application of coinsurance, co-payments, deductibles, and coordination of benefits. ANTHEM will not reimburse Providers for items the Provider receives free of charge and items the Provider provides to the member free of charge.

Section III: Exclusions
1. Any services not specified in the Fee Schedule(s) are not reimbursable.
EXHIBIT C

UTILIZATION REVIEW PROCEDURES

I. INTRODUCTION

A. [Company Name] has established a Utilization Review program to conduct Utilization Review as provided in Article VII. [Company Name] and/or any and all Review Organizations with which [Company Name] may contract shall establish and maintain review procedures and screening criteria which take into account locally acceptable standards for quality medical care.

B. The Utilization Review process has two primary objectives:

(1) To assure that PROVIDER services provided to Members are Medically Necessary; and
(2) To assure that PROVIDER services meet locally developed community standards for quality care and are provided at the appropriate level of care.

C. [Company Name] shall accept approval decisions made by an outside Review Organization, designated by [Company Name], regarding Medical Necessity as binding on [Company Name]. Denial decisions shall be subject to the appeal procedures provided in Exhibit D.

II. DEFINITIONS

The following definitions are in addition to any definitions in Article II of this Agreement:

A. "Certification Letter" means a document on which is stated [Company Name] determinations regarding Utilization Review pursuant to this Agreement.

B. "Norms" means numerical or statistical measures of observed performance of health care services derived from aggregated information related to the health care services provided to a statistically significant number of persons, as developed by the Review Organization.

C. "Physician Advisor" means a validly licensed physician who is employed by or on contract to [Company Name] to carry out Utilization Review.

D. "Review Coordinator" means a professionally qualified person who is competent to conduct initial review, data analysis and other functions involved in the Utilization Review performed pursuant to this Agreement.
E. "Review Organization" means an entity which provides the Utilization Review services described in this Agreement. It applies to the Managed Care Services Department, as well as to other entities who may perform review activities on behalf of.

F. "Screening Criteria" means those written guidelines adopted by pursuant to this Exhibit C.

G. "Working Day" means any day, Monday through Friday, excluding legal holidays.

III. RESPONSIBILITIES OF 

A. shall develop, update and maintain Screening Criteria. (1) Screening Criteria shall be developed for the purpose of making an initial determination of whether Covered Services/Supplies are Medically Necessary. (2) Screening Criteria shall be based on professional expertise, current professional literature, and cumulative information on health care services provided within the community to a statistically significant number of persons. (3) Screening Criteria shall be developed to enable the Review Coordinator to select for review by the Physician Advisor only those cases which appear outside locally accepted professional Norms.

B. shall utilize professionally qualified review personnel to perform the duties of Review Coordinators. Such Review Coordinators shall have authority to use the Screening Criteria to provide approval for Covered Services/Supplies. A Review Coordinator shall have no authority to deny Covered Services/Supplies.

C. may deny Covered Services/Supplies, but only by a Physician Advisor, after a review by the Physician Advisor of information contained in the Member's medical record and after consultation with the Attending Physician. If the Attending Physician is unavailable for consultation with the Physician Advisor and available information is insufficient for approval of the Covered Services/Supplies, the Physician Advisor shall deny the commencement or continuation of services subject to reconsideration and other appeal as provided in Article VII and Exhibit D of this Agreement.

D. When pre-service review is performed, shall respond to requests by providing a determination by telephone within three (3) Working Days of such requests. A certification number shall be given to the Attending Physician and to the PROVIDER from whom the patient is scheduled to receive the Covered Services/Supplies.

E. shall provide written notification on a Certification Letter of approved requests for pre-service review within three (3) Working Days of the request. Such notification shall be mailed to the Attending Physician, PROVIDER, and the Member.

F. shall respond to requests for reconsideration of denied pre-service requests pursuant to Section 7.3, by making a pre-determination and communicating the results to the Attending Physician and PROVIDER by telephone and in writing within three (3) Working Days of the request.

