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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

Horisons Unlimited, a California nonprofit corporation and Horisons Unlimited Health Care, a California Corporation, Plaintiffs, vs. Santa Cruz-Monterey-Merced Managed Medical Care Commission dba Central California Alliance for Health; County of Merced; The Board of Supervisors of the County of Merced and the Individual Members Thereof, Defendants.	Case No. COMPLAINT FOR DAMAGES AND INJUNCTIVE RELIEF (Jury Trial Demanded)

I. JURISDICTION

1. Plaintiffs Horisons Unlimited and Horisons Unlimited Health Care bring this action pursuant to the provisions of 15 USC sections 15 and 26 and 42 USC section 1983. Jurisdiction of this action is based on 28 USC sections 1331 and 1337. Jurisdiction of supplemental claims under California law is based on 28 USC section 1367(a). Venue is proper in the United State District Court for the Eastern District of California in that the defendants can be found in and transact business within the District.

II. PARTIES

2. Plaintiffs Horisons Unlimited and Horisons Unlimited Health Care (individually and collectively, referred to herein as "Horisons") are and have been at all times mentioned herein a California nonprofit corporation and for profit corporation, each licensed by the State of California as a clinic for the provision of primary medical care services and authorized by the United States government to provide such services as a certified Rural Health Clinic. Horisons is and has been a nondenominational religious-based provider of healthcare services. Horisons was established by and their respective members and shareholders include clergy and church members, and the members of its governing body include clergy and church members. Services provided at Horisons' clinic locations include and have included pastoral comfort and assistance for those desirous of same.

3. Defendant Santa Cruz-Monterey-Merced Managed Medical Care Commission dba Central California Alliance for Health ("Alliance") is and has been at all times mentioned herein an entity distinct from each of Santa Cruz, Monterey and Merced Counties created by ordinance by those three counties pursuant to the provisions of California Welfare & Institutions Code section 14087.54 and empowered to perform all activities authorized by section 14087.54, including without limitation competing with other Merced County commercial insurers and health maintenance organizations for the provision of managed healthcare services to publicly supported programs, private businesses and individuals.

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4. The County of Merced is and has been a political subdivision of the State of California.

5. The Board of Supervisors of the County of Merced and the Individual Members Thereof (collectively, "Merced") are and have been the governing body of the County of Merced. The individual members are sued in their official capacity.

III. BACKGROUND

6. Pursuant to California Welfare & Institutions Code sections 14000 et seq., California enacted Medi-Cal as its Medicaid program under 42 USC section 1396a. Welfare and Institutions Code section 14000 states:

> The purpose of this chapter is to afford to qualifying individuals health care and related remedial or preventive services, including related social services which are necessary for those receiving health care under this chapter.
>
> The intent of the Legislature is to provide, to the extent practicable, through the provisions of this chapter, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family's future minimum self-maintenance and security. It is intended that whenever possible and feasible:
>
> (a) The means employed shall allow, to the extent practicable, eligible persons to secure health care in the same manner employed by the public generally, and without discrimination or segregation based purely on their economic disability. The means employed shall include an emphasis on efforts to arrange and encourage access to health care through enrollment in organized, managed care plans of the type available to the general public.
>
> (b) The benefits available under this chapter shall not duplicate those provided under other federal or state laws or under other contractual or legal entitlements of the person or persons receiving them.
>
> (c) In the administration of this chapter and in establishing the means to be used to provide access to health care to persons eligible under this chapter, the department shall emphasize and take advantage of both the efficient organization and ready accessibility and availability of health care facilities and resources through enrollment in managed health care plans and new and innovative fee-for-service managed health care plan approaches to the delivery of health care services.

7. Before January 1, 2014, Medi-Cal qualifying individuals were generally required to have income that did not exceed 100 percent of the federal poverty and such individuals did not include childless adults. As of January 1, 2014, the eligible income level for Medi-Cal qualifying individuals increased to 138% of the federal poverty level and eligibility was expanded to include childless adults. As of December 2013, Merced County Medi-Cal enrollment was approximately 80,000 individuals out of a total County population of approximately 262,000. Due to the expansion of Medi-Cal effective on Janaury1, 2014, at least another 18,000 individuals are expected to be eligible for and seek Medi-Cal services in Merced County.

8. In 1977, Congress Adopted the Rural Health Clinics Act to address the shortage of healthcare providers in rural areas. At the time, mid-level practitioners, such as physician's assistants and nurse practitioners, were the main source of care in such areas, but were not generally reimbursed by Medicaid and Medicare. The Rural Health Clinics Act established Medicaid and Medicare reimbursement for such services. A Rural Health Clinic is required to be staffed by a team that includes at least one mid-level provider that must be onsite to see patients at least 50 percent of the time that the clinic is open, and a physician to supervise the mid-level practitioner. Rural Health Clinics are required to provide outpatient primary care services and basic laboratory services, but may provide additional services.

9. Horisons maintains and has maintained clinics in Los Banos, Livingston, and Gustine in Merced County. These clinics are located in rural healthcare shortage areas and provide services under Horisons' Rural Health Clinic certification. Horisons has employed between approximately 75-80 employees and contractors to service these three clinics, of which four currently are physician's assistants, six currently are family nurse practitioners, five are physicians, and six are dentists. At these clinics, Horisons has provided general primary care, laboratory, mental health, substance abuse, prenatal and maternity care, chiropractic, acupuncture, podiatry, OBGYN, dermatology, cardiology, dental and weight loss services through qualified professionals to Medi-Cal beneficiaries and to the "working poor" who do not

qualify for public assistance.

10. In 2008, the Board of Supervisors of Merced adopted Ordinance 1850 to create Alliance. Under Ordinance 1850, all persons in Merced eligible for Medi-Cal were and are required to be a member of a County approved Medi-Cal managed care plan in order to receive healthcare services under Medi-Cal. Although Merced and Alliance were empowered under Welfare & Institutions Code section 14087.54 to subcontract with more than one commercial Managed Medi-Cal Plan to encourage competition between the commercial plans for competitive pricing and enhanced access for the delivery of care, Merced and Alliance elected to establish Alliance as the sole Medi-Cal Managed care entity in Merced and with which all healthcare providers seeking to provide services to Medi-Cal beneficiaries would have to be contracted. All Merced County Medi-Cal eligible persons are and were required to be a member of Alliance in order to receive Medi-Cal services. Failure of a primary care provider to be contracted with Alliance means and meant that Medi-Cal patients would be informed that the provider was not authorized to provide services to Alliance members, the patient's services would not be paid for by Medi-Cal through Alliance, and any referrals by the noncontracted primary care provider to specialists would not be paid for by Alliance even if the specialist was a member of Alliance. By virtue of the foregoing action of Merced and Alliance, Alliance obtained a monopoly in Merced County for the provisions of Medi-Cal managed care healthcare services.

11. Horisons had been providing clinic services in Merced County since 2004 to all Merced County residents eligible for Medi-Cal before the adoption of Ordinance 1850. Following the adoption of that Ordinance, the monopoly that Merced and Alliance created forced Horisons to enter into a contract with and become a member of Alliance. Had Horisons not done so, Horisons would have been limited to treating only those Medi-Cal eligible patients who ignored the requirement to be a member of Alliance or ignored Alliance's assignment of the patient to another primary care provider. The number of patients electing to ignore Alliance would have been negligible and the financial loss so devastating to Horisons that it would have

no longer been able to provide services. As of today, it remains true that unless Horisons is contracted with Alliance, Horisons will be financially devastated and unable to remain in business for the foregoing reasons.

12. Effective January 1, 2011 Horisons entered into the contract required by Merced and Alliance, a true and correct copy, with amendments, is attached hereto as Exhibit A and incorporated herein by this reference. Save for the name of the contracting Horisons corporation the contract is the same for both Plaintiffs. Among other provisions, this contract in Article II, Section 2.3.4 states:

> "**Credentialing.** Provider and its Provider Professionals shall meet Plan's credentialing standards as specified in the Provider Manual and must be approved by the Plan before providing Covered Services to Members. Provider shall respond to requests form Plan for credentialing information. Failure to timely respond to such requests shall be grounds for termination pursuant to Section 5.2."

13. The Provider Manual states in relevant part:

> **"Provider Application, Credentialing and Contracting**
> To participate in the Alliance network, a provider must sign a Provider Services Agreement and his/her credentials must be approved by the Peer Review and Credentialing Committee which is comprised of Alliance-contracted network physicians from major disciplines, including primary care and specialty practices. Providers are re-credentialed within 36 months after the initial credentialing date or the last re-credentialing approval date.
>
> Pursuant to Article II of the Provider Services Agreement, all new providers and those eligible for re-credentialing must return a signed California Participating Physician Application (CPPA) to the Alliance, along with all required attachments, including, but not limited to, copies of the following documents:
>
> - Current Medical License or Business License.
> - Current Clinical Laboratory Improvement Amendments (CLIA) or Waiver.
> - Current Drug Enforcement Agency (DEA) License.
> - Documentation for National Provider Identifier (NPI) and Taxonomy Code.
> - Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).

- Signed Taxpayer Identification Form (W-9).
- Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.
- Signed Declaration of Confidentiality form (new providers only).
- Language Verification Form (new providers only).

If a provider is a supervising physician for a non-physician medical practitioner (NPMP), all new NPMPs and those eligible for re-credentialing must return a signed CPPA, along with all required attachments and copies of the following documentation:

- Current completed NPMP/Physician Assistant (PA) Delegation of Services Agreement(s), if applicable.
- Current NPMP staff licenses.
- Current NPMP staff malpractice insurance face sheets.
- Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
- Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.
- Signed Declaration of Confidentiality form (new providers only).

Before the verification process is finalized, a nurse from the Alliance will visit each Medi-Cal Primary Care Physician (PCP) site to conduct a site review. After the site review and verification of the credentialing information, the provider's initial credentialing and re-credentialing files are submitted to the Peer Review and Credentialing Committee for review and approval. If a provider's credentials are approved, the Alliance's Chief Executive Officer will countersign the Provider Services Agreement and within 10 days of approval, new contracted providers will begin to receive training and a new provider orientation from our Provider Services Department.

For additional information about the Alliance's credentialing policies and procedures, please visit the credentialing policies link on the Alliance website."

Before and as of January 1, 2013, the Provider Manual stated:

"**Provider Application, Credentialing and Contracting**
To participate in the Alliance network, a provider must sign a Provider Services Agreement and his/her credentials must be approved by the Peer Review and Credentialing Committee of the Santa Cruz-Monterey-Merced Managed Medical Care Commission. Providers are re-credentialed within 36 months after the initial credentialing date or last re-credentialing approval date.

> Pursuant to Article II of the Provider Services Agreement, all new providers and those eligible for re-credentialing must return a signed Application Form to the Alliance, along with all required attachments, including, but not limited to, copies of the following documents:
>
> - Language Verification Form (new providers only).
> - Current Medical License or Business License.
> - Current Clinical Laboratory Improvement Amendments (CLIA) or Waiver.
> - Current Drug Enforcement Agency (DEA) License.
> - Documentation for National Provider Identifier (NPI) and Taxonomy Code.
> - Professional Liability Insurance (malpractice) face sheet (required limits are $1,000,000 per occurrence/$3,000,000 annual aggregate).
> - Signed Taxpayer Identification Form (W-9).
> - Signed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form.
> - Signed Declaration of Confidentiality form (new providers only).
>
> If a provider is the supervising physician for mid-level practitioners who work 32 hours per week or more, the following information and copies of documentation are needed (in addition to the above):
>
> - Current completed mid-level agreement(s)/Physician Assistant (PA) Delegation of Services Agreement(s), if applicable.
> - Current mid-level staff licenses, if applicable.
> - Current mid-level staff malpractice insurance face sheets, if applicable.
> - Date of birth and social security number for mid-level staff, if applicable.
>
> Before the verification process is finalized, a nurse from the Alliance will visit each Medi-Cal Primary Care Physician (PCP) to conduct a site review. After the site review and verification of the credentialing information provided, providers' initial credentialing and re-credentialing files are submitted to the Peer Review and Credentialing Committee for review and approval. If a provider's credentials are approved, the Alliance's Executive Director will countersign the Provider Services Agreement and within 10 days of approval, new providers will receive training and new provider orientation from our Provider Services Department."

14. Alliance policy No. 300-4030, referenced in the credentialing policies link in the current version of the Provider Manual states in relevant part:

> 2.a. Provisional Credentialing
>
> i. Providers applying for participation in the Alliance network for the first time who meet all of the credentialing criteria standards and having "clean" credentialing files may be recommended by the Provider Services Network Manager or Provider Services Director for Provisional credentialing approval.
>
> ii. The Medical Director will review and may approve such "clean" credentialing files for new providers on a provisional basis, pending final PRCC approval, as needed to meet specific access needs within the network between quarterly PRCC meetings.

A true and correct copy of Policy No. 300-4030 is attached hereto as Exhibit B and incorporated herein by this reference.

15. Notwithstanding the provision in Policy No. 300-4030 for temporary credentialing, notwithstanding that Alliance's Peer Review and Credentialing Committee meets infrequently, and notwithstanding that Alliance can take up to six months to complete credentialing, as to Horisons, Alliance has refused and is refusing to credential temporarily any of Horisons' otherwise licensed and qualified mid-level and physician professional providers, thereby refusing to allow these individuals to work for Horisons in their chosen profession pending completion of credentialing. Alliance's refusal to allow such providers to provide services on a temporary basis imposes great hardship on the providers, Horisons and the public. Merced County is not a destination location for professional healthcare providers. Newly licensed healthcare providers frequently work for Horisons in order to obtain experience and training that will enable them to secure employment in more attractive locations, which causes a large turnover of such staffing at Horisons and requires prompt replacements to continue the level of services. Obtaining professionals to work for Horisons is also practically impossible if the professionals are told they cannot work and be paid as professional for many months.

16. The County of Merced has higher incidences of poverty, obesity, asthma, diabetes, and related disabled persons than California generally. Horisons' rural clinic locations

serve and have served these populations to a proportionately greater extent than other primary care providers in Merced County. Delaying full credentialing for many months for critically needed professionals and refusing to allow temporary credentialing limits access to these individuals to critically needed healthcare, is contrary to Policy Information Notice 2001-16 of federal Rural Health Center Policies and to the Joint Commission on Accreditation of Healthcare Organizations at MS.06.01.11 and .13, which is incorporated into this Rural Health Center Policy. In accordance with Rural Health Center Policy, and to meet patient needs, Horisons has allowed licensed and competent professionals to provide professional services to patients pending Alliance's completion of full credentialing.

17. On or about December 20, 2013, asserting that Horisons' temporary credentialing of these professional violated Article II, Section 2.3.4 of the contract above referenced, Alliance stopped new enrollments at Horisons of persons enrolled in Alliance's Medi-Cal Managed Care Plan and has threatened to terminate Horisons' contract altogether immediately. In addition to discontinuing new member enrollment, Alliance has also refused to inspect a new Horisons' clinic site in the City of Merced and refused to credential at all a Horisons chiropractor, thereby further limiting patient access and damaging Horisons.

18. In addition to the foregoing, despite the needs of Horisons' obese, asthmatic, diabetic, and disabled patients, Alliance has for the past year threatened to terminate Horisons' contract unless the annual visits of these patients average no more than 3.2. These patients frequently require more visits to Horisons' clinics due to the health conditions and disability, in order to keep the Alliance contract, Horisons has been forced not to bill Alliance for many of these medically necessary visits so that the average number of annual patient visits do not exceed 3.2.

FIRST CLAIM

(Violation of Sections 1 and 2 of the Sherman Antitrust Act)

19. Plaintiff incorporates herein and makes a part hereof by this reference all of the allegations contained in Paragraph 1 through 18.

20. The main competition in Merced County to Horisons for Medi-Cal Managed Care patients is and has been Golden Valley Health Centers, a federally qualified healthcare clinic. At all relevant times and currently, the Deputy Chief Executive Officer of Golden Valley Health Centers has been a member of Alliance's governing body. While serving in that capacity, Christine Noguera has objected to religious services, such as prayer support, provided at Horisons' clinics, which are an essential component of Horisons' faith-based mission to serve the healthcare needs of the poor. Ms. Noguera has otherwise rebuffed Horisons' efforts to work cooperatively with Golden Valley Heath Centers to meet patient needs and has indicated that it is the goal of Golden Valley Health Centers to take over Horisons. Golden Valley Health Centers is and has been on a campaign of expansion of its clinics in multiple counties. On information and belief, Golden Valley Health Centers is permitted by Alliance to use temporary credentialed professional providers who are similarly situated to Horisons' new professional providers without any adverse consequence to Golden Valley Health Centers.

21. On multiple occasions in 2012 and 2013, Horisons' Chief Executive Officer and members of Horisons' governing body have met and otherwise communicated with the Chair of the Merced Board of Supervisors and other representative of that Board and requested that Merced establish one or more additional Medi-Cal managed medical care plans to compete with Alliance. Horisons has clinics in Mariposa and Madera Counties and is contracted with commercial managed care plans in those counties that allow temporary credentialing. Merced has repeatedly refused to consider eliminating Alliance's monopoly for Medi-Cal Managed Healthcare services.