G. may conduct continuing review of Members' Covered Services/Supplies.

H. shall use the Screening Criteria to establish review dates for Covered Services/Supplies. Review dates shall be noted. If the Member continues to receive services, an additional concurrent review may be conducted on or before the noted review date, a pre-determination made and, if appropriate, a new review date established pursuant to this section. This process shall continue until either the Member is discharged or the Physician Advisor determines that, based on available information from the Member's medical record and the Attending Physician, continued Covered Services/Supplies are not approved as Medically Necessary.
I. If the Physician Advisor determines, on the basis of available information obtained from the Member's medical records and the Attending Physician, that continued Covered Services/Supplies are not approved, [Company Name] shall notify the PROVIDER, the Attending Physician and the Member or the Member's authorized representative, in writing, on the Certification Letter, within three (3) Working Days. Such notification shall include an explanation of the procedure for requesting reconsideration.

J. If reconsideration of a denied continuation of Covered Services/Supplies is requested, [Company Name] shall reconsider the decision and communicate it to the PROVIDER by telephone and to the PROVIDER, the Attending Physician and the Member, in writing, within three (3) Working Days of the request if the Member is still receiving services. Otherwise, [Company Name] shall notify the PROVIDER, the Attending Physician and the Member of the reconsideration decision, in writing, on the Certification Letter, within twenty (20) Working Days of the request. Further appeal shall be conducted, if requested, according to the appeal procedures provided in Exhibit D.

K. In making any determination regarding whether PROVIDER's commencement or continuation of services is Medically Necessary, [Company Name] shall consider all relevant information. [Company Name] shall thoroughly document its actions and the rationale for its determinations.
IV. RESPONSIBILITIES OF PROVIDER AND/OR ATTENDING PHYSICIAN

A. PROVIDER and/or Attending Physician shall request a pre-service review from ANTHEM at least three (3) Working Days prior to scheduled Covered Services/Supplies to avoid retrospective denial of payment for such services provided to Member. This may be done by phoning the Managed Care Services Department at (800) 274-7767. Pre-service review will be done in accordance with Section III. D of this Exhibit C.

B. PROVIDER and/or Attending Physician shall provide the following information to ANTHEM at the time of the request for pre-authorization:

(1) Patient's name and Member certificate number;
(2) Patient's age and sex;
(3) Patient's diagnosis;
(4) Attending Physician's name and telephone number;
(5) Description of services; e.g., drug name, dosage, frequency, duration and treatment course;
(6) Planned date(s) of service;
(7) Name and telephone number of planned PROVIDER; and
(8) Other information requested by ANTHEM.

V. REFERRAL CARE

A. Scheduled referral to providers of Covered Services/Supplies who are not Participating Providers:

(1) Pre-service review should be requested for any scheduled referral for Covered Services/Supplies to providers who are not Participating Providers if the Member is to receive maximum benefits available under the Member's Benefit Certificate.

(2) Pre-service review for referral care shall be requested by the Attending Physician and/or the PROVIDER. When pre-service review is performed, ANTHEM shall determine whether the services are Medically Necessary and if they could be provided by a Participating Provider of Covered Services/Supplies. ANTHEM shall not authorize commencement of Covered Services/Supplies or continued Covered Services/Supplies from a provider of Covered Services/Supplies which is not a Participating Provider which could be provided by a Participating Provider in a manner consistent with the needs of the Members.

(3) ANTHEM shall provide notification of the determination regarding referral care by telephone and in writing on the Certification Letter within three (3) Working Days of the request.

B. Emergency Services and continuing provision of Covered Services/Supplies from a provider which is not a Participating Provider may be reviewed by ANTHEM to determine if the services are Medically Necessary and whether the services should be commenced by a Participating Provider in order to provide maximum benefits available under the Member's Benefit Agreement.