22. Merced County Ordinance 1850 at section 9.43.070 of the County Code states in relevant part:

> "A. The commission shall be considered an entity [separate (sic)] from the county of Santa Cruz, the county of Monterey, and the county of Merced. The commission shall have all the powers made available generally to commissions under the Welfare and Institutions Code Section 14087.54. Specifically, the commission shall have the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for

> services to meet its obligations, and to sue or be sued. Any obligations of the commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of either the county of Santa Cruz, the county of Monterey, or the county of Merced.
>
> B. Prior to approving an initial managed medical care system plan, the commission shall submit a proposed draft plan to each respective board of supervisors for their review and comment, and shall consider any comments or recommendations made by each board of supervisors, thereafter, prior to submission to the state or execution by the parties, the commission shall submit: (1) the initial managed medical care system plan, as approved by the commission; (2) any amendment to the system plan; (3) any contract with the California Department of Health Care Services for the provisions of health care services to each respective board of supervisors for their review and comment. (Ord. 1850, 2008)."

As a distinct separate entity from Merced, Merced's arrangement with Alliance enables Merced to insulate itself from the uncertainties and liabilities of a Medi-Cal managed care plan, but its approval of Alliance as the sole Medi-Cal managed care plan is a combination in restraint of trade in violation of 15 USC sections 1and 2 in that it gives Alliance a monopoly and eliminates competition between plans for the Merced County Medi-Cal managed care business. Alliance's exercise of its monopoly power also allows Alliance to eliminate competition between Merced County providers for Medi-Cal managed care business, as Alliance is now doing in rendering Horisons unable to compete with Golden Valley Health Centers. Pursuant to the broad powers of Merced and Alliance in California Welfare and Institutions Code section 14087.54 to allow for competition between Medi-Cal managed care plans and providers, California's general policy is not to displace competition with regulation and Alliance and Merced are subject to 15 USC sections 1 and 2.

23. The actions of Merced and Alliance restrain trade and commerce among the states in that it limits and/or denies access to crucial health services for persons moving though interstate commerce who pass through or relocate to Merced County, in that it frustrates the movement of licensed healthcare professionals for professional experience and training through interstate commerce frustrates the establishment of rural health services that the Rural Health

Clinics Act intended to foster, and limits the interstate movement of goods, services and financial transactions from, into and out of the County of Merced that certified Rural Health Clinics and other primary care clinics require.

24. The actions of Merced and Alliance also violate 15 USC section 2 in that the two entities have conspired between themselves and, on information and belief, with Golden Valley Health Centers, to monopolize Medi-Cal managed healthcare services in Merced County through the elimination of any competing managed care plans, through the elimination of competition against Golden Valley Health Centers and through the elimination of providers that are disfavored because of the populations they serve and their religious orientation.

25. As a legal and proximate result of each defendant's violations of 15 USC sections 1 and 2, Horisons has been damaged in that it has lost and will lose millions of dollars in an amount to be shown according to proof but at least $350,000 per month from the nonenrollment of new members, and will lose additional money from the refusal to inspect and approve Horisons' Merced clinic, from the refusal to approve chiropractic services, from the refusal to allow more than an average number of 3.2 annual patient visits, and from the refusal to allow temporary credentialing of Horisons' providers. The foregoing threatens Horisons with imminent bankruptcy. If Alliance proceeds with its threat to terminate the contract alleged above altogether, Horisons will be forced into bankruptcy and forced to discontinue its services altogether, leaving its rural health clinic patients without reasonable access to critical healthcare services and increasing the damages to be suffered by Horisons. Pursuant to 15 USC section 15, Horisons is entitled to treble the amount of its actual damages, interest as provided in that section, and attorney fees, all against Alliance.

26. Pursuant to the provisions of 15 USC section 26, Horisons is also entitled to an injunction against each defendant from (a) further denying Horisons' enrollment of new Alliance members based on Alliance's policy that Horisons' professional healthcare providers must be credentialed with Alliance before providing services to Alliance's members and/or not to allow temporary credentialing, (b) terminating the contract alleged above on either of the foregoing

grounds, (c) denying otherwise qualified chiropractic care at Horisons, (d) refusing to inspect Horisons' Merced site based on any of the foregoing, (e) refusing to allow an average of more than 3.2 patient visits per year, and (f) continuing the Alliance monopoly. Horisons, and its patients, are without an adequate remedy at law in that money damages cannot adequately compensate Horisons for being driven into bankruptcy and its patients are and will be without access to crucial healthcare services. At the present time, there are Horisons patients who wish to have Horisons' services even though they are enrolled in Alliance as a new member, but Alliance refuses to allow such patients to be referred to urgently needed specialists, such as a surgeon, unless the patient is first sent to an authorized Alliance primary care provider, thereby delaying or denying critically need care for the patient and denying the patient his/her freedom of choice. The need of Horisons, its patients, its potential patients, and the public is immediate, sharp and weighty.

SECOND CLAIM

(Deprivation of Federal Civil Rights in Violation of 42 USC Section 1983)

27. Plaintiff incorporates herein and makes a part hereof by this reference all of the allegations contained in Paragraphs 1 through 26.

28. The decision of Alliance to cease enrollment of new members in Horisons and Alliance's threat to terminate the contract were and will be made by Alliance's governing body or an official of Alliance to whom the governing body has delegated its policymaking authority. In addition, Alliance's governing body as a matter of official policy has adopted administrative review procedures that are inapplicable to the matters complained of herein and opaque.

29. In taking the actions alleged above, Alliance, acting under color of state law and California Welfare And Institutions Code section 14087.54, in violation of 42 USC section 1983 has deprived Horisons of the free exercise of religion guaranteed by the First Amendment to the United States Constitution and to procedural and substantive due process of law under the Fifth Amendment thereto as applied to the states by the Fourteenth Amendment to that Constitution. As a proximate and legal result of Alliance's actions, Horisons has been and will

be damaged as alleged above, entitling Horisons to compensatory damages as alleged above, injunctive relief, and to attorney and expert fees as provided in 42 USC section 1988, all against Alliance.

THIRD CLAIM

(California Business & Professions Code Sections 16720, 16721 and 16750)

30. Plaintiff incorporates herein and makes a part hereof all of the allegations contained in Paragraphs 1 through 29.

31. California Business & Professions Code sections 16700-16761 render unlawful under California antitrust law the same acts of Merced and Alliance that are alleged above to have violated Sections 1 and 2 of the Sherman Antitrust Act at 15 USC sections 1 and 2. In addition, Business & Professions Code section 16721 states in relevant part:

> 16721. Recognizing that the California Constitution prohibits a person from being disqualified from entering or pursuing a business, profession, vocation, or employment because of sex, race, creed, color, or national or ethnic origin, and guarantees the free exercise and enjoyment of religion without discrimination or preference; and recognizing that these and other basic, fundamental constitutional principles are directly affected and denigrated by certain ongoing practices in the business and commercial world, it is necessary that provisions protecting and enhancing a person's right to enter or pursue business and to freely exercise and enjoy religion, consistent with law, be established.(a) No person within the jurisdiction of this state shall be excluded from a business transaction on the basis of a policy expressed in any document or writing and imposed by a third party where that policy requires discrimination against that person on the basis of any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code or on the basis that the person conducts or has conducted business in a particular location.(b) No person within the jurisdiction of this state shall require another person to be excluded, or be required to exclude another person, from a business transaction on the basis of a policy expressed in any document or writing that requires discrimination against that other person on the basis of any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code or on the basis that the person conducts or has conducted business in a particular location.(c) Any violation of any provision of this section is a conspiracy against trade.

As a proximate and legal result of Alliance's and Merced's violations of sections 16720 and 16721, Horisons has and will be damaged as alleged above and as to Alliance is entitled to

treble actual damages, injunctive relief, interest, and a reasonable attorney fee, and as to Merced is entitled to injunctive relief and a reasonable attorney fee.

FOURTH CLAIM

(Violation of California Civil Code Section 51.5)

32. Plaintiff incorporates herein and makes a part hereof by this reference all of the allegations contained in Paragraphs 1through 31.

33. California Civil Code section 51.5 states in relevant part:

> 51.5. (a) No business establishment of any kind whatsoever shall discriminate against, boycott or blacklist, or refuse to buy from, contract with, sell to, or trade with any person in this state on account of any characteristic listed or defined in subdivision (b) or (e) of Section 51, or of the person's partners, members, stockholders, directors, officers, managers, superintendents, agents, employees, business associates, suppliers, or customers, because the person is perceived to have one or more of those characteristics, or because the person is associated with a person who has, or is perceived to have, any of those characteristics.(b) As used in this section, "person" includes any person, firm, association, organization, partnership, business trust, corporation, limited liability company, or company.

Among the characteristics listed in Civil Code section 51(b) and (e) are religion, race, national origin, ancestry, disability and medical condition. By reason of the acts alleged above, Alliance has been and is discriminating against Horisons on the basis of religion and on the basis of Horisons providing healthcare services to persons who are disabled within the meaning of sections 12926 and 12926.1 of the California Government Code and who are predominately Hispanic.

34. As a proximate and legal result of Alliance's violation of Civil Code section 51.5, Horisons has been and will be damaged as alleged above and is entitled to the remedies against Alliance provided in Civil Code section 52 for each and every offense consisting of actual damages and up to three times the amount of actual damages, injunctive relief and attorney fees.

FIFTH CLAIM

(Mandamus Pursuant to California Code of Civil Procedure Section 1085)

35. Plaintiff incorporates herein and makes a part hereof by this reference all of the

allegations contained in Paragraphs 1 through 34.

36. California Government Code section 11135 states in relevant part:

> (a) No person in the State of California shall, on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, genetic information, or disability, be unlawfully denied full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state.

California Welfare and Institutions Code section 10000 states:

> The purpose of this division is to provide for protection, care, and assistance to the people of the state in need thereof, and to promote the welfare and happiness of all of the people of the state by providing appropriate aid and services to all of its needy and distressed. It is the legislative intent that aid shall be administered and services provided promptly and humanely, with due regard for the preservation of family life, and without discrimination on account of ancestry, marital status, political affiliation, or any characteristic listed or defined in Section 11135 of the Government Code. That aid shall be so administered and services so provided, to the extent not in conflict with federal law, as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society.

37. The policies and actions of Alliance alleged above in denying temporary privileging of Horisons' professional providers are and have been arbitrary, capricious, and unlawful as alleged above and in that by their impact as alleged above on access to healthcare services for disabled Hispanics and their impact on Horisons' state and federal constitutional rights to offer religious-based healthcare services, they violate the mandates of California Government Code sections 11135 and Welfare and Institutions Code sections 10000 and 14000 as set forth above. Alliance has a clear, present and existing ministerial legal duty to cease its patently irrational and unlawful practice of denying temporary credentialing and using this practice to cease enrollment of Medi-Cal managed care plan beneficiaries in Horisons. Alliance also has a clear, present and existing ministerial duty to cease arbitrarily threatening Horisons with adverse actions and contract termination based on patients' having more than 3.2 average

number of annual patient visits when additional visits are medically necessary. The need of plaintiff and the public is sharp, immediate and weighty.

38. Pursuant to the provisions of California Code of Civil Procedure section 1085, Plaintiff is entitled to a writ of mandamus compelling Alliance to perform its mandatory duty to permit temporary credentialing in accordance with the provisions of the Joint Commission on Healthcare Organizations and standard industry practice, compelling Alliance to cease adverse action against Horisons based on Alliance's policy that patient visits should not exceed an average of 3.2 per year irrespective of medical necessity.

SIXTH CLAIM

(Breach of Contract)

39. Plaintiff incorporates herein and makes a part hereof by this reference all of its allegations contained in paragraphs 1 through 38.

40. Plaintiff has performed all of the terms and conditions of the contract alleged herein on its part to be performed; to the extent, if any, that California Government Code § 905 et seq. applies, Plaintiffs have complied or substantially complied with those provisions.

41. The acts of Alliance alleged above are and have been material breaches of the aforementioned contract. As a proximate and legal result of Alliance's breach of contract, Horisons has been and will be damaged as alleged above and is entitled to compensatory damages against Alliance as alleged above.

WHEREFORE, Horisons prays for judgment as follows:

1. (a) A temporary, preliminary and permanent injunction barring defendants from further denying Horisons' enrollment of new Alliance members based on Alliance's policy that Horisons' professional healthcare providers must be credentialed with Alliance before providing services to Alliance's members and/or Alliance's policy not to allow temporary credentialing, (b) terminating the contract alleged above on either of the foregoing grounds, (c) denying otherwise qualified chiropractic care at Horisons, (d) refusing to inspect Horisons' Merced site based on any of the foregoing, (e) refusing to allow an average for more than 3.2 patient visits per year,

and (f) continuing the Alliance monopoly.

2. That a writ of mandate issue under seal of the Court ordering Alliance to refrain from the actions described in the preceding paragraph and adopt a rational policy for temporary credentialing.

3. Compensatory damages to be shown according to proof, trebled as provided in the First, Third, and Fourth Claims, against Alliance.

4. Attorney fees under the First through Fourth Claims and as provided in California Code of Civil Procedure section 1021.5 against Alliance and against Merced under the First and Third Claims

5. Interest as allowed by law.

6. Such other and further relief as the Court deems proper.

Dated: January 27, 2014

DOWLING AARON INCORPORATED

By: _____
DANIEL O. JAMISON
CHRISTOPHER E. SEYMOUR
Attorneys for Plaintiffs

JURY DEMAND

A jury is demanded.

Dated: January 27, 2014

DOWLING AARON INCORPORATED

By: _____
DANIEL O. JAMISON
CHRISTOPHER E. SEYMOUR
Attorneys for Plaintiffs

16082-001-01443413-3

EXHIBIT A

CANFQ-3-4

CENTRAL CALIFORNIA ALLIÁNCE FOR HEALTH
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

Horisons Unlimited Health Care

EXHIBIT A

CAN 2-35

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Central California Alliance for Health
Primary Care Physician Services Agreement

RECITALS

This Primary Care Physician Services Agreement ("Agreement") is made and entered into as of the Commencement Date specified herein, by and between Santa Cruz-Monterey-Merced Managed Medical Care Commission, doing business as Central California Alliance for Health ("Plan"), and Horisons Unlimited Health Care, a California corporation ("Provider"), with reference to the following facts:

WHEREAS, Plan has entered into or will enter into a contract or contracts with the State of California Department of Health Care Services ("DHCS") or other entities under which the Plan has agreed to arrange for the provision of health care services and benefits to eligible Santa Cruz, Monterey, and Merced County Medi-Cal beneficiaries or other covered individuals under the programs identified in Exhibit A hereto.

WHEREAS, Provider desires to participate in Plan's network of contracting providers by providing Covered Services, including Primary Care Physician Services, to Members.

NOW THEREFORE, in consideration of the foregoing and for other good and valuable consideration, the parties hereto agree as follows:

ARTICLE I.
DEFINITIONS

Whenever used in this Agreement, the following terms shall have the definitions contained in this Article I. Terms used in this Agreement which are defined by Law shall be interpreted consistent with such Laws.

1.1. Accreditation Organization. Accreditation Organization means any organization engaged in accrediting or certifying Plan or Providers.

1.2. Case Managed Services. Case Managed Services shall mean providing or arranging for all Covered Services including health assessments, identification of risks, treatment planning, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; coordination of Medically Necessary Covered Services; provision of preventive services in accordance with established standards and periodicity schedules; maintenance of a medical record with documentation of referral services, and follow-up as medically indicated, including but not limited to post-Emergency follow-up; ordering of therapy, admission to hospitals, coordinated hospital discharge planning that includes necessary post-discharge care, and referral to services. Case Managed Services includes the responsibility for organizing and monitoring a pattern of supportive medical resources and continuity of care, so that Members may be appropriately served by medical advice and supervision seven (7) days each week and twenty-four (24) hours per day. Case Managed Services, also known as Primary Care Physician Services subject to Case Management, are described in the Provider Manual.

1.3. Complete Claim. Complete Claim shall have the meaning set forth in Title 28 of the California Code of Regulations, Section 1300.71 (a)(2).

1.4. Commencement Date. Commencement Date is the date this Agreement becomes effective, as specified in Section 5.1.

1.5. Covered Services. Covered Services are those Medically Necessary health care services, supplies and benefits which are required by a Member pursuant to the coverage provisions of a Program, as further

1.6. specified in the Program Requirements and in the applicable Member Group Contracts and Membership Contracts.

1.7. Covered Services Documentation. Covered Services Documentation means documentation developed by Primary Care Physicians to support the Covered Services, including Primary Care Physician Services, provided hereunder, including, without limitation, claims for payment, encounter data, discharge summaries, medical records, emergency visit records and diagnostic reports.

1.8. Covering Physicians. Covering Physicians are Primary Care Physicians who have entered into contracts with Provider to provide Primary Care Physician Services under the terms of this Agreement when Provider is not available and who are Participating Providers or have been approved by the Plan.

1.9. DHCS. DHCS is the State of California Department of Health Care Services, the agency responsible for administering the Medi-Cal program in California.

1.10. Emergency Services. Emergency Services are health care services furnished by a qualified provider and needed to evaluate or stabilize a medical condition, including a psychiatric emergency medical condition (as defined in California Health and Safety Code Section 1317.1(k)(1)), which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of Member (or in the case of a pregnant Member, the health of the Member or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

1.11. Fiscal Year. Fiscal Year of Plan shall mean each twelve (12) month period beginning January 1st and ending December 31st.