IV. OTHER PROCEDURES AND INFORMATION

A. Utilization Review and Payment of Claims:

(1) When applicable, the certification number shall be written on the claim form or a copy of the Certification Letter shall be attached to the claim form when the claim is submitted to ANTHEM for payment. Claim forms without the Certification number or letter may be returned to the PROVIDER.

(2) The Utilization Review decision made by ANTHEM is solely for determining whether Covered Services/Supplies are Medically Necessary and/or can be safely provided in the home. Claim processing and payment determination shall be the sole responsibility of ANTHEM.
EXHIBIT D

ARBITRATION FOR UTILIZATION REVIEW

The initial decision regarding whether Covered Services or Medical Supplies are Medically Necessary shall be made pursuant to Section 7.1. PROVIDER may appeal such a decision pursuant to the terms of Section 7.3. Arbitration under that section shall follow the procedures below.

A. PROVIDER agrees to submit any dispute concerning a Utilization Review decision, unresolved by reconsideration or review pursuant to the terms of Section 7.3, to binding arbitration. The arbitration shall be commenced by PROVIDER by making written demand on ANTHEM. The scope of that arbitration shall be limited to a determination of whether, or to what extent, benefits specified in the applicable MMC Program Benefit Agreement were Medically Necessary or otherwise payable for the claim or claims in dispute.

B. The arbitration shall be conducted under the Commercial Rules of the American Arbitration Association, unless otherwise mutually agreed in writing by ANTHEM and PROVIDER. PROVIDER and ANTHEM agree that the arbitration findings shall be binding upon any subsequent litigation.
EXHIBIT E

PROVIDER INFORMATION, (SECTION 4.12)

For: SILICON VALLEY INDEPENDENT LIVING CENTER

(1) Names of the officers and owners of PROVIDER: Board of Directors: Patricia Kokes, President Richard Wentz, Vice President Gabe Lopez, Treasurer John Robinson, Secretary Saraada Achanta Dana Bolles Anne Cohen Gaeir Dietrich Minerva Galavan Roger Peterson Nicole Sebek Vivian Wong Robert Yanagida

(2) Stockholders owning more than ten percent (10%) of the stock issued by the PROVIDER:

(3) Major creditors holding more than five percent (5%) of the debt of PROVIDER:

N/A

N/A
EXHIBIT F

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.

Practice Information

<table>
<thead>
<tr>
<th>Check one that most closely describes you: Individual</th>
<th>Group Practice Disclosing Entity</th>
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<tbody>
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<td>DBA Name:</td>
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<tr>
<td>Address:</td>
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</tr>
<tr>
<td>Federal Tax Identification Number:</td>
<td>Provider CAQH #:</td>
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</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Name of individual or entity</th>
<th>DOB</th>
<th>Address</th>
<th>SSN (if listing an individual) TIN (if listing an entity)</th>
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<tr>
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Section II

Section III

Are any of the individuals listed above related to each other? Yes No If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

<table>
<thead>
<tr>
<th>Names</th>
<th>Type of relation</th>
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Are there any subcontractors that the **Disclosing Entity** has direct or indirect ownership of 5% or more? Yes No If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of **5% or more**. (42 CFR 455.104)

<table>
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<tr>
<th>Name of individual or entity</th>
<th>DOB</th>
<th>Address</th>
<th>SSN (if listing an individual) TIN (if listing an entity)</th>
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Section IV

Has any person who has an ownership or co ever been convicted of a crime related to the program? Yes No (verify through H If yes, please list those persons below. (42 control interest in the provider, or is an agent or managing employ at person’s involvement in any program under Medicaid, Medic HHS-OIG Website) CFR 455.106) yee of the provider care, or Title XX