1.12. Law. Law means any and all laws and regulations of the State of California or of the United States and all orders, instructions and other requirements of any government agency which are applicable to this Agreement.

1.13. Linked Member. Linked Member shall mean a Member that has been assigned to Provider as their Primary Care Physician, pursuant to Plan's policies for such assignment as set forth in the Provider Manual, for the provision of Case Managed Services and Primary Care Physician Services.

1.14. Medi-Cal Provider Manual. Medi-Cal Provider Manual means the DHCS provider manual, issued by DHCS' fiscal intermediary.

1.15. Medically Necessary. Medically Necessary means, unless otherwise defined in a Membership Contract, Program Requirements or by Law, those reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. No service or supply is a Covered Service unless it is Medically Necessary.

1.16. Member. Member is an individual who is enrolled in a Program and who is determined to be eligible for membership in the applicable Program as of the date of service.

1.17. Member Group Contract(s). Member Group Contract(s) refers to the contracts between the Plan and various government agencies, including the State Medi-Cal Contract, as amended from time to time, under which the Plan has agreed to arrange for the provision of Covered Services to Members.

1.18. Member Payment. Member Payment means an amount (whether expressed as either a percentage of cost or as a specific dollar amount) that a Member is obligated to pay directly to a Participating Provider for a specific service in accordance with the Program under which he or she is covered and in accordance with any applicable Membership Contract. Member Payments shall include, but not be limited to, those payments commonly referred to as "coinsurance," "copayments," and/or "deductibles."

1.19. Membership Contract(s). Membership Contract(s) refers to the evidences of coverage or member handbooks, as amended from time to time, that the Plan issues to its Members and that include complete descriptions of the terms, conditions and benefits available to Members under applicable Programs.

1.20. Participating Provider(s). Participating Provider(s) are physicians, medical groups, IPAs, health care professionals, hospitals, facilities and other providers of health care services or supplies that have entered into written contracts directly or indirectly with Plan to provide Covered Services to Members pursuant to a Program.

1.21. Primary Care Physician ("PCP"). PCP is a Participating Provider who provides Primary Care Physician Services to Members. PCP must meet Plan's criteria for participation as a PCP. Primary Care Physicians must be physicians practicing in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology, or another specialty approved by Plan and DHCS.

1.22. Primary Care Physician Services. Primary Care Physician Services are those Case Managed Services and other Covered Services provided by Provider to Members as further described in this Agreement and in the Provider Manual.

1.23. Program. Program means any health care plan for the provision of Covered Services as more fully described in the Exhibits hereto, the Provider Manual, and any applicable Membership Contract(s), as each may be amended from time to time. The specific Program(s) under which Provider renders Covered Services are set forth on the Schedule of Programs attached as Exhibit A hereto, as may be amended from time to time.

1.24. Program Requirements. Program Requirements are those requirements as established under Law and through any Member Group Contracts and Membership Contracts applicable to specific Programs as summarized in the Exhibits hereto.

1.25. Provider Manual. Provider Manual means that document or series of documents created, maintained, updated and distributed from time to time by Plan that describes the Plan's policies and procedures and provides administrative and Program Requirements for Provider. The Provider Manual is incorporated into this Agreement and made a part hereof.

1.26. Provider Professional(s). Provider Professional(s) are Participating Providers who are physicians and other professionals who are shareholders or partners of, employed by or contract with Provider to deliver Covered Services hereunder. Provider Professionals must meet Plan's criteria for participation as a Participating Provider. References to Provider hereunder shall include Provider and its Provider Professionals.

1.27. Quality Management and Improvement ("QI") Program. Quality Management and Improvement ("QI") Program are those standards, protocols, policies and procedures adopted by Plan to monitor and improve the quality of clinical care and quality of services provided to Members. A summary of the QI Program is included in the Provider Manual, which may be updated from time to time by Plan.

1.28. Referral Services. Referral Services shall mean any Covered Services provided by physicians which are not Primary Care Physician Services, and which are provided by physicians on referral from a Primary Care Physician.

1.29. Self-Referral Services. Self-Referral Services are those Covered Services, including Emergency Services, that Members may access without a referral as set forth for each Program in the Membership Contracts and Provider Manual. Self-Referral Services are subject to the Plan's UM Program.

1.30. Utilization Management ("UM") Program. Utilization Management ("UM") Program are those standards, protocols, policies and procedures adopted by Plan regarding the management, review and approval of the

provision of Covered Services to Members. The UM Program is included in the Provider Manual, which may be updated from time to time by Plan.

ARTICLE II.
DUTIES OF PROVIDER

2.1. Primary Care Physician Services. Provider shall provide Covered Services, including Primary Care Physician Services, in accordance with the terms and conditions set forth in this Agreement, the Provider Manual, the Plan's QI and UM Programs, the applicable Program Requirements, applicable Accreditation Organization standards and the Law. Provider shall be the sole source of primary medical contact and advice for its Linked Members and shall be responsible for Case Managed Services for Linked Members except for Emergency Services, Self-Referral Services and non-Covered Services. Provider shall verify a Member's eligibility with Plan prior to rendering non-Emergency Services. Provider shall comply with prospective, concurrent and post-service review requirements as specified in the UM Program. Provider shall ensure that Covered Services provided under this Agreement are readily available, accessible, appropriate, and provided in a prompt and efficient manner as required by applicable Law.

2.2. Referral Services. Provider shall arrange any necessary Referral Services to be provided by specialists or other providers in accordance with the Plan's UM Program by referring Members to the Plan's selection of Participating Providers, except for Emergency Services, Self-Referral Services, and in other cases where the Plan authorizes such a referral. Provider shall obtain a referral from the Member's Primary Care Provider and an authorization request approved by Plan, if required by Plan, prior to providing Referral Services to Members who are not Linked Members, except for Emergency Services and Self-Referral Services.

2.3. Professional Standards. The primary concern of Provider shall be the quality of Covered Services provided to Members. All Covered Services provided by Provider shall be provided by duly licensed, certified or otherwise authorized professional personnel in accordance with (i) the generally accepted medical and surgical practices and standards prevailing in the applicable professional community at the time of treatment, (ii) Plan's QI and UM Programs, (iii) applicable rules and regulations of California state medical boards, (iv) Law, and (v) the standards of Accreditation Organizations.

2.3.1. Licensure of Provider. Provider shall maintain in good standing at all times and ensure that any and all professionals that provide or assist Provider in the provision of Covered Services hereunder maintain in good standing at all times, any and all licenses, certificates, and/or approvals required under Law and by the Plan.

2.3.2. Hospital Privileges. Provider shall maintain in good standing at all times medical staff membership and clinical privileges, or have executed a formal agreement with another physician to admit and follow patients, at one or more of the Plan's contracted network hospital(s) as necessary to provide Covered Services to Members.

2.3.3. No Conflicts. Provider is not subject to any agreements or obligations that would interfere with Provider's ability to enter into or perform its obligations under this Agreement in accordance with its terms.

2.3.4. Credentialing. Provider and its Provider Professionals shall meet Plan's credentialing standards as specified in the Provider Manual and must be approved by the Plan before providing Covered Services to Members. Provider shall respond to requests from Plan for credentialing information. Failure to timely respond to such requests shall be grounds for termination pursuant to Section 5.2 hereto.

2.3.5. Right to Withdraw. Plan reserves the right to immediately withdraw from Provider any or all Members in the event that the health or safety of Members is endangered by the actions of

Provider or if Provider ceases to maintain required licenses, hospital privileges, or ceases to meet Plan's credentialing criteria.

2.3.6. Change in Status or Information. Provider shall immediately notify Plan in writing of any change in licensure or hospital privilege status, any change in information provided to Plan through the credentialing process, and any change in address or practice status.

2.4. Access and Availability. Provider shall comply with the access and availability requirements and conditions for each applicable Program as required by Law and as further delineated in the Provider Manual, including but not limited to prompt scheduling of appointments and availability of Primary Care Physician Services.

2.5. Covering Physicians. If Provider and its Provider Professionals are unable to provide Covered Services from time to time, Provider shall secure the services of qualified Covering Physicians who are Participating Providers or who otherwise meet the Plan's credentialing criteria and who are approved by the Plan to provide Primary Care Physician Services to Members. Provider shall enter into written agreements with Provider Professionals and Covering Physicians consistent with the terms and conditions of this Agreement and the requirements of Law. Provider shall provide the Plan with a complete list of its Provider Professionals and Covering Physicians, together with the information required by the Plan for credentialing and plan administration, which this Agreement is signed and thereafter whenever requested by the Plan. Upon request, Provider shall make such written agreements available to Plan or any applicable government agency, for review and approval.

2.6. Acceptance and Transfer of Members. Provider agrees to provide Primary Care Physician Services to at least one hundred (100) Linked Members, unless excepted by Plan. The Plan process for linking Members to Provider is described in the Provider Manual. Provider may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients. Provider shall not request or demand the transfer, discharge, or removal of any Member for reasons of the Member's need for, or utilization of, Primary Care Physician Services, except in accordance with the procedures established by Plan for such action. Provider shall not request or demand the transfer, discharge or removal of any Member while the Member is hospitalized or is in the middle of a course of treatment and a determination has been made that interruption of care would be detrimental to the health of the Member. Provider shall not refuse or fail to provide or arrange Primary Care Physician Services to any Linked Member. Provider shall be responsible for a Linked Member's Case Managed Services until the time such Linked Member's Primary Care Physician is changed in accordance with Plan's policies.

2.7. Medical Records. Provider shall maintain all patient medical records relating to Covered Services provided to Members, in such form and containing such information as required by the Provider Manual, QI and UM Programs, Accreditation Organizations and Law. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review by Provider and Plan pursuant to the QI Program. Medical records shall be maintained in a form and physical location which is accessible to Provider, Plan, government agencies and Accreditation Organizations. Upon request and within the timeframe requested, Provider shall provide to Plan, at Provider's expense, copies of Member medical records for purposes of conducting quality assurance, case management and utilization review, credentialing and peer review, claims processing, verification and payment, resolving Member grievances and appeals and other activities reasonably necessary for the proper administration of the applicable Program consistent with Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by Law.

2.8. Insurance. Provider shall maintain professional and general liability insurance in the minimum amounts required by Law but not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate, to apply separately for each physician and health care practitioner who is insured under the policy (or policies) and for a period of seven (7) years following termination. In the event Provider procures a "claims made" policy as distinguished from an occurrence policy, Provider shall procure and maintain prior to termination of such insurance, continuing tail or extended reporting coverage for a period of not less than seven (7) years following such termination.

Provider, at its sole cost and expense, shall also maintain throughout the term of this Agreement, workers' compensation insurance as required by the State of California and general liability insurance, including but not limited to premises, personal injury and contractual liability insurance, in a minimum amount of one million dollars ($1,000,000) per occurrence, combined single limit, bodily injury and property damage, to insure Provider and its employees, agents, and representatives against claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the performance of any Covered Services provided under this Agreement, (ii) the use of any property and facilities of the Provider, and (iii) activities performed in connection with this Agreement.

All insurance required of Provider under this Agreement shall be provided by insurers licensed to do business in the State of California and who have obtained an A.M. Best financial strength rating of A- or better and are classified by A.M. Best as being of financial size category VIII or greater. Provider may substitute comparable self-insurance coverage for the insurance coverage required by this Section only upon the prior written approval of Plan.

A certificate of insurance shall be issued to Plan prior to the Commencement Date and upon each renewal of the insurance coverage specified in this Section. The certificate shall provide that Plan shall receive thirty (30) days prior written notice of cancellation or material reduction in the insurance coverage specified in this Section. Notwithstanding anything to the contrary, if Provider has a claims-made based policy and such policy (or policies) is cancelled or not renewed, Provider agrees to exercise any option contained in the policy (or policies) to extend the reporting period to the maximum period permitted; provided, however, that Provider need not exercise such option if the superseding insurer will accept all prior claims. Notwithstanding any other provision of this Agreement, Provider's failure to provide the certificate of insurance shall be grounds for immediate termination of this Agreement.

2.9. Notice of Charges. Provider shall notify Plan immediately of the issuance of any formal charges against Provider or any professional delivering Covered Services on behalf of Provider by any governmental authority or licensing or Accreditation Organization which would, if sustained, impact the Provider's ability to comply with its duties and obligations pursuant to this Agreement. Provider shall further notify the Plan immediately of the initiation of any complaint, formal inquiry, investigation, or review with or by any licensing or regulatory authority, peer review organization, hospital committee, or other committee, organization or body which reviews quality of medical care which complaint, inquiry, investigation, or review directly or indirectly, evaluates or focuses on the quality of care provided by Provider either in any specific instance or in general.

2.10. Administrative Requirements. Provider agrees to perform its duties under this Agreement in accordance with Plan's administrative guidelines, policies and procedures as set forth in this Agreement, the Provider Manual, the Medi-Cal Provider Manual and Law. In the event of a conflict between this Agreement and the Provider Manual, the terms of this Agreement shall govern. In the event of a conflict between the Medi-Cal Provider Manual and either this Agreement or the Provider Manual, this Agreement or the Provider Manual, as applicable, will govern.

2.11. Data Requirements.

2.11.1. General Data and Information. Provider shall maintain and provide at no cost to Plan, upon written request, any and all information required by Plan, Law, government agencies or Accreditation Organizations. Provider shall submit such information and data to Plan in the format and within the time periods specified by Plan. Provider shall allow Plan personnel reasonable on-site access to Provider records in connection with Plan's QI Program, UM Program or for other valid purposes. Provider shall accurately and completely maintain all information and data required by this Agreement, including medical records, necessary to characterize the scope and purpose of Covered Services provided to Members for the time period required by Law.

2.11.2. Covered Services Documentation. Upon reasonable request and as required by the Provider Manual, Provider shall provide Plan with Covered Services Documentation at no cost to Plan. Provider will utilize and cooperate with Plan reporting tools for Covered Services Documentation

as set forth in the Provider Manual. All Covered Services Documentation shall be provided on a timely basis and shall be supported by information recorded in the applicable Member's medical chart. By signing this Agreement, Provider hereby attests to the accuracy, completeness and truthfulness of all Covered Services Documentation provided pursuant to this Agreement. Provider shall provide additional attestations as requested by the Plan to support the accuracy, completeness and truthfulness of the Covered Services Documentation.

2.11.2.1. Without limiting Section 2.11.2 above, Provider shall provide encounter data in the format of a claim to Plan within thirty (30) days of the provision of Case Managed Services to Provider's Linked Members, if Provider is paid capitation for such Members. Such encounter data shall contain the elements and shall be on the form and in the format as set forth in the Provider Manual.

2.12. Pharmaceuticals. If Provider is licensed to prescribe drugs and medications, Provider shall prescribe drugs and medications in accordance with all applicable Law and the Plan's drug formulary. Plan's drug formulary is the Medi-Cal drug contract list as specifically modified by Plan. Provider may access the Plan's formulary online at http://www.ccah-alliance.org/formulary.html to find out if a particular medication is listed.

2.13. HIPAA Compliance. Provider represents and warrants that it is presently and shall remain at all relevant times compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Provider represents and warrants with respect to all Protected Health Information ("PHI"), (as defined under 45 C.F.R. § 164.501), that it is a Covered Entity under 45 C.F.R. Section 164.501 (and not a business associate of Plan), and that it shall use all appropriate safeguards to prevent the use or disclosure of PHI other than as allowed by Law.

2.14. Identification of California Children's Services Eligible Conditions. Provider will comply with Plan's policies and procedures as described in the Provider Manual for the identification and referral of Members with suspected California Children's Services ("CCS") eligible conditions to the local CCS Program Office. If a CCS eligible Member is identified, Provider shall continue to provide all Primary Care Physician Services other than those services necessary to treat the CCS eligible condition. Provider agrees to coordinate services for such CCS eligible Members with CCS specialty providers and the CCS Program.

2.15. Training. Provider and its practitioners and staff will participate in applicable training programs available through the Plan as required by any applicable Member Group Contract or as required by the Plan to address any Plan policies and procedures. The Plan will notify Provider of any training program that must be completed pursuant to a Member Group Contract and the timeframe for completing such required training.

ARTICLE III.
DUTIES OF PLAN

3.1. Assignment of Members. Plan shall allow Members whose Program and status requires assignment of a Primary Care Physician to select and then be assigned to a Primary Care Physician and shall assign Members who do not make such a selection in accordance with Plan policies. A Member that selects and is assigned or does not select and is assigned to a Primary Care Physician is considered to be a Linked Member as to the Primary Care Physician for the provision of all Primary Care Physician Services.

3.2. Plan Communications. Plan shall establish a system of Member identification, communicate the requirements of the Provider Manual to Participating Providers, and identify Participating Providers to Members. Plan shall be responsible for providing applicable notification to Members upon notification of termination of Provider.

3.3. Records. Plan shall maintain and furnish such records and documents as may be required by applicable Law, and shall create, maintain and transmit such records and documents in accordance with generally accepted industry standards and the requirements of applicable Laws.

3.4. Licensure. Plan shall maintain such licenses as are necessary for the performance of its obligations hereunder.

3.5. Limitations. Plan makes no representations or guarantees concerning the number of Members it can or will assign to Provider under this Agreement. Plan shall not be obligated to include Provider in all Participating Provider directories or in all Programs or to utilize or market Provider for all services available from Provider.

3.6. Continuation of Care. In the event this Agreement is terminated due to Plan's insolvency, Plan shall provide for continuation of Covered Services to Members for the duration of the period for which payment has been made by DHCS to Plan, as well as for inpatient admissions until discharge. Plan shall comply with its legal obligations to ensure continuity of care for its Members pursuant to California Law.

ARTICLE IV.
COMPENSATION

4.1. Submission of Claims. Provider agrees to submit to Plan all fee-for-service Complete Claims for Covered Services rendered to eligible Members. Complete Claims shall be submitted to the location described in the Provider Manual within one (1) year of the provision of Covered Services and in the format specified in the Provider Manual. Complete Claims will be paid within the timeframe required by Law as applicable to each Program. If Plan is the secondary payor, coordination of benefits claims may be submitted within ninety (90) days after the primary payor's date of payment or date of contest, denial or notice, if such period is longer than one (1) year. Plan may deny payment for claims not submitted by Provider within the timeframe set forth above and in accordance with the billing procedures set forth in the Provider Manual. Provider agrees that Plan will be materially damaged by late claim submittals and agrees to waive any right to assert that it is entitled to payment for claims asserted beyond the time periods specified above, unless Provider submits a dispute pursuant to Section 6.5 and shows good cause for delay.

4.2. Payment. Plan shall pay Provider for Covered Services rendered to eligible Members in accordance with the provisions of this Agreement, including Exhibit H hereto, and the Provider Manual. Provider agrees to accept such amounts paid by Plan, and any applicable Member Payment, as payment in full.

4.3. Adjustments to Payments. Only those charges for Covered Services billed in accordance with the Plan's claims coding standards will be payable. If Plan determines that services rendered are inappropriate or not Medically Necessary, coding practices do not comply with Plan standards, payment is not in accordance with the terms of this Agreement or services were provided to a patient who was not an eligible Member as of the date of service, Plan may deny, reduce, or otherwise adjust payment to Provider. The Plan may also adjust payment rates as specified in Exhibit H for the following reasons:

4.3.1. Adjustments to Fee Schedules. In the event a government program (including, without limitation, the Medi-Cal Program, as defined in Exhibit B) revises a payment rate or a procedure or revenue code under a Program fee schedule pursuant to which payments are determined under this Agreement, Plan shall, in order to ensure payment according to the current fee schedule, adopt such adjustments in the same manner and on the same effective date as adopted by the government program.

4.3.2. Audit and Recovery. Plan, or the Plan's third party designee, shall have the right to conduct periodic audits of all records maintained by the Provider with respect to all payments received by Provider from Plan for Covered Services rendered to Members during the term of this Agreement. If an audit shows that the Plan has overpaid any claim or if Plan identifies an overpayment through any other process, Plan will send a written request for the reimbursement of the overpayment.

within one year (365 days) of the date of the claim overpayment as required by applicable Law, unless the overpayment was caused in whole or in part by Provider's fraud or misrepresentation, in which case Plan shall not be limited to 365 days. If Provider does not contest the Plan's request for reimbursement of the overpayment within thirty (30) days in writing or reimburse the Plan, the Plan may offset or recoup the amounts overpaid against amounts due and owing from Plan to Provider. If Provider contests a request for reimbursement, then Provider shall send a written notice to Plan stating the basis for which the claim was not overpaid and the matter shall be resolved in accordance with the Plan's provider dispute resolution process in Section 6.5 of this Agreement and the Provider Manual. This provision shall survive the termination of this Agreement.

4.4. Coordination of Benefits. Provider agrees to comply with the Plan's coordination of benefits ("COB") policies and procedures as specified in this Agreement, the Provider Manual, the Membership Contracts, and any applicable Law.

4.4.1. Member Screening. Provider agrees to screen each Member receiving Covered Services to determine if the Member has Medicare coverage or other health coverage, and agrees to provide such information to Plan upon request.

4.4.2. Plan is Primary. When Plan is primary under the Plan's coordination of benefits rules, Plan shall pay Provider, as set forth in this Agreement, the amount due for Covered Services rendered to Members.

4.4.3. Plan is Secondary. When Plan is secondary under the Plan's coordination of benefits rules, Plan shall pay for Covered Services according to the Plan's policies and procedures as set forth in the Provider Manual. Plan will deny claims from Provider if it fails to first make recoveries from other health care coverage sources.

4.4.4. Refund. If following payment by Plan for Covered Services Provider discovers that it is entitled to payment or receives payment from another payor that is primary to Plan, Provider shall notify Plan and promptly refund any amount overpaid by Plan.

4.5. Claim Correction Requests and Disputes. If Provider believes Provider is entitled to any payment for a Covered Service from Plan, or for payment in excess of the amount the Plan has paid or indicated it will pay, then Provider shall not directly or indirectly bill for or seek to collect from Plan any such payment or additional payment for Covered Services beyond the amount that Plan has paid or indicated it will pay for such Covered Services except pursuant to either a request for a claim correction submitted to the Claims Department as specified in the Provider Manual, or pursuant to a dispute filed with Plan as specified in Section 6.5 of this Agreement and the Provider Manual.

4.6. Hold Harmless. Provider agrees that, in no event, including but not limited to nonpayment by Plan, insolvency of Plan, breach of this agreement, or denial of claims by Plan due to Provider's failure to properly submit claims, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or any person acting on behalf of a Member to whom Covered Services have been provided in accordance with the terms of this Agreement or any Program, or the State of California for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting Member Payments as specifically provided under any applicable Member Group Contract or Membership Contract or from pursuing claims against the applicable primary payor. Failure to comply with this Section shall be deemed a material breach of this Agreement and Provider may be terminated for cause pursuant to Section 5.2.2 of this Agreement as the result of such failure. This provision shall survive the termination of the Agreement, regardless of the reason for termination, including insolvency of Plan.

4.7. No Surcharges. Provider understands that surcharges against Members are prohibited and that Plan will take appropriate action if surcharges are imposed. A "surcharge" is an additional fee which is charged to a

Member for a Covered Service but which is not a Member Payment as provided for under the applicable Member Group Contract and Membership Contract.

4.8. Reporting of Surcharges and Member Payments. Provider will report to Plan all surcharge and Member Payment monies paid by Member directly to Provider and shall refund all surcharges.

4.9. No Charge for Non-Covered Services. Provider shall not charge a Member for a service which is not a Covered Service unless, in advance of the provision of such service, the Member has been notified by Provider that the particular service will not be covered and Provider obtains a written statement in a form acceptable to the Plan, signed by the Member or the person responsible for paying for services rendered that he or she shall be responsible for payment of charges for such service.

4.10. Payments Following Termination of this Agreement. Following termination of this Agreement and during the continuing care period described in Section 5.10 hereto, Plan shall compensate Provider at the applicable Program payment rates set forth in Exhibit H to this Agreement for providing and arranging Primary Care Physician Services to Members until such Members are assigned to other Plan Participating Providers.

4.11. Incentive Programs. Provider shall participate in Plan's Utilization Management Incentive Program, as described in Addendum 1 hereto, and Quality Based Incentive Program, as described in Addendum 2 hereto, for the respective terms of such programs, and may elect to participate in the Care Based Incentive Program, as described in Addendum 3 and Attachment 1 hereto. Provider must separately execute Addendum 3 in order to participate in the Care Based Incentive Program.

4.12. No Inducement to Deny Covered Services. Provider acknowledges and agrees that this Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary health care services.

ARTICLE V.
TERM AND TERMINATION

5.1. Term. The term of this Agreement shall commence on January 1, 2011 (the "Commencement Date"), and shall expire on December 31 of the same year of the Commencement Date. Thereafter, the term of this Agreement shall be automatically extended for a one (1) year term on each succeeding January 1 (the "Renewal Date"), unless terminated by either party as provided herein.

5.2. With Cause Termination of Agreement. Either Plan or Provider may terminate this Agreement for cause as set forth below, subject to the notice requirement and cure period set forth below.

5.2.1. Cause for Termination of Agreement by Provider. The following shall constitute cause for termination of this Agreement by Provider:

5.2.1.1. Non-Payment. Material failure by Plan to make any payments due Provider hereunder within forty-five (45) days of any such payment's due date and Plan's failure to cure such failure to make such payments due to Provider within the cure period provided at Section 5.2.3, below.

5.2.1.2. Breach of Material Term and Failure to Cure. Plan's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2. Cause for Termination of Agreement by Plan. The following shall constitute cause for termination of this Agreement by Plan:

5.2.2.1. Breach of Material Term and Failure to Cure. Provider's material breach of any material term, covenant, or condition and subsequent failure to cure such breach as provided in Section 5.2.3, below.

5.2.2.2. Insolvency. Provider becomes insolvent, as reasonably determined by Plan.

5.2.2.3. Failure to Comply with Standards. Provider fails to provide Covered Services in accordance with the standards set forth in this Agreement and Plan's QI Program and UM Program. Plan reserves the right to immediately transfer from Provider any Linked Members and cease referrals of any or all Members in the event the health or safety of Members is endangered by the actions of Provider, or as a result of continuation of this Agreement.

5.2.3. Notice of Termination, Cure Period and Effective Date of Termination. The party asserting cause for termination of this Agreement (the "terminating party") shall provide written notice of termination to the other party specifying the breach or deficiency with sufficient information to allow the receiving party to identify the actions necessary to cure such breach. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the terminating party (the "Cure Period"). If such party fails to cure the breach or deficiency to the reasonable satisfaction of the terminating party within the Cure Period or if the breach or deficiency is not curable, the terminating party shall have the right to provide written notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period. The Agreement shall terminate thirty (30) calendar days following receipt of the written notice of failure to cure or at such later date as may be specified in such notice. During the Cure Period and the period following the Cure Period, Plan may begin transferring Members to other Participating Providers. Notwithstanding the above, in the event Plan provides notice of termination as the result of a breach by Provider and the Plan reasonably determines the health and safety of Members is endangered by the actions of Provider, Plan shall have the right to terminate the Agreement immediately.

5.3. Automatic Termination Upon Revocation of License or Certificate. This Agreement shall automatically terminate upon the revocation, suspension or restriction of any license, certificate or other authority required to be maintained by Provider or Plan in order to perform the services required under this Agreement or upon the Provider's or Plan's failure to obtain such license, certificate or authority. In addition, this Agreement shall automatically be terminated if: (i) Provider is excluded from participation in the Medicare program or is subjected to sanctions imposed by the Medicare program or the Medicaid program; (ii) Provider's professional liability insurance or any other Provider insurance required under this Agreement is cancelled, non-renewed, or is no longer in effect; (iii) Provider fails to comply with Section 2.3 of this Agreement; or (iv) Provider dies or becomes incapacitated (as reasonably determined by Plan).

5.4. Termination of Member Group Contract. If any Member Group Contract terminates, this Agreement shall automatically terminate with respect to Members covered under the Member Group Contract on the date the Member Group Contract and any continuing care obligations under the Member Group Contract terminate.

5.5. Termination Without Cause. Either party may terminate this Agreement without cause at any time by giving the other party at least one hundred twenty (120) days prior written notice.

5.6. Termination if No Agreement on Provider Manual Modifications or Material Changes to Agreement. This Agreement may be terminated pursuant to the terms specified in Sections 6.8.2 and 6.8.3.

5.7. Transfer of Medical Records. Following termination of this Agreement, at Plan's request, Provider shall copy all requested Member medical records in the possession of Provider and forward such records to another provider of Covered Services designated by Plan, provided such copying and forwarding is not

otherwise objected to by such Members. The cost of copying the Members' medical records shall be borne by Provider. Provider shall maintain the confidentiality of such Member medical records at all times.

5.8. Repayment Upon Termination. Within one hundred eighty (180) calendar days of the effective date of termination of this Agreement, an accounting shall be made by Plan of the monies due and owing either party and payment shall be forthcoming by the appropriate party to settle such balance within thirty (30) calendar days of such accounting.

5.9. Termination Not an Exclusive Remedy. Any termination by either party pursuant to this Article V is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement. Notwithstanding the foregoing, the parties agree to waive any and all rights they may have to assert claims for or recover exemplary or punitive damages against the other party.

5.10. Continuing Care Obligations of Provider. If this Agreement is terminated for any reason, Provider shall continue to provide Covered Services, including Primary Care Physician Services, to Members, including any Members who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the first to occur of (i) a period of one hundred and twenty (120) days following termination of this Agreement or such longer period required for any Member as required by Law, or (ii) the date Plan provides written notice to Provider that it has made arrangements for all Members to receive services from another Participating Provider of Primary Care Physician Services. In addition, Provider will continue to provide Covered Services, including Primary Care Physician Services, to any Members who cannot be transferred within the time period specified above for Members who are hospitalized upon the expiration of the continuing care period, for Members who are entitled to continuing care as the result of their condition pursuant to Law, and otherwise in accordance with Plan's legal and contractual obligations to ensure continuity of care for its Members.

5.11. Fair Hearing. Notwithstanding the time periods for termination set forth in Sections 5.2 through 5.5 of this Agreement, in all cases in which Plan terminates this Agreement and Provider is entitled to a fair hearing under Plan's applicable notification and hearing procedures set forth in the Provider Manual, the termination will be final thirty (30) days from notice of the right to request a hearing, unless Provider requests a hearing within such thirty (30) day period. If such a hearing is requested, this Agreement will continue in effect until a decision is rendered; provided, however, upon the request of Plan, Provider shall not thereafter provide Covered Services to Members until a decision is rendered and Plan reserves the right to transfer Linked Members to other Participating Providers in its reasonable discretion.

ARTICLE VI.
GENERAL PROVISIONS

6.1. Independent Contractor Relationship. The relationship between Plan and Provider is an independent contractor relationship. Neither Provider nor its employees or agents are employees or agents of Plan. Neither Plan nor its employees or agents are partners, employees or agents of Provider.

6.2. Indemnification. Provider shall indemnify and hold harmless Plan and its directors, officers, employees, affiliates and agents against any claim, loss, damage, cost, expense or liability (including reasonable costs of defense) arising out of or related to the performance or nonperformance by Provider, its employees or agents of any Covered Services or other services to be performed or arranged by Provider under this Agreement; provided, however, that Provider shall not be responsible for indemnifying Plan for Plan's own acts or omissions.

6.3. Member Grievances. Plan shall be responsible for resolving Member claims for benefits under the Programs and all other claims against Plan. Provider will immediately refer Members to contact Plan or deliver any written complaint to Plan for handling pursuant to Plan's Member Grievance Procedures. Provider shall comply with all final determinations made by Plan through the Member Grievance Procedures.

6.4. Disputes Between Provider and Member. Any controversies or claims between Provider and a Member arising out of the performance of this Agreement by Provider, other than claims for benefits under the Program, are not governed by this Agreement. Provider and the Member may seek any appropriate legal action to resolve such controversy or claim deemed necessary. Provider will provide written notice to Plan of any dispute between Provider and Member.

6.5. Disputes Between Plan and Provider. Any claim, dispute, or other matter arising out of, relating to, or in any way connected with this Agreement, shall be addressed through the Plan's provider dispute resolution procedure as set forth in the Provider Manual. Provider will be informed of any changes to the provider dispute procedures including any changes to the procedures for processing and resolving disputes and the location and telephone number where information regarding disputes may be submitted. If the procedure set forth in this Section has been exhausted and such matter is not resolved to the satisfaction of the parties, either party may pursue any available legal remedy. Venue shall be in Santa Cruz, Monterey or Merced County. Plan retains all immunities applicable to public entities to which it is entitled by law.

6.6. Notice. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission. The addresses or facsimile number specified on the signature page shall be the addresses for delivery or mailing of notice. The parties may change the names, addresses, and facsimile numbers noted above through written notice in compliance with this Section. Notices shall be effective upon receipt.

6.7. Assignment. Neither this Agreement nor any portion of this Agreement shall be assigned, transferred or pledged in any way by Provider and shall not be subject to execution, attachment or similar process without the prior written consent of Plan. A change of ownership through the sale of Provider's stock or assets shall be deemed an assignment requiring consent pursuant to this Section.

6.8. Amendments. Except as provided herein, no amendments or modifications to this Agreement shall be valid unless made in writing and signed by both Provider and Plan, and unless any required regulatory approvals are obtained.

6.8.1. Legally Required Modifications. The Plan may amend this Agreement at any time in order to comply with Law or any requirements of a private sector Accreditation Organization, as reasonably interpreted by the Plan. Plan shall notify Provider of such legally required modification. Such amendment shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.2. Provider Manual Modifications. If Plan materially amends a manual, policy or procedure document referenced in the Agreement ("Provider Manual Modification"), Plan will provide at least forty five (45) business days' notice to Provider, and Provider will have the right to negotiate and agree to the change. If the parties cannot agree to the Provider Manual Modification, Provider will have the right to terminate the Agreement prior to the implementation of the Provider Manual Modification.