<table>
<thead>
<tr>
<th>Name/Title</th>
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<th>Address</th>
<th>SSN</th>
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Business Transactions: Has the disclosing e or any significant business transactions with If yes, list the ownership of any subcontract $25,000 during the previous twelve month p wholly owned supplier, or between the prov separate sheet if necessary. entity had any financial transaction with any subcontractors total h any subcontractors? Yes No tor with whom this provider has had business transactions tota period; and any significant business transactions between this vider and any subcontractor, during the past 5-year period. (42 C ling more that $25,000 aling more than s provider and any CFR 455.105). Attach a

<table>
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<tr>
<th>Name Supplier/Subcontractor</th>
<th>Address</th>
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Section V

Have you identified your status (under Prac If yes, for Disclosing Entities, list each mem (DOB), Address, Social Security Number (S ctice Information) as a Disclosing Entity? Yes No mber of the Board of Directors or Governing Board, including th SSN), and percent of interest. he name, date of birth

<table>
<thead>
<tr>
<th>Name/Title</th>
<th>DOB</th>
<th>Address</th>
<th>SSN</th>
<th>% Interest</th>
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Section VI

I certify that the information provided here in, is true and accurate. Additions or revisions to the information n above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Practice Information refers to the first area of this form

Signature

Name (please print)

Title (or indicate if authorized Agent)

Date

ATTACHMENT C
SCOPE OF WORK

Primary Goal:

Measure the impact of Contractor's services on reducing health care costs for Managed Care Plan Members, by providing and coordinating lower cost Home and Community Based Services (HCBS), rather than utilization of higher cost services provided in hospitals and other Long Term Care (LTC) facilities, including but not limited to emergency room visits, hospital admissions, and Skilled Nursing Facility (SNF) utilization.

This Scope of Work (SOW) entered into effective as of the _________ day of _______ 2013 (the "Effective Date"), pursuant to that certain Independent Contractor Services Agreement (the "Agreement") effective as of _____________, 2013 by and between Company and Contractor. Company and Contractor are collectively hereinafter the "Parties" or singularly "Party". This SOW shall become an additional attachment to the Agreement as of the above referenced Effective Date.

Health Plan Training Services
Contractor will conduct the following two-hour training for Company’s staff, to educate them about disability law, trends in providing Home and Community Based Services (HCBS), and an introduction to Silicon Valley Independent Living Center (SVILC), including, but not limited to:  (see Addendum 1 for specific topic outlines)

- Independent Living and Social Model of Disability
- American’s with Disabilities Act (ADA)
- The Olmstead decision
- Application

Community Transition Program
Contractor will provide Company’s members, hereinafter the “Members” or singular “Member”, Community Transition Program services to Members residing in skilled nursing facilities (SNF’s) and other Long Term Care (LTC) facilities that wish to transition into the community; Members at risk of institutionalization; and Members in the community who are frequent users of high cost urgent care and short term hospitalization benefits for the lack of adequate Long Term Services and Supports (LTSS). Community Transition Program services aim to maximize independence and to assist Members covered by Medi-Cal only, Cal-MediConnect, and Medicare only, in fully integrating into the community of their choice. Services provided consist of the following: Assessment Services, Options Counseling, Care Transition Services and Community Living Services.

I. Assessment Services
Contractor will conduct two face-to-face assessments during the first month with Member upon referral, using Contractor’s Assessment tools. The assessment will determine if the Member can benefit from Community Transition Program services and chooses to do so. These assessments determine the Member's medical,
behavioral health, social services, and LTSS needs, if any. Based on the Assessment, a determination is made by the Company for the Member to receive:

- **Care Transition Services and Community Living Services** for Members who are in SNF or other Long Term Care (LTC) facilities and transitioning to a community setting;
- **Options Counseling and Community Living Services** for Members who are at risk of institutionalization and for Members in the community who are frequent users of high cost urgent care and short term hospitalization benefits for the lack of adequate LTSS.

Contractor will meet with the Member at their location when possible, to enroll the Member into the next phase of the program. Contractor will obtain a release of information from the Member and then submit an Assessment Summary, and other relevant information requested by the Company (to determine service needs), via fax or another process, as agreed upon by the parties.