6.8.3. Material Changes to Agreement. For Providers compensated on a fee-for-service basis, Plan may amend a material term to the Agreement by providing a minimum of ninety (90) business days' notice of its intent to change a material term of the Agreement ("Material Change Notice"). Provider shall have the right to negotiate and agree to the change within thirty (30) business days of Provider's receipt of the Material Change Notice ("Right to Negotiate") by providing written notice of such intent within the thirty (30) business day period. Provider shall have the right to terminate the Agreement effective ninety (90) business days following the receipt of the Material Change Notice if Provider does not exercise Provider's Right to Negotiate or no agreement is reached during the ninety (90) business day period and if Provider provides notice of its intent to terminate prior to the expiration of the ninety (90) business day period. The material change shall become effective ninety (90) business days following the Material Change Notice if Provider does not exercise its Right to Negotiate or does not provide timely notice of its intent to terminate as

described above. The parties may agree to the material change at any time during the ninety (90) business day period by mutual written agreement.

6.8.4. Non-Material Amendments to Agreement. The Plan may notify Provider of amendments to non-material terms of this Agreement. Such amendments shall be effective upon written notice to Provider, and shall not require the written consent of Provider.

6.8.5. Program Benefit Changes. Program benefit changes shall be effective upon implementation, following receipt of any required regulatory approvals.

6.9. Confidential and Proprietary Information.

6.9.1. Information Confidential and Proprietary to Plan. Provider shall maintain confidential all information designated in this Section. The information which Provider shall maintain confidential (the "Confidential Information") consists of: (i) any information containing the names, addresses and telephone numbers of Members which has been compiled by Plan; (ii) the financial arrangements between Plan and any of Plan's Participating Providers, including Provider; and (iii) any other information compiled or created by Plan which is proprietary to Plan and which Plan identifies in writing to Provider.

6.9.2. Non-Disclosure of Confidential Information. Provider shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Provider may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of Plan. Upon the effective date of termination of this Agreement, Provider shall provide and return to Plan the Confidential Information in their possession in the manner specified by Plan.

6.9.3. Plan Names, Logos and Service Marks. Provider shall obtain the written consent of Plan prior to using Plan's name, product names, logos and service marks in any of Provider's promotional, marketing or advertising materials or for any other reason.

6.10. Solicitation of Plan Members. Provider shall not engage in solicitation of Members without Plan's prior written consent. Solicitation shall mean conduct by an officer, agent, employee or contractor of Provider or their respective assignees or successors during the term of this Agreement, and during the twelve (12) months immediately following the effective date of termination of this Agreement which may be reasonably interpreted as designed to persuade Members to disenroll from the Program or discontinue their relationship with Plan. Provider agrees that Plan shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Provider to enforce its rights under this Section in a manner consistent with and to the extent permitted by California law.

6.11. No Restrictions on Discussing a Member's Health Care. Nothing in this Agreement shall be interpreted to discourage or prohibit Provider or its Provider Professionals from discussing a Member's health care including, without limitation, communications regarding treatment options, alternative health plans or other coverage arrangements, unless such communications are for the primary purpose of securing financial gain.

6.12. Invalidity of Sections of Agreement. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

6.13. Survival. The following provisions of this Agreement shall survive the termination of this Agreement: Sections 2.7, 2.8, 2.11, 2.13, 3.6, Article IV, Sections 5.6, 5.7, 5.8, 5.9, 5.10, 6.2, 6.4, 6.5, 6.10, 6.11 and any other section where survival of termination is required by Law.

6.14. Waiver of Breach. The waiver by either party to this Agreement of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

6.15. Entire Agreement. This Agreement, including all exhibits, attachments, addenda, and amendments hereto and the Provider Manual contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

6.16. Incorporation of Exhibits and Attachments. The schedules, exhibits, addenda, and attachments to this Agreement and the Provider Manual are integral parts of this Agreement and are incorporated in full herein by this reference.

6.17. Authority to Bind. Each signatory of this Agreement represents and warrants individually on behalf of himself or herself, and the party on whose behalf he or she executes this Agreement, that he or she is duly authorized to execute this Agreement.

ARTICLE VII.
GOVERNING LAW AND REGULATORY REQUIREMENTS

7.1. Governing Law. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California, except where preempted by federal law, and the laws of the United States of America.

7.2. Americans with Disabilities Act of 1990. Provider's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled which includes, but is not limited to ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

7.3. Civil Rights Act of 1964. Provider will comply with Title VI of the Civil Rights Act of 1964 and any implementing regulations that prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

7.4. Language Assistance. Provider agrees to comply with the Plan's Language Assistance Program as detailed in the Plan's Policies and Procedures and Provider Manual.

7.5. Certification. As required by Title 31 U.S.C. Section 1352, if payments under this Agreement are $100,000 or more, Provider certifies to the best of Provider's knowledge and belief that no Federally appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the making, awarding or entering into of this Agreement, and the extension, continuations, renewal, amendment, or modification of this Agreement. If payments under this Agreement are $100,000 or more, Provider shall submit to Plan the "Certification Regarding Lobbying" set forth in the Provider Manual. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Agreement, Provider shall complete and submit to Plan standard form LLL, "Disclosure of Lobbying Activities", in accordance with its instructions. Provider shall file such disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed by Provider. Provider shall require that the language of this certification be included in all subcontracts at all tiers which exceed $100,000 and that all subcontractors shall certify and disclose accordingly. All such disclosure forms of subcontractors shall be forwarded to Plan.

7.6. Antifraud Plan. Provider agrees to comply with Plan's antifraud plan, as detailed in the Provider Manual. Provider will immediately notify Plan of (i) investigations of Provider or Provider's employees in which there are allegations relating to fraud, waste or abuse, and (ii) suspected cases where there is reason to believe that an incident of fraud, waste or abuse has occurred.

7.7. No Inducement for Referrals. The parties acknowledge and agree that: (1) they intend to comply with the safe harbor requirements set forth in 42 C.F.R. §1001.952(t); (2) in establishing the terms of the Agreement, including the exhibits, addenda and attachments hereto, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by the Agreement) for which payment may be made in whole or in part by a federal health care program on a fee-for-service or cost basis; and (3) neither party will shift the financial burden of the Agreement to the extent that increased payments are claimed from a federal health care program. Plan represents and agrees that it is an eligible managed care organization, as defined in 42 C.F.R. §1001.952(t). Provider represents and agrees that (a) Provider is a first tier contractor under the Agreement, defined as an individual or entity that has a direct contract with Plan, as the managed care organization, to provide or arrange for items or services; and (b) Provider cannot and will not claim payment in any form, directly or indirectly, from a federal health care program for items or services covered under the Agreement for Members enrolled in the Plan, except as provided in 42 C.F.R. §1001.952(t).

7.8. Compliance with Law. Provider and any subcontractor to Provider shall comply with the Program Requirements set forth in the exhibits hereto. Any provisions required to be included in the Agreement by applicable Law, including the Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code Section 1340 et seq.) and the regulations promulgated thereunder, shall be binding upon and enforceable against the parties to the Agreement and shall be deemed incorporated herein whether or not expressly set forth in the Agreement, including the exhibits hereto.

IN WITNESS WHEREOF, the undersigned have executed this Agreement effective as of the Commencement Date.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

By: Jane B Parker

Print: Jane Parker

Title: CCAH, Chair

Date: December 17, 2010

PROVIDER

By: Sandra Haar

Print: Sandra Haar

Title: CEO

Date: 10-8-10

Provider Address and Facsimile Number for Notices:

Street: 1208 Paseo de la Dr.

City, State ZIP: Merced Ca 95348

Facsimile Number: (209) 384-1167

CAM-254

EXHIBIT A

SCHEDULE OF PROGRAMS

Provider has been approved to provide Covered Services, including Primary Care Physician Services, under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

Medi-Cal Program: is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Merced, Monterey, and Santa Cruz Counties.

Healthy Families Program: Provider is not participating in this Program with Plan.

Alliance Care IHSS Health Program: Provider is not participating in this Program with Plan.

Healthy Kids Program: Provider is not participating in this Program with Plan.

Alliance Care Access for Infants and Mothers (AIM) Program: Provider is not participating in this Program with Plan.

Alliance Care Individual Conversion Program: Provider is not participating in this Program with Plan.

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EXHIBIT B
MEDI-CAL PROGRAM ATTACHMENT

This Exhibit B sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Medi-Cal Program.

1. With respect to the Medi-Cal Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Medi-Cal Member Group Contract and Medi-Cal Member Handbook. Covered Services, including Primary Care Physician Services, for Medi-Cal Members are set forth in Title 22 of the California Code of Regulations Section 51301 et seq., and Title 17 of the California Code of Regulations Section 6840 et seq. Information regarding Primary Care Physician Services, excluded services, and certain health screening and preventive services for Medi-Cal Members is set forth in the Provider Manual.

2. With respect to the Medi-Cal Program, the term "Medi-Cal Member" shall mean an individual who is enrolled in Medi-Cal and who is determined to be eligible for membership in the Medi-Cal Program. A newborn of a Medi-Cal Member is covered under the mother's membership for the month of birth and the following calendar month. A newborn born in the month immediately preceding the mother's enrollment as a Medi-Cal Member is covered under the mother's membership during the mother's first month of enrollment.

3. Provider agrees to make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying: (A) By the California Department of Health Care Services ("DHCS"), the United States Department of Health and Human Services, the California Department of Corporations, the United States Department of Justice, and the California Department of Managed Health Care; (B) At all reasonable times at the Provider's place of business, or at such other mutually agreeable location in California; (C) In a form maintained in accordance with the general standards applicable to such book or record keeping; (D) For a term of at least five years from the close of the Fiscal Year in which this Agreement was in effect; five years from the close of the current Fiscal Year in which the date of service occurred; five years from the date that the record or data was created or applied, and for which the financial record was created, or such longer period as required by Law; and (E) including all Covered Services Documentation for a period of at least 5 years, or such longer period as required by Law.

4. Member Payments are not permitted under the Medi-Cal Program. Provider shall not seek reimbursement of any such payments from Medi-Cal Members for any Covered Services provided under this Agreement.

5. Provider agrees to submit reports as required by Plan.

6. Plan shall conduct site reviews on all Primary Care Physician Services sites according to Medi-Cal Managed Care Division Policy Letter 02-02.

7. If this Agreement terminates for any reason, Provider will assist the Plan in the transfer of care. Additionally, Provider will assist in the orderly transfer of necessary data and records to the Plan, a successor Plan, or DHCS. Provider will assist in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Provider will make available to Plan or DHCS copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director of DHCS. In no circumstances will a Medi-Cal Member be billed for this activity.

8. Provider shall notify DHCS in the event the Agreement is terminated. Notice to the Department is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Notice should be mailed to the Department of Health Care Services,

Medi-Cal Managed Care Division, County Organized Health Systems MS 4408, P.O. Box 997413, Sacramento, CA 95899.

9. Provider agrees that the assignment or delegation of any part of this Agreement shall be void unless prior written approval is obtained from DHCS in those instances where prior approval is required.

10. Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child.

11. Prior to commencing services under the Agreement, Provider shall provide Plan with any necessary disclosure statements, including the statement set forth in Title 22 of the California Code of Regulations, Section 51000.35.

12. If Provider provides Covered Services through nurse practitioners, physician assistants, or nurse midwives ("Non-Physician Medical Practitioners"), the ratio of one physician to Non-Physician Medical Practitioners may not exceed the following: (i) four (4) nurse practitioners; (ii) three (3) nurse midwives; (iii) four (4) physician assistants; or (iv) four (4) of the above individuals in any combination which does not exceed three (3) nurse midwives or two (2) physician assistants. Each individual Non-Physician Medical Practitioner shall maintain a full-time equivalent provider to patient caseload of no more than one thousand (1,000).

13. Provider shall ensure that Members are informed of the full array of covered contraceptive methods when appropriate and that informed consent is obtained from Members for sterilization consistent with requirements of applicable Law.

14. Provider will comply with the Medi-Cal Minor Consent Services program. Minors do not need parental consent in order to access services related to sexual assault, including rape, drug or alcohol abuse (for children 12 years of age or older), pregnancy, family planning, and STDs and HIV/AIDS (in children 12 years of age or older).

15. For Medi-Cal Members under the age of 21, the term "Medically Necessary" includes those standards set forth in Title 22 of the California Code of Regulations Sections 51340 and 51340.1.

16. When Provider provides Emergency Services to a Medi-Cal Member and such Member's treatment requires the use of drugs, Provider shall provide to the Member at least a 72-hour supply of Medically Necessary drugs, which may include an initial dose and a prescription for additional drugs.

17. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of payment and other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state the Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

18. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

19. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

20. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

21. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

22. In the event of the Provider's noncompliance with the requirements of the provisions herein or with any Federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Provider may be declared ineligible for further Federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

23. By signing this Agreement, Provider agrees that if any performance under this Agreement or any subcontract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC Section 263a (CLIA) and the regulations thereto.

24. Provider shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 (29 USC Section 794) Nondiscrimination under Federal grants and programs; Title 45 CFR Part 84 Nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance; Title 28 CFR.Part 36 Nondiscrimination on the basis of disability by public accommodations and in commercial facilities; Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 the Age Discrimination Act of 1975; and all other laws regarding privacy and confidentiality.

25. Provider shall comply with Plan's policies and procedures as described in the Provider Manual relating to the identification of Members that may be eligible for other Programs.

26. Provider shall make no claim for recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving the tort or Workers Compensation liability of a third party, casualty liability coverage, or any other third-party liability which could result in recovery by the Medi-Cal Member of funds for which DHCS has lien rights under Welfare and Institutions Code Section 14124.70. Provider shall identify and notify Plan of cases in which such an action could result in recovery by the Member. Provider shall notify Plan immediately upon the discovery of such cases and shall provide any requested information promptly to Plan. DHCS retains the right to such third-party tort and Workers Compensation liability, and casualty liability recoveries with respect to Medi-Cal Members as set forth in Welfare and Institutions Code Section 14124.70 and following.

EXHIBIT C

HEALTHY FAMILIES PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

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EXHIBIT D

ALLIANCE CARE IHSS HEALTH PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

EXHIBIT E

HEALTHY KIDS PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

EXHIBIT F

ALLIANCE CARE ACCESS FOR INFANTS AND MOTHERS PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

EXHIBIT G

ALLIANCE CARE INDIVIDUAL CONVERSION PROGRAM ATTACHMENT

Provider is not participating in this Program with Plan.

EXHIBIT H

COMPENSATION SCHEDULE

1. Payment in Full. Provider agrees to accept payment rendered pursuant to this Exhibit H, and any applicable Member Payment, as payment in full for any Covered Services provided by Provider to a Member, as well as any necessary administrative services. Payment may be subject to adjustment as described in Section 4.3 of this Agreement, and is subject to the Coordination of Benefits rules set forth in Section 4.4 of this Agreement.

2. Definitions. The following definitions are applicable to this Exhibit H:

   a. "Medi-Cal Linked Members" are Medi-Cal Members, as defined in Exhibit B, Section 2, who are also Linked Members.

   b. "Medi-Cal Rate" shall mean the current applicable Medi-Cal rate, as published by the California Department of Health Care Services in effect at the time Covered Services are rendered.

   c. "Outpatient Clinical Laboratory Services" shall mean clinical laboratory testing for Members not provided or ordered as part of an inpatient hospitalization that provides information for the diagnosis, prevention, or treatment of disease, or the assessment of medical condition and includes, but is not limited to, microbiological, serological, chemical, hematological, cytological, immunohematology, and pathological examinations performed on materials derived from the human body. Outpatient Clinical Laboratory Services also include consulting services for all tests performed or arranged by Provider, all necessary and required supplies, requisition forms, and the collection, preparation, and storage of specimens.

3. Payment for Covered Services Provided to Medi-Cal Members.

   a. List of Members. Plan will provide Provider with a list of Provider's Medi-Cal Linked Members by the first (1st) day of each month (the "Medi-Cal Linked Members List").

   b. Fee-For-Service Payment. Plan shall pay Provider for Covered Services provided to Medi-Cal Members as set forth below in subsections i., ii., iii., iv., and v.

      i. Plan shall pay Provider for Covered Services provided to Medi-Cal Members who are Provider's Medi-Cal Linked Members, and for Primary Care Physician Services that are not Case Managed Services provided to Provider's Medi-Cal Linked Members, and for Covered Services that are not Case Managed Services provided to Medi-Cal Members who are not linked to Provider, at one hundred percent (100%) of the Medi-Cal Rate in effect on the date the Covered Service was rendered; provided, however, Plan may pay Provider for Covered Services provided to Medi-Cal Members who are Provider's Medi-Cal Linked Members, and for Primary Care Physician Services that are not Case Managed Services provided to Provider's Medi-Cal Linked Members, and for Covered Services that are not Case Managed Services provided to Medi-Cal Members who are not linked to Provider, at a percent of the Medi-Cal Rate greater than one hundred percent (100%) as set forth below in subsection ii.

      ii. Plan conducted an actuarially sound and audited study of the compensation rates in effect for the Medicare Program in 1999, for the ten most common procedure codes for each specialty type ("1999 Compensation Rates"). Plan shall calculate an amount for each specialty which equals seventy percent (70%) multiplied by the average of the Compensation Rates for that specialty. If Plan determines that seventy percent (70%) of the average 1999 Compensation Rates for Provider's specialty is greater than one hundred percent (100%) of the Medi-Cal Rate, then Provider shall be paid at the percent of the

Medi-Cal Rate as determined by Plan that approximates seventy percent (70%) of the average 1999 Compensation Rates for Provider's specialty, for Covered Services (that are not durable medical equipment and medical supplies, physician-administered drugs, or Outpatient Clinical Laboratory Services) provided to Medi-Cal Members who are not Provider's Medi-Cal Linked Members, and for Primary Care Physician Services that are not Case Managed Services provided to Provider's Medi-Cal Linked Members.

iii. Durable Medical Equipment and Medical Supplies. Plan will pay Provider for Covered Services that are durable medical equipment and medical supplies provided to Medi-Cal Members at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

iv. Physician-Administered Drugs. Plan will pay Provider for Covered Services that are physician-administered drugs provided to Medi-Cal Members at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

v. Outpatient Clinical Laboratory Services. Plan shall pay Provider for Outpatient Clinical Laboratory Services provided to Medi-Cal Members as set forth below in subsections (1) and (2).

(1) Providers with a CLIA certificate of waiver. Plan shall pay Providers granted waived status under CLIA for Outpatient Clinical Laboratory Services that are listed in the Provider Manual and are not Case Managed Services at one hundred percent (100%) of the Medi-Cal Rate in effect on the date such service is rendered. All other Outpatient Clinical Laboratory Services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

(2) Providers with a CLIA certificate of provider-performed microscopy procedures (PPMP), a CLIA certificate of compliance, or a CLIA certificate of accreditation. Plan shall pay Providers granted a CLIA certificate of performed microscopy procedures (PPMP), a CLIA certificate of compliance, or a CLIA certificate of accreditation for Outpatient Clinical Laboratory Services that are not Case Managed Services, including for CLIA waived tests as listed in the Provider Manual, at one hundred and two percent (102%) of the Medi-Cal Rate in effect on the date such service is rendered. All other Outpatient Clinical Laboratory Services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

ADDENDUM 2

PRIMARY CARE PHYSICIAN QUALITY BASED INCENTIVE PROGRAM

The Quality Based Incentive Program ("**QBI**") is a pay for performance program that uses positive incentives to promote quality clinical practices such as appropriate preventive services and chronic disease management. In addition to the payment set forth elsewhere in this Agreement, Plan shall budget an amount annually for the QBI for each Fiscal Year and may update such amount during the Fiscal Year, which is reviewed and approved by its governing board and which shall be allocated to the QBI (the "**Total Quality Pool**"). An accounting of the transactions and operations of the QBI shall be rendered by Plan annually four (4) months after the conclusion of each Fiscal Year and shall be certified by its Finance Director. Such annual accounting shall be based on the Fiscal Year of Plan. Distributions are made to Primary Care Physicians following Plan approval of such accounting and are made not later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

Amounts distributed through the QBI program are based on 1) the quality points earned for clinical performance and access to care and 2) the implementation of pain management contracts and pediatric asthma plans by each Primary Care Physician Practice Site during the Fiscal Year.

A "**Practice Site**" is defined as the Primary Care Physician individual or group to whom Linked Members are assigned. Practice Sites are divided into three (3) categories: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the family practice/general practice category.

Certain measurements are based on the number of Medi-Cal Members without other health coverage, such as Medicare coverage. References to "**Medi-Cal Prime Members**" in this QBI Program Addendum means Medi-Cal Members without other health coverage.

A. Quality Pools for Clinical Performance and Access to Care. The Total Quality Pool is divided into three (3) pools (each a "Quality Pool"): 1) the FP/GP Quality Pool, 2) the PED Quality Pool and 3) the IM Quality Pool. Amounts are allocated to each pool depending on the number of Medi-Cal Prime Members linked to each category of Practice Site as of the end of the Fiscal Year. All Medi-Cal Member calculations for the QBI program are made together for Monterey County Medi-Cal Members, Santa Cruz County Medi-Cal Members, and Merced County Medi-Cal Members. There are no separate Quality Pools for each county.

Quality points are assigned to each Practice Site based on clinical performance and access to care measures. The maximum number of quality points that a Practice Site may earn each Fiscal Year is one hundred (100). There is a possible total of eighty (80) points for the clinical performance measures and a possible total of twenty (20) points for the access to care measures.

1. Clinical Performance Measures. The clinical performance measures are HEDIS defined measures. The measurements follow the applicable HEDIS methodology. The clinical performance measures are based on claims and encounter data and not on chart review. In order for a Practice Site to receive points for a clinical performance measure, there must be a minimum of five (5) Medi-Cal Prime Members that qualify for the measure based on HEDIS specifications. Each qualifying Practice Site is then compared to the performance of the same category of qualifying Practice Sites for each clinical performance measure and assigned points based on the Practice Site's rank. For example, a qualifying IM Practice Site is ranked in comparison to all other qualifying IM Practice Sites for each clinical performance measure. A Practice Site, however, may earn the maximum points available for a clinical performance measure by meeting the Plan Goal percentage for such measure, even if the Practice Site is not ranked in the top quartile. The "**Plan Goal**" is established by the Plan for each performance criteria and is calculated for each Practice Site based on the HEDIS algorithm.

    a. IM Practice Site Clinical Performance. For IM Practice Sites, there are five (5) clinical performance measures, as follows: (1) breast cancer screening, (2) cervical cancer screening, (3) diabetes LDL-C screening, (4) diabetes HbA1c screening, and (5) monitoring of persistent angiotensin converting enzyme inhibitors/angiotensin receptor blockers (ACE/ARBs). For each

IM Practice Site clinical performance measure, sixteen (16) points are assigned for a rank of more than seventy-five percent (75%) when compared to other IM Practice Sites, eight (8) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if an IM Practice Site meets or exceeds the Plan Goal for a clinical performance measure the Practice Site shall be assigned sixteen (16) points for such clinical performance measure, even if the Practice Site is not in the top quartile. The Plan Goal is ninety percent (90%) for each IM Practice Site clinical performance measure.

b. PED Practice Site Clinical Performance. For PED Practice Sites, there are three (3) clinical performance measures, as follows: (1) well child visit 3 – 6 years, (2) well adolescent visit 12 – 21 years, and (3) asthma controller medication. For the well child visit 3 – 6 years clinical performance measure, thirty (30) points are assigned for a rank of more than seventy-five percent (75%) when compared to other PED Practice Sights, fifteen (15) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if a PED Practice Site meets or exceeds the Plan Goal for the well child visit 3 – 6 years clinical performance measure the Practice Site shall be assigned thirty (30) points for such clinical performance measure, even if the Practice Site is not in the top quartile. For the adolescent child visit 12 - 21 years clinical performance measure, thirty (30) points are assigned for a rank of more than seventy-five percent (75%), fifteen (15) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if a PED Practice Site meets or exceeds the Plan Goal for the well adolescent visit 12 - 21 years clinical performance measure the Practice Site shall be assigned thirty (30) points for such clinical performance measure, even if the Practice Site is not in the top quartile. For the asthma controller medication clinical performance measure, twenty (20) points are assigned for a rank of more than seventy-five percent (75%), ten (10) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%). provided, however, if a PED Practice Site meets or exceeds the "Plan Goal" for the asthma controller medication clinical performance measure the Practice Site shall be assigned twenty (20) points for such clinical performance measure, even if the Practice Site is not in the top quartile. The Plan Goal is ninety percent (92.5%) for asthma controller medication, and ninety percent (90%) for the other clinical performance measures.

c. FP/GP Practice Site Clinical Performance. For FP/GP Practice Sites, there are eight (8) clinical performance measures, as follows: (1) well child visit 3 – 6 years, (2) well adolescent visit 12 – 21 years, (3) asthma controller medication (4) breast cancer screening, (5) cervical cancer screening, (6) monitoring of persistent angiotensin converting enzyme inhibitors/angiotensin receptor blockers (ACE/ARBs), (7) diabetes LDL-C screening, and (8) diabetes HbA1c screening. For each FP/GP Practice Site clinical performance measure, ten (10) points are assigned for a rank of more than seventy-five percent (75%) when compared to other FP/GP Practice Sites, five (5) points are assigned for a rank of fifty percent (50%) through seventy-five percent (75%), and zero (0) points are assigned for a rank of below fifty percent (50%); provided, however, if a FP/GP Practice Site meets or exceeds the Plan Goal for a clinical performance measure the Practice Site shall be assigned ten (10) points for such clinical performance measure, even if the Practice Site is not in the top quartile. The Plan Goal is ninety percent (92.5%) for asthma controller medication, and ninety percent (90%) for the other clinical performance measures.

2. Access to Care Measures. For all Practice Sites, there are two access to care measures as follows: (1) level of Medi-Cal Prime Member linkage, and (2) appropriate emergency department use.

a. IM, PED and FP/GP Level of Medi-Cal Prime Member Linkage Access Measure. The level of Medi-Cal Prime Member linkage access to care measure is based on administrative linkage data. If a Practice Site is open to auto assignment of Medi-Cal Prime Members for ten (10) or more months in the Fiscal Year, then the Practice Site is assigned ten (10) points. Practice Sites not

open to auto assignment for ten (10) or more months are assigned points based on the average number of Medi-Cal Prime Members linked to the Practice Site during the Fiscal Year, as follows:

0-49	0 points
50-99	1 point
100-199	2 points
200-299	3 points
300-399	4 points
400-499	5 points
500-599	6 points
600-699	7 points
700-799	8 points
800-899	9 points
900 or more	10 points

b. IM, PED and FP/GP Appropriate Emergency Department Use. The appropriate emergency department use access measure is based on claims data. In order for a Practice Site to receive points for the appropriate emergency department use measure, the Practice Site must have a minimum of one thousand two hundred (1,200) Medi-Cal Prime Member months in the Fiscal Year. The number of non-emergent Medi-Cal Prime Member emergency department visits (CPT codes 99281 – 99283) are calculated for each Practice Site and the rate of utilization is determined for one thousand (1,000) Medi-Cal Prime Member months for such Site. Each Practice Site is then compared to the performance of the same category of Practice Sites for the access measure and assigned points based on the number of standard deviations away from the average. Ten (10) points are assigned if the Practice Site has a rate which is less then one (1) standard deviation below the average, five (5) points are assigned for a rate of one (1) standard deviation below the average through one (1) standard deviation above the average, and zero (0) points are assigned for a rate of more than one standard deviation above the average.

3. Clinical Performance and Access to Care Distribution. After the assignment of points for the clinical performance measures and access to care measures, the total quality points are determined for each Practice Site. The total quality points are multiplied by the number of Linked Medi-Cal Prime Member months for the Practice Site during the Fiscal Year to determine the Practice Site's "Weighted Points". Percentages are then determined for each Practice Site by comparison to the totals for Practice Sites of the same category, as follows: Total Weighted Points For Practice Site divided by Total Weighted Points for all Practice Site of the same category (IM, PED or FP/GP) equals the PCP's "QBI Distribution Percentage"

Practice Sites will receive a portion of the applicable Quality Pool (e.g. IM Quality Pool, PED Quality Pool or FP/GP Quality Pool) by multiplying the Site's QBI Distribution Percentage by the total amount of funds in such Quality Pool.

B. Best Practice Implementation. The implementation of medication agreements and pediatric asthma action plans during the Fiscal Year are calculated for each Practice Site. Each Practice Site is paid fifty-dollars ($50) for the submission of a qualifying medication agreement for chronic pain management of Medi-Cal Prime Members and thirty-five dollars ($35) for the submission of a qualifying pediatric asthma action plan for Medi-Cal Prime Members 0 through 18 years of age with the proper prescription. Payment is made within thirty (30) calendar days of the submission of a qualifying medication agreement or a qualifying pediatric asthma action plan. Reimbursement is limited to one medication agreement and one pediatric asthma action plan per Medi-Cal Prime Member each Fiscal Year.

1. PED Practice Sites are eligible to submit pediatric asthma action plans.

2. IM Practice Sites are eligible to submit medication agreements.

3. FP/GP Practice Sites are eligible to submit both pediatric asthma action plans and medication agreements.

C. Term of QBI.

The term of this QBI shall begin on January 1, 2011 and end on December 31, 2011 (the QBI Term").

D. QBI Programs for Future Periods.

Plan, in its sole and absolute discretion, may implement quality incentive programs for periods after completion of the QBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the QBI Term, no such program shall be binding upon Plan.

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

This Addendum sets forth the terms of care based incentives offered to PCPs by Plan. The program is designed to compensate PCPs for efforts undertaken to improve the care provided to Eligible Members as reflected by data measured by Plan, all as described herein (the "Care-Based Incentive" or the "CBI").

The CBI consists of two components: (1) the CBI Incentive Program and (2) the CBI Fee-for-Service Incentive. The CBI continues for a limited term, as described in Section 7 of this Addendum 3, unless it is specifically extended by mutual written agreement of the parties hereto. The budget for the CBI Incentive Program is separate for the Medi-Cal and Healthy Families Programs. The budget and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Families, Healthy Kids, Alliance Care IHSS, Alliance Care AIM and Alliance Care Individual Conversion Programs.

2. Definitions.

In addition to other terms defined in this Addendum 3 or in the Agreement, the following terms shall have the meanings set forth below:

2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.

2.2 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.

2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP Site's performance under the CBI Incentive Program.

2.4 CBI Incentive Program is a program whereby PCP Sites are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance.

2.5 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.

2.6 Comparison Group is the group of PCP Sites to which Provider is compared to determine Provider's percentile ranking within the group. PCP Sites are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.

2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

2.8 Eligible Members

2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.

2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz County Healthy Kids Members; the Monterey County IHSS Members, Monterey County AIM Members, and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.

2.9 Measurement Component shall mean the measures as described in the CBI Table.

2.10 Measurement Period is the period for which Plan shall measure data in order to calculate the applicable CBI Incentive Payment.

2.11 Methodology is the internally developed methodology, or the source of data utilized by Plan, to measure Provider's performance for each Measurement Component under the CBI.

2.12 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.

2.13 Performance Target Measures are those Measurement Components for which the PCP Site receives points based upon meeting a specified Performance Target.

2.14 PCP Site is the individual or group of PCPs to whom Linked Members are assigned.

2.15 Plan Goal is the percentage of Eligible Members for whom the PCP Site provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for all Quality of Care Measures is ninety percent (90%).

2.16 Relative Ranking Measures are those Measurement Components for which a PCP Site receives points based on its ranking relative to performance other PCP Sites within the PCP Site's Comparison Group

3. CBI Incentive Program.

PCP Sites are eligible to receive an incentive payment from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each category correlate to each PCP Site's rank within its Comparison Group for each measure or for the PCP Site meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.2 through 3.8 below. Section 3.1 below establishes an eligibility requirement for participation in the CBI Pool.

3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than one standard deviation, the Provider is not eligible to participate in the CBI Incentive Program. The Member Reassignment Threshold eligibility requirement is not applied to PCP Sites with less than one hundred (100) Linked Members.

3.2 Rate of Preventable Inpatient (IP) Admissions. This Measurement Component measures the rate of preventable inpatient admissions for PCP Site's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable admissions per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP Site must have a minimum of one hundred (100) Linked Members as of December 31, 2011.

3.3 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP Site's Linked Members among all prescriptions filled for PCP Site's Linked Members as determined by a review of claims data.

3.4 Rate of use of Controller Medications for Asthma Cases. This Measurement Component measures the percent of controller medications filled for PCP Site's Linked Members among all controller and rescue medications filled for PCP Site's Linked Members, as determined by a review of claims data.

3.5 Quality of Care Measures. The Quality of Care Measures Component are HEDIS defined clinical performance measures that follow the applicable HEDIS methodology and are based on claims and encounter data, not on chart review. In order for a PCP Site to receive points for a Quality of Care Measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications.

3.5.1 Internal Medicine (IM) Quality of Care. For IM PCP Sites, there are five (5) clinical performance measures, as follows: (1) breast cancer screening, (2) cervical cancer screening, (3) diabetes LDL-C screening, (4) diabetes HbA1c screening, and (5) diabetes care – monitoring for diabetic nephropathy.

3.5.2 Pediatrics (PED) Quality of Care. For PED PCP Sites, there are three (3) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, and (3) Body Mass Index (BMI) percentile calculated.

3.5.3 FP/GP Quality of Care. For FP/GP PCP Sites, there are eight (8) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) breast cancer screening, (4) cervical cancer screening, (5) diabetes LDL-C screening, (6) diabetes HbA1c screening (7) comprehensive diabetes care – monitoring for diabetic nephropathy, and (8) Body Mass Index (BMI) percentile calculated.

3.6 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP Site's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP Site must have a minimum of one hundred (100) Linked Members as of December 31, 2011.

3.7 Rate of Primary Care Visits. This Measurement Component measures the rate of primary care visits provided to PCP Site's Linked Members on an annual basis. The target for this measure is more than three (3) PCP visits per Linked Member, per Fiscal Year. Partial points may be earned by Provider for visits per Linked Member per Fiscal Year between two and one-quarter (2.25) and three (3) visits per Member per Fiscal Year.