II. **Options Counseling**
Contractor will conduct face-to-face meeting(s) with Member to discuss various service options through a person centered process intended to support informed long-term care decision-making through assistance provided to individuals and families to understand their “strengths, needs, preferences, and unique situations” and translate this knowledge into possible “support strategies, plans and tactics based on the choices available in the community.”

III. **Care Transition Services**
Contractor will meet individually with each Member to explain the program and the Participants’ Rights and Responsibilities, complete all necessary program enrollment paperwork, and develop the Comprehensive Service Plan (CSP) which is a team project involving the Member, family (optional), Company Case Management/Social Services and/or facility Discharge Planner/Social Worker and other Service Personnel to ensure a successful transition. Contractor will submit the CSP and all relevant information to Company via fax or other process, as agreed upon by the parties. All parties involved in the transition strategy approve and agree to the plan, before the transition begins.

Based on the approved CSP, and the level of care required by the Member, a determination is made by the Contractor as to which Home and Community Based Services (HCBS) waiver services may be appropriate for each enrollee.

Working in collaboration with the Member as well as Company and facility staff, Contractor will provide information and support within the scope of their job, and the CSP, to successfully transition the Member into the community. Examples include: (see Addendum 2)

- Peer Counseling (Stepping Stones 10-week program)
- Independent Living Skills Training
- Assistive Technology and Device Lending/Loan Program
- Housing/Personal Care Attendant Services
- Advocacy Support Services

*NOTE:* Members who are receiving Community Transition Program Services, who are residing in a SNF or another LTC facility, who are at risk of institutionalization, or Members living in the community who are frequent users of high cost urgent care and short term hospitalization benefits for the lack of adequate LTSS, will be assisted by the Contractor through a variety of available sources to receive access to social supports and services in the community. Contractor may potentially request funding for these Members in following
categories for successful and sustainable transition in the community: Rental deposit, First month’s rent, Basic furniture, Initial stock of groceries, Basic household items, Assistive Technology (AT) items, and Home and/or Vehicle Modifications, if needed.

Once transitioned, Contractor will continue to work with the Member to assist them in meeting the goals that they set in their Independent Living Plan (ILP) through Community Living Services (case management and monitoring activities).

IV. **Community Living Services (case management & monitoring)**

For Members who transitioned from a SNF or other Long Term Care (LTC) facility will receive Community Living Services for 365 days following the day of discharge. Member lives in the community and receive LTSS as identified in their individual Comprehensive Service Plan (CSP).

Once it is determined that the Member would benefit from Community Living Services, the Contractor will develop an Independent Living Plan (ILP), in coordination with Member, and will provide ongoing monitoring and care coordination, as needed. Contractor will submit all relevant information to Company via fax or other process, as agreed upon by the parties. Contractor will contact every Member in case management at least once a month to monitor and identify “red flags,” service needs, adjustments in the ILP, as needed. Contractor will also be available to provide additional support to Members to effectively resolve issues for the purpose of resolution and navigation with Company and its providers to ensure that Member receives access to needed care.

Contractor will provide linkages and coordination of additional services necessary as specified in the Member’s CSP/ILP, or just the ILP (if applicable), including but not limited to: (see Addendum 2)

- Peer Counseling (Stepping Stones 10-week program)
- Independent Living Skills Training
- Assistive Technology and Device Lending/Loan Program
- Housing/Personal Care Attendant Services
- Advocacy Support Services

A key component of Community Living Services and the most effective method for measuring the success of the Member receiving HCBS in a community setting is the Quality of Life (QoL) Survey. The QoL is structured to measure the Member’s quality of life, based on multiple areas, and is used to compare the Member’s situation between the institutional setting and the community setting, or between their situation prior to receiving Community Transition Program services and afterward. The goal is to demonstrate that the Member’s quality of life improves once in the community and when receiving Community Transition Program services. QoL Survey administration schedule:

- At the start of entering the program, or just prior to transition or within ten days after day of transition
- Eleven months after transition
- Twenty-four months after transition

*NOTE: Members who are receiving Community Transition Program Services, who are residing in a SNF or another LTC facility, who are at risk of institutionalization, or Members living in the community who are frequent users of high cost urgent care and short term hospitalization benefits for the lack of adequate LTSS, will be assisted by the Contractor through a variety of available sources to receive access to social supports and
services in the community. Contractor may potentially request funding for these Members in following categories for successful and sustainable transition in the community: Rental deposit, First month's rent, Basic furniture, Initial stock of groceries, Basic household items, Assistive Technology (AT) items, and Home and/or Vehicle Modifications, if needed.

**Contractor's Internal Workflow**

The internal workflow of Contractor will be as follows:

**Step 1.** Referral request for services from Company is received. This may take the form of, but not limited to, file transfer or facsimile to Contractor staff and/or website posting.

**Step 2.** Contact Member to schedule date and time to conduct Assessment. If Member is a resident of a SNF or other LTC facility, Contractor will make every effort to meet with Member in the facility as per follows:

- Member referred Monday- Wednesday- within 48 hours of the referral
- Member referred Thursday noon-by Friday 5pm
- Member referred Thursday after 12 noon or Friday-by following Monday 5pm

**Step 3.** Contractor completes the following documents and uploads the data files and forms via fax (or other means as parties agreed upon):

First Month:

1. Assessment Summary
2. Comprehensive Service Plan (CSP) – only for those Members in a SNF or other LTC facility to transition into the community

Following Months (submitted within the 30-day period):

1. Independent Living Plan (ILP) – specifically reporting Consumer Progress, Staff Activity and Outcome and Status delivered to Company
2. Updated Comprehensive Service Plan (CSP) – indicating progress toward transition into the community as well as domicile status (continued in community, re-institutionalized, other) delivered to the Company
3. Monthly Report delivered to the Company including but not limited to:
   a. List of Members with contact status (achieved, number of tries, not achieved), “red flags” identified if any, ILP progress by goal, changes in service needs. If Contractor has provided additional support to Members, report describes this.
   b. Other periodic Status Reports as agreed upon by parties

**Step 4.** Contractor facilitates linkages to needed community supports, where appropriate and available, and coordinates the delivery of services/interventions to Members.

**Step 5.** Contractor continually documents actions on behalf of Members and provides periodic updates to Company, as needs change.
Step 6. Contractor checks Member eligibility each month to determine Member inclusion/exclusion from Community Living Services.

Additional Deliverables:

Step 7. Contractor participates in regular Joint Operations Committee Meeting with Company, as requested. These meetings will take place on a weekly basis at the onset of the CSP, and continue on a regular basis, as needed.

Step 8. Parties will conduct cross-trainings, as needed, to ensure that both parties understand each other’s business and processes, on dates and times convenient for both parties.

EXHIBIT G

ADJUSTMENTS TO THE CONTRACT LANGUAGE

This exhibit sets forth the clarification of the contract language as it applies to the PROVIDER. The Agreement and this exhibit shall supersede the contract language in the previous and subsequent exhibits.

A. The term Medically Necessary is expanded to include services and products that will keep an Enrollee as independent and living in their own environment. Historically, such services have been considered social services, community based services or local access resources. As the goal of the Agreement is to maintain individuals in the community and not in licensed facilities, the term Medically Necessary will now include non-medical services, products and resources.

B. Both Parties of this Agreement understand that the PROVIDER is not, and does not plan to be, MediCare Certified. While the contract language states otherwise, the agreed to services under Exhibit A, 4. Have been negotiated in good faith and do not require a MediCare Certification to provide those services.

C. The current billing arrangements for the PROVIDER does not include the collections of deductible, copayment or Share of Cost. This Agreement does not change that arrangement and the copayment, deductible and Share of Cost references do not apply to the PROVIDER.