3.8 Electronic Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP Site's eligible claims and encounter data submitted to the Plan electronically. Eligible claims include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. Distributions are made to PCP Sites following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

4.1 Relative Ranking Measures. Except as stated below in 4.1.1, PCP Sites shall be awarded the maximum number of points for each measure in which the PCP Site is ranked at or above the 76th percentile. PCP Site shall be awarded one-half the maximum number of points for each measure in which the PCP Site is ranked between the 51st and 75th percentile. PCP Site shall receive zero (0) points for any measure in which the PCP Site is ranked at the 50th percentile or below.

4.1.1 Quality of Care Measures. For the Quality of Care Measures, if the PCP Site meets or exceeds the Plan Goal, the PCP Site shall be awarded the maximum number of points for the measure even if the PCP Site is not in the top quartile for the measure.

4.2 Performance Target Measures. PCP Site shall be awarded the full amount of points if the PCP Site meets the Performance Target for the Electronic Claims/Encounter Data Submittal Measure. If the PCP Site falls below the Performance Target for this measure, the PCP Site earns zero (0) points. PCP Site shall be awarded the full amount of points if the PCP Site meets or exceeds the Performance Target for the Rate of Primary Care Visits Measure. PCP Sites shall be awarded partial points if they provide between two and one-quarter (2.25) and three (3) visits per Linked Member per Fiscal Year. If the PCP Site falls below two (2) visits per Linked Member per Fiscal Year, it will earn zero (0) points.

4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP Site. The total points are multiplied by the number of Eligible Member months for the PCP Site during the Fiscal Year to determine the PCP Site's "Weighted Points". Percentages are then determined by comparison to the totals for PCP Sites of the same Comparison Group, as follows: Total Weighted Points for PCP Site divided by Total Weighted Points for all PCP Sites of the same Comparison Group equals the PCP Site's "CBI Distribution Percentage".

4.4 PCP Sites will receive a portion of the applicable CBI Pool (e.g. IM CBI Pool, PED CBI Pool or FP/GP CBI Pool) by multiplying the Site's CBI Distribution Percentage by the total amount of funds in such CBI Pool.

5. Fee-for-Service Incentives

5.1 Increased preventive and disease management actions. Plan shall pay a fee-for-service incentive for performance of the following:

5.1.1 Pediatric Asthma Action Plans. Plan shall pay each Provider thirty-five dollars ($35) per Asthma Action Plan submitted per Linked Member, ages zero (0) to eighteen (18), per Fiscal Year. Payment shall be made to the first Primary Care Provider to submit the Pediatric Asthma Action Plan in the Fiscal Year if a Linked Members switches PCPs during the Fiscal Year.

5.1.2 Childhood Obesity Notification. Plan shall pay Provider twenty-five dollars ($25) per Fiscal Year for the first notification received by the Plan per Linked Member between the ages of three (3) and eighteen (18) years of age that indicates a BMI at or above the 90th percentile and counseling of the Member regarding Plan's support program. Such notification shall be made on the Plan's notification form which may be found in the Provider Manual.

5.1.3 Diabetes Services. Plan shall pay Provider per Linked Member, ages 21 years old or older, one hundred dollars ($100) per Fiscal Year for the performance of all four (4) of the following elements of care by December 31, 2011: HbA1c, LDL-C, referral of Member to a retinal exam, nephropathy screen. Payment shall be made to the PCP to whom the Member is Linked at the date of service.

5.1.4 Medication Management Agreements. Plan shall pay Provider fifty-dollars ($50) for Plan's receipt of the first submitted Medication Management Agreement per Linked Member per Fiscal Year.

5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of capitation or the fee-for-service equivalent for non-capitated Programs for holding office hours for at least eight (8) hours beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCP Sites under Provider's contract located within a 5 mile radius of the site with extended hours availability if Linked Members may access care during the extended hours at the extended hours site.

5.3 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. Distributions are made to PCP Sites following Plan approval of such accounting and are made no later than ninety (90) calendar days after the conclusion of each quarter.

6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.

7. Term of CBI. The term of this CBI shall begin on January 1, 2011 and end on December 31, 2011 (the "CBI Term").

8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.

9. Effect of Termination of Agreement. In the event of the termination of the Agreement for any reason prior to the expiration of the CBI Term, no CBI Incentive Payments shall be earned or made hereunder.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

By: Jane B. Parker

Title: Jane Parker
CCAH, Chair

Date: December 17, 2010

PROVIDER

Provider Name

By: [signature]

Title: CEO

Date: 11-8-10

ATTACHMENT 1 – CBI Table						
CBI Program Measurement Components	**Available Points**	**Member Requirement**	**Performance Target/Relative Ranking**	**Measurement Period**	**Measurement Data Source**	**Methodology**
Health and Cost Management:	***45 total***					
Rate of Preventable IP admissions Number of preventable IP admissions per 1,000 Linked Members per Fiscal Year.	30	≥ 100 Linked Members as of 12/31.	Relative Ranking[4]	FY 2011	Claims	AHRQ[1]
Rate of Generic Prescriptions Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking[4]	FY 2011	Claims	IHA P4P[2]
Rate of Controller Medications for Asthma Percent of Controller Medications among Controller and Rescue Medications.	5	None.	Relative Ranking[4]	FY 2011	Claims	IHA P4P[3]
Quality of Care (HEDIS):						
Internal Medicine HEDIS	**25 total**					
Breast Cancer Screening	5	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Cervical Cancer Screening	5	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Diabetes LDL-C Screening	5	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Diabetes HbA1c Screening	5	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Diabetes Care – Monitoring for Diabetic Nephropathy	5	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Pediatrics HEDIS	**25 total**					
Well Child Visit 3-6 Years	8	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Well Adolescent Visit 12-21 Years	8	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Body Mass Index (BMI) percentile calculated.	9	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS

ATTACHMENT 1 – CBI Table						
FP/GP HEDIS	**25 total**					
Well Child Visit 3-6 Years	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Well Adolescent Visit 12-21 Years	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Breast Cancer Screening	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Cervical Cancer Screening	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Diabetes LDL-C Screening	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Diabetes HbA1c Screening	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Comprehensive Diabetes Care – Monitoring for Diabetic Nephropathy	3	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
BMI Percentile Calculated	4	≥ 5 continuously Linked Members[5]	Relative Ranking[4]	FY 2011	Claims	HEDIS
Appropriate Access to Care	***25 total***					
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	≥ 100 Linked Members as of 12/31	Relative Ranking[4]	FY 2011	Claims	Medi-Cal ER Collaborative definition based on NYU study
Rate of Primary Care Visits Greater than three (3) Primary Care visits provided by Provider to Linked Members per Fiscal Year. Partial points will be awarded for 2.25 to 3 visits PMPY.	5	None	>3.0 PMPY Performance Target	FY 2011	Claims	Plan developed
Information Technology	***5 total***					
Electronic Claims/Encounter Data Submittal 95% of eligible claims/encounter data submitted electronically to the Alliance.	5	None	95% Performance Target	FY 2011	Claims	# eligible electronic claims All eligible claims

ATTACHMENT 1 – CBI Table				
CBI FFS Incentive Measurement Component	**Amount (All paid quarterly.)**	**Member Requirement**	**Measurement Period**	**Measurement Data Source**
Extended Office Hours Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per Primary Care Site covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours site.	5% of Cap. or Case Management Fee-for-Service	None	FY 2011	Administrative Data
Diabetes Services Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, Retinal exam, Nephropathy screen during the Fiscal Year. The Member must be linked to the Provider at the date of service of each of the above elements for Provider to receive payment.	$100 PM/PY	Members ages 21 and older, linked to Provider at date of service for each service.	FY 2011	Claims
Childhood Obesity Notification Provider to notify Plan by Plan's notification form of child 3 – 18 y/o with BMI at or above the 90th percentile. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about Plan's support program.	$25 PM/PY	Members aged 3 to 18	FY 2011	Notification Form
Pediatric Asthma Action Plans (PAAP) Provider to submit PAAP to Plan for Members with Asthma. Incentive paid to the PCP who first submits the PAAP in the Fiscal Year and is paid only once per Fiscal Year.	$35 PM/PY	Members ages zero to 18	FY 2011	Plans Submitted by Providers
Medication Management Agreements (MMA) Provider to submit MMA for members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Fiscal Year.	$50 PM/PY	None	FY 2011	Plans Submitted by Providers

[1] http://www.ahrq.gov/data/safetynet/billappb.htm
[2] http://www.iha.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf
[3] http://www.iha.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf
[4] For relative ranking measures, PCP Sites ranked at 100th to 76th percentile amongst peers earns maximum available points, ranked at 75th to 51st percentile earns one-half available points, ranked below 50th percentile earns no points for the measure.
[5] For HEDIS Measures, the continuously Linked Members must be qualified per HEDIS specifications.

Note: If a Provider has 100 or more Linked Members, and the Provider's rate of member reassignment per 1,000 Linked Members exceeds the Plan mean of member reassignment rate per 1,000 Linked Members by one standard deviation, the Provider is not eligible to participate in the CBI Incentive Program.

C

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

Provider Contracts - Cover Page

Document ID:	D04-C01-S14
Contract Type and Category:	Amendment - PCP
Contract Sub-Category:	FQHC (=FFS)
Signed Date:	06/01/2011
Master Group Code:	A496
Group Name:	HORISONS UNLIMITED HEALTHCARE
Model Year:	2011
Program Schedules:	E1-HKM
Received Date :	06/14/2011
Effective Date:	07/01/2011
Addenda:	
For Amendments...	
Number:	1
Name:	A1_PCP_FQHC_HKM_070111_050411
Core Changes:	Yes
Addenda Changes:	No
Unique:	No
Notes:	

FIRST AMENDMENT TO THE PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

(HEALTHY KIDS MERCED PROGRAM)

This First Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective July 1, 2011 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, a public entity organized under the laws of California, doing business as the Central California Alliance for Health, hereinafter referred to as "Plan", and Horisons Unlimited Health Care, a California corporation, hereinafter referred to as "Provider," with reference to the following facts:

WHEREAS, Plan is a public entity organized pursuant to Welfare and Institutions Code section 14087.54, Santa Cruz County Code Chapter 7.58, Monterey Municipal Code section 2.45.010, and Merced County Code Chapter 9.43.

WHEREAS, Provider and Plan have entered into the Primary Care Physician Services Agreement ("Agreement") effective January 1, 2011, as amended, for the provision of health care services;

WHEREAS, Plan has entered into an agreement with the County of Merced for the Healthy Kids Merced Program;

WHEREAS, Provider desires to participate as a Participating Provider for the Healthy Kids Merced Program.

WHEREAS, subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment; and

WHEREAS, references to Sections and Exhibits below are references to sections and exhibits, respectively, of the Agreement.

NOW, THEREFORE, Plan and Provider hereby agree as follows:

1. Exhibit A, Schedule of Programs, shall be deleted in its entirety and replaced with the Exhibit A, Schedule of Programs, attached hereto, and incorporated into this Agreement.

2. Exhibit E, Healthy Kids Program Attachment shall be deleted in its entirety and replaced with the Exhibit E, Healthy Kids Merced Program Attachment, attached hereto, and incorporated into this Agreement.

3. The following shall be added to Exhibit H, Compensation Schedule:

4. Payment for Covered Services Provided to Healthy Kids Merced Members.

   a. List of Members. Plan will provide Provider with a list of Provider's Linked Members enrolled in and determined to be eligible for the Healthy Kids Merced Program ("Healthy Kids Merced Members") by the first (1st) day of each month.

   b. Fee-For-Service Payment. Plan will pay Provider for Covered Services (that are not durable medical equipment and medical supplies, or Outpatient Clinical Laboratory Services) provided to Healthy Kids Merced Members at one hundred and twenty percent (120%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

   c. Durable Medical Equipment and Medical Supplies. Plan will pay Provider for Covered Services that are durable medical equipment and medical supplies provided to Healthy Kids Merced Members at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the Covered Service was provided.

   d. Outpatient Clinical Laboratory Services. Plan shall pay Provider for Outpatient Clinical Laboratory Services provided to Healthy Kids Merced Members as set forth below in subsections i. and ii.

      i. Providers with a CLIA certificate of waiver. Plan shall pay Providers granted waived status under CLIA for Outpatient Clinical Laboratory Services that are listed in the Provider Manual at one hundred percent (100%) of the Medi-Cal Rate in effect at the time the service was provided. All other outpatient clinical laboratory services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

      ii. Providers with a CLIA certificate of provider-performed microscopy procedures (PPMP), a CLIA certificate of compliance, or a CLIA certificate of accreditation. Plan shall pay Providers granted a CLIA certificate of performed microscopy procedures (PPMP), a CLIA certificate of compliance, or a CLIA certificate of accreditation for Outpatient Clinical Laboratory Services, including for CLIA waived tests as listed in the Provider Manual, at one hundred and two percent (102%) of the Medi-Cal Rate in effect at the time the service was provided. All other outpatient clinical laboratory services are excluded from this Agreement and shall be referred to a clinical laboratory contracted with Plan.

All other terms and provisions of the Agreement shall remain in full force and effect so that all rights, duties and obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Amendment and the Agreement, then the terms of this Amendment shall govern. Terms used in this Amendment shall have the meanings assigned to them in the Agreement, unless otherwise specified in this Amendment.

Plan Central California Alliance for Health	Provider
By: Jane Parker	By: Sandy Haar
Print Name: Jane Parker	Print Name: Sandy Haar
Title: Chair, CCAH	Title: CEO
Date: 6/22/2011	Date: 6-1-11

EXHIBIT A

SCHEDULE OF PROGRAMS

Provider has been approved to provide Covered Services, including Primary Care Physician Services, under the Programs defined below and pursuant to the applicable terms and conditions of the Agreement. The Plan may amend the counties in which each Program operates from time to time, by providing Provider with written notice of such changes.

Medi-Cal Program: is a state- and federally-funded Program pursuant to a contract between the Plan and DHCS for coverage of Members who meet Medi-Cal eligibility requirements, as determined by DHCS. The Medi-Cal Program is, as of the Commencement Date, offered in Merced, Monterey, and Santa Cruz Counties.

Healthy Families Program: Provider is not participating in this Program with Plan.

Alliance Care IHSS Health Program: Provider is not participating in this Program with Plan.

Healthy Kids Merced Program: is a Program funded by Merced County for coverage of Members who are minors between birth and 18 years of age (inclusive) and whose medical care is legally required to be under the direction of their parents or legal guardians, except when otherwise provided for under California law, and who meet Merced County's Healthy Kids Merced Program income eligibility requirements, as determined by Merced County.

Alliance Care Access for Infants and Mothers (AIM) Program: Provider is not participating in this Program with Plan.

Alliance Care Individual Conversion Program: Provider is not participating in this Program with Plan.

EXHIBIT E

HEALTHY KIDS MERCED PROGRAM ATTACHMENT

This Exhibit E sets forth requirements, in addition to those requirements set forth elsewhere in the Agreement, applicable to Covered Services provided to Members enrolled in and determined to be eligible for the Healthy Kids Merced Program.

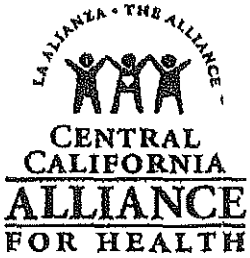
1. With respect to the Healthy Kids Merced Program, the term "Covered Services" shall mean Medically Necessary health care services and benefits which Members are entitled to receive under the Healthy Kids Merced Member Group Contract, as specified in the Healthy Kids Merced Evidence of Coverage and the Plan's Provider Manual.

2. Provider agrees to maintain and make available to the County of Merced and Plan accurate books and records relative to all its activities under this Agreement. Provider shall permit the County of Merced to audit, examine and make excerpts and transcripts from such records, and to conduct audits or reviews of all invoices, materials, records or personnel or other data related to all other matters covered by this Agreement. Provider shall maintain such data and records in an accessible location and condition for a period of not less than three (3) years from the date of final payment under this Agreement, or until after the conclusion of any audit, whichever occurs last. The State of California and/or any federal agency having an interest in the subject of this Agreement shall have the same rights conferred upon the County of Merced herein. For purposes of this subsection, records shall include personnel records not otherwise subject to disclosure under the California Public Records Act or student records subject to the confidentiality provisions of the California Education Code or the Federal Family Educational Rights and Privacy Act of 1974 as amended or any other records determined to be confidential under any other applicable provision of state or federal law.

3. Provider will provide extended payment plans for Members utilizing a significant number of health services for which Member Payments are required.

4. Provider shall not use County of Merced funds for any political activity, to further the election or defeat of any candidate for political office, or for purposes of religious worship, instruction, or proselytizing.

5. To the extent allowed by law, Provider shall not have in its employ or service any official, officer, employee, volunteer or other authorized or prospectively authorized representative, (including all persons as described in Health and Safety Code Section 1596.871(b)(1)) whose duties are or will be directly connected to the Healthy Kids Merced Program or activity, who has been convicted (a conviction shall include a plea, verdict, or finding of guilt regardless of whether sentence is imposed by the court or an arrest pending trial) of any sex crime, drug crime, or crime of violence as described in Penal Code Section 11105.3 (h), or any other crime against a minor child or any felony theft, fraud or embezzlement crime.



Provider Contracts - Cover Page

Document ID:	D04-C01-S14
Contract Type and Category:	Amendment - PCP
Contract Sub-Category:	FQHC (=FFS)
Signed Date:	11/10/2011
Master Group Code:	A496
Group Name:	HORISONS UNLIMITED HEALTHCARE
Model Year:	2011
Program Schedules:	
Received Date :	11/16/2011
Effective Date:	01/01/2012
Addenda:	
For Amendments...	
Number:	2
Name:	A2_PCP_FQHC_CBI 2012_010112_110311 LW
Core Changes:	No
Addenda Changes:	Yes
Unique:	No
Notes:	

SECOND AMENDMENT TO THE
PRIMARY CARE PHYSICIAN SERVICES AGREEMENT

This Second Amendment to the Primary Care Physician Services Agreement ("Amendment") is effective January 1, 2012 ("Effective Date of Amendment"), by and between the Santa Cruz-Monterey-Merced Managed Medical Care Commission, a public entity organized under the laws of California, doing business as the Central California Alliance for Health, hereinafter referred to as "Plan", and Horisons Unlimited Health Care, a California corporation, hereinafter referred to as "Provider," with reference to the following facts:

WHEREAS, Plan is a public entity organized pursuant to Welfare and Institutions Code section 14087.54, Santa Cruz County Code Chapter 7.58, Monterey Municipal Code section 2.45.010, and Merced County Code Chapter 9.43;

WHEREAS, Plan and Provider entered into the Primary Care Physician Services Agreement effective as of the Commencement Date (the "Agreement"), as amended, for the provision of health care services;

WHEREAS, both Plan and Provider desire to change certain compensation terms of the Agreement;

WHEREAS, subject to any necessary approval by the State, this Amendment shall be effective on the Effective Date of Amendment; and

WHEREAS, references to Sections and Exhibits below are references to sections and exhibits, respectively, of the Agreement.

NOW, THEREFORE, the parties hereby amend the terms of the Agreement as follows:

1. Addendum 3, Primary Care Physician Care Based Incentive Program, shall be amended and replaced with the attached Addendum 3, Primary Care Physician Care Based Incentive Program.

All other terms and provisions of the Agreement shall remain in full force and effect so that all rights, duties and obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Amendment and the Agreement, then the terms of this Amendment shall govern. Terms used in this Amendment shall have the meanings assigned to them in the Agreement, unless otherwise specified in this Amendment.

Plan	Provider
Central California Alliance for Health	Horisons Unlimited Healthcare
By: James B Parker	By: Sandra Haar
Print Name: Jane Parker	Print Name: Sandra Haar
Title: Chair, CCAH	Title: CEO
Date: 12/7/2011	Date: 11-10-11

ADDENDUM 3

PRIMARY CARE PHYSICIAN CARE BASED INCENTIVE PROGRAM

1. Introduction.

This Addendum sets forth the terms of care based incentives offered to PCPs by Plan. The program is designed to compensate PCPs for efforts undertaken to improve the care provided to Eligible Members as reflected by data measured by Plan, all as described herein (the "Care-Based Incentive" or the "CBI").

The CBI consists of two components: (1) the CBI Incentive Program and (2) the CBI Fee-for-Service Incentive. The CBI continues for a limited term, as described in Section 7 of this Addendum 3, unless it is specifically extended by mutual written agreement of the parties hereto. The budget for the CBI Incentive Program is separate for the Medi-Cal and Healthy Families Programs. The budget and allocation for the CBI Fee-for-Service Incentive are separate for the Medi-Cal, Healthy Families, Healthy Kids, Alliance Care IHSS, Alliance Care AIM and Alliance Care Individual Conversion Programs.

2. Definitions.

In addition to other terms defined in this Addendum 3 or in the Agreement, the following terms shall have the meanings set forth below:

2.1 Available Points is the maximum number of points available under each Measurement Component as determined in the sole discretion of Plan.

2.2 CBI Fee-for-Service Incentives are fee-for-service payments, in addition to those payments described elsewhere in the Agreement, which PCPs are eligible to receive in exchange for performing specific activities as described in Section 5 to this Addendum 3.

2.3 CBI Incentive Payments are the annual or quarterly payments, as described in Section 4 to this Addendum 3, which are based upon a PCP's performance under the CBI Incentive Program.

2.4 CBI Incentive Program is a program whereby PCPs are measured against Performance Targets and against a Comparison Group and are eligible for incentive payment based upon their performance.

2.5 CBI Table means the table set forth in Attachment 1 to this Addendum 3 specifying the Available Points, Member Requirement, Performance Target/Relative Ranking Measures, Measurement Period, Measurement Data Source and Methodology for each Measurement Component.

2.6 Comparison Group is the group of PCPs to which Provider is compared to determine Provider's percentile ranking within the group. PCPs are divided into three (3) Comparison Groups: 1) family practice/general practice (FP/GP), 2) pediatrics (PED) and 3) internal medicine (IM). Any obstetrician/gynecologist that is a Primary Care Physician will be included in the FP/GP Comparison Group.

2.7 Dual Coverage Members are Members who are eligible for either Medi-Cal or Healthy Families and for coverage from another source, such as Medicare or a commercial health plan.

2.8 Eligible Members

2.8.1 Eligible Members for the CBI Incentive Program measures are the Santa Cruz, Monterey or Merced Medi-Cal Members and the Santa Cruz or Monterey Healthy Families Members, excluding Dual Coverage Members.

2.8.2 Eligible Members for the CBI Fee-For Service Incentives are the Santa Cruz, Monterey or Merced Medi-Cal Members; the Santa Cruz or Monterey Healthy Families Members; the Santa Cruz or Merced Healthy Kids Members; the Monterey County IHSS Members, Monterey County AIM Members, and the Monterey County Individual Conversion Plan Members, excluding Dual Coverage Members.

2.9 Eligible Member Months. Eligible Member Months for the CBI Incentive Program is the total number of member months each Eligible Member is linked to the PCP during the measurement period, except that member months for a PCP's Linked Medi-Cal Members who are in the Aged, BCCTP, Disabled and Long Term Care Medi-Cal aid code categories are multiplied by four (4) to determine the Eligible Member Months applicable to those Linked Members. Member months are determined by identifying the total number of Linked Members linked to the PCP during each month of the Measurement Period.

2.10 Measurement Component shall mean the measures as described in the CBI Table.

2.11 Measurement Period is the period for which Plan shall measure data in order to calculate the applicable CBI Incentive Payment.

2.12 Methodology is the internally developed methodology, or the source of data utilized by Plan, to measure Provider's performance for each Measurement Component under the CBI.

2.13 PCP is the individual or group of PCPs to whom Linked Members are assigned.

2.14 Performance Targets are the targets established in the sole discretion of Plan. Performance Targets are set forth in the CBI Table.

2.15 Performance Target Measures are those Measurement Components for which the PCP receives points based upon meeting a specified Performance Target.

2.16 Plan Goal is the percentage of Eligible Members for whom the PCP provided the applicable Measurement Component of the Quality of Care (HEDIS) measures. The Plan Goal for all Quality of Care Measures is ninety percent (90%).

2.17 Relative Ranking Measures are those Measurement Components for which a PCP receives points based on its ranking relative to performance of other PCPs within the PCP's Comparison Group

3. CBI Incentive Program.

PCPs are eligible to receive an incentive payment from a set budget or pool ("CBI Pool"). Funding of the CBI Pools shall be at the sole discretion of Plan. The CBI Pools are divided into three (3) sub-pools: (1) the FP/GP CBI Pool, (2) the PED CBI Pool, and (3) the IM CBI Pool. Amounts paid under each category correlate to each PCP's rank within its Comparison Group for each measure or for the PCP meeting a specific Performance Target. The CBI Incentive Program consists of the Measurement Components as set forth in Sections 3.1 through 3.8 below.

3.1 Member Reassignment Threshold is the Plan mean of Member reassignments per 1,000 members per Fiscal Year as determined by the Plan and if exceeded by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Performance Target Measures will be

reduced by fifty-percent (50%). The Member Reassignment Threshold is not applied to PCPs with less than one hundred (100) Linked Members.

3.2 Rate of Ambulatory Care Sensitive Admissions. This Measurement Component measures the rate of ambulatory care sensitive admissions for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have a minimum of one hundred (100) Linked Members as of December 31, 2012.

3.3 Rate of Generic Prescriptions. This Measurement Component measures the percent of generic prescriptions filled for PCP's Linked Members among all prescriptions filled for PCP's Linked Members as determined by a review of claims data.

3.4 Quality of Care Measures. The Quality of Care Measures Component are HEDIS or IHA P4P defined clinical performance measures that follow the applicable methodology and are based on claims and encounter data, not on chart review. In order for a PCP to receive points for a Quality of Care Measure, there must be a minimum of five (5) Eligible Members that qualify for the measure based on HEDIS specifications. The total points available for the Quality of Care Measures will be allocated across only those measures for which the PCP has five (5) Eligible Members that qualify for the Measure.

3.4.1 There are nine (9) clinical performance measures, as follows: (1) well child visit 3 - 6 years, (2) well adolescent visit 12 - 21 years, (3) breast cancer screening, (4) cervical cancer screening, (5) diabetes LDL-C screening, (6) diabetes HbA1c screening (7) diabetes medical attention for nephropathy, (8) body mass index (BMI) percentile calculated, and (9) asthma medication ratio.

3.5 Rate of Preventable Emergency Department (ED) Visits. This Measurement Component measures the rate of preventable emergency department visits for PCP's Linked Members as determined by a review of claims data. The rate is reported by the number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year. To qualify for this measure, a PCP must have a minimum of one hundred (100) Linked Members as of December 31, 2012.

3.6 Rate of Primary Care Visits. This Measurement Component measures the rate of primary care visits provided to PCP's Linked Members on an annual basis. The target for this measure is more than three (3) PCP visits per Linked Member, per Fiscal Year. Partial points may be earned by Provider for visits per Linked Member per Fiscal Year between two and one-quarter (2.25) and three (3) visits per Member per Fiscal Year.

3.7 Electronic Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP's eligible claims and encounter data submitted to the Plan electronically. Eligible claims include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims submitted electronically.

3.7.1 Claims/Encounter Data Submittal. This Measurement Component measures the percentage of PCP's eligible claims and encounter data submitted to the Plan electronically. Eligible claims/encounter data include those that are not for CHDP services, Medicare-Medi-Cal crossover claims, or claims with attachments. The target for this measure is ninety-five percent (95%) of all eligible claims/encounter data submitted electronically.

3.7.2 Referral Submittal: This Measurement Component measures the percentage of PCP's eligible referrals submitted to the Plan through the Plan's web portal. The target for this

measure is 75% of all eligible referrals submitted through the web portal. Eligible referrals are those referrals that providers may submit through the web portal

4. Calculation and Payment of CBI Incentive Payments. An accounting of CBI Incentive Payments shall be made annually four (4) months after the conclusion of each Fiscal Year and shall be certified by the Plan's Chief Financial Officer. The accounting will be based only on claims and data submitted for dates of service within the CBI Term and received by Plan no later than January 31, 2013. Distributions are made to PCPs following Plan approval of such accounting and are made no later than one hundred eighty (180) days after the conclusion of each Fiscal Year.

4.1 Relative Ranking Measures. Except as stated below in 4.1.1, PCPs shall be awarded the maximum number of points for each measure in which the PCP is ranked at or above the 76th percentile. PCP shall be awarded one-half the maximum number of points for each measure in which the PCP is ranked between the 51st and 75th percentile. PCP shall receive zero (0) points for any measure in which the PCP is ranked at the 50th percentile or below.

4.1.1 Quality of Care Measures. For the Quality of Care Measures for which the PCP qualifies, if the PCP meets or exceeds the Plan Goal, the PCP shall be awarded the maximum number of points for the measure even if the PCP is not in the top quartile for the measure.

4.2 Performance Target Measures. PCP shall be awarded the full amount of points if the PCP meets the Performance Target for the Electronic Claims/Encounter Data Submittal Measure. If the PCP falls below the Performance Target for this measure, the PCP earns zero (0) points. PCP shall be awarded the full amount of points if the PCP meets or exceeds the Performance Target for the Rate of Primary Care Visits Measure. PCPs shall be awarded partial points if they provide between two and one-quarter (2.25) and three (3) visits per Linked Member per Fiscal Year. If the PCP falls below two (2) visits per Linked Member per Fiscal Year, it will earn zero (0) points.

4.3 After the assignment of points for the Relative Ranking Measures and the Performance Target Measures, the total CBI Incentive Program points are determined for each PCP. In the event that the PCP exceeded the Member Reassignment Threshold by more than two standard deviations, PCP's total CBI Incentive Program points will be reduced by fifty-percent (50%). The total points are multiplied by the number of Eligible Member Months for the PCP during the Fiscal Year to determine the PCP's "Weighted Points". Percentages are then determined by comparison to the totals for PCPs of the same Comparison Group, as follows: Weighted Points for PCP divided by total Weighted Points for all PCPs of the same Comparison Group equals the PCP's "CBI Distribution Percentage".

4.4 PCPs will receive a portion of the applicable CBI Pool (e.g. IM CBI Pool, PED CBI Pool or FP/GP CBI Pool) by multiplying the PCP's CBI Distribution Percentage by the total amount of funds in such CBI Pool.

5. Fee-for-Service Incentives

5.1 Increased preventive and disease management actions. Plan shall pay a fee-for-service incentive for performance of the following:

5.1.1 Asthma Action Plans. Plan shall pay each Provider thirty-five dollars ($35) per Asthma Action Plan submitted per Linked Member, ages three (3) to fifty-six (56), per Fiscal Year. Payment shall be made to the first Primary Care Provider to submit the Asthma Action Plan in the Fiscal Year if a Linked Member switches PCPs during the Fiscal Year.

5.1.2 Healthy Weight for Life Program (HWL).

5.1.2.1. Referral to HWL. Plan shall pay Provider fifteen dollars ($15) per Fiscal Year for the first HWL referral received by the Plan per Linked Member between the ages of two (2) and eighteen (18) years of age that indicates a BMI at or above the 85th percentile and counseling of the Member regarding nutrition, physical activity and the HWL. Such notification shall be made on the Plan's HWL referral form which may be found in the Provider Manual.

5.1.2.2. Program Follow Up Visit. Plan shall pay Provider fifteen dollars ($15) per Fiscal Year for the submission of the Plan's HWL follow up form completed at the first six-month follow up visit for each Linked Member referred to the Plan's HWL program. The HWL form must document the Member's BMI percentile at the time of each six month follow up visit and further patient education regarding nutrition, physical activity and the Plan's HWL program. The HWL follow up form may be found in the Provider Manual.

5.1.3 Diabetes Services. Plan shall pay Provider per Linked Member, ages 21 years old or older, one hundred dollars ($100) per Fiscal Year for the performance of all four (4) of the following elements of care by December 31, 2012 and only if Linked Member is linked to PCP on the date(s) all such services are provided: HbA1c, LDL-C, retinal exam, and diabetes medical attention for nephropathy.

5.1.4 Medication Management Agreements. Plan shall pay Provider fifty-dollars ($50) for Plan's receipt of the first submitted Medication Management Agreement per Linked Member per Fiscal Year.

5.2 Increased prevalence of extended hours. Plan shall pay Provider five percent (5%) of capitation or the fee-for-service equivalent for non-capitated Programs for holding office hours for at least eight (8) hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. during the quarter. Plan shall pay Provider the enhanced payment for all PCPs under Provider's contract located within a 5 mile radius of the location with extended hours availability if Linked Members may access care during the extended hours at the extended hours location.

5.3 Payment of Fee-for-Service Incentives. An accounting of Fee-for-Service Incentives shall be made each quarter within forty five (45) calendar days after the conclusion of each quarter. PCP should submit all Fee-for-Service Incentives within 30 days of the close of each quarter and will not receive payment for any Fee-for-Service Incentives submitted to Plan after January 31, 2013. Distributions are made to PCPs following Plan approval of such accounting. Distributions for the first, second and third quarters are made no later than ninety (90) calendar days after the conclusion of the quarter. The distribution for the fourth quarter Fee-for-Service Incentives shall be made with the distribution of the CBI Incentive Payments no later than one hundred eighty (180) days after the conclusion of the Fiscal Year.

6. CBI Payments Determination Final. Plan's calculation of payments under the CBI shall be final. Provider recognizes that the measurement of the CBI data is subject to variation and reasonable statistical and operational error. Provider acknowledges that Plan would not be willing to offer the CBI if Plan's calculation of payments under the CBI would expose Plan to increased risk of disputes and litigation arising out of Plan's calculation. Accordingly, in consideration of Plan's agreement to offer the CBI to Provider, Provider agrees that Provider will have no right to dispute Plan's determination of payments due under the CBI, including determination of any data or the number of Eligible Members.

7. Term of CBI. The term of this CBI shall begin on January 1, 2012 and end on December 31, 2012 (the "CBI Term").

8. CBI Programs for Future Periods. Plan, in its sole and absolute discretion, may implement care-based incentive programs for periods after completion of the CBI Term. Any such programs shall be on terms determined by Plan. Until Plan and Provider enter into a written agreement with respect to any such new program extending beyond the CBI Term, no such program shall be binding upon Plan.

9. Effect of Termination of Agreement. In the event of the termination of the Agreement for any reason prior to the expiration of the CBI Term, no CBI Incentive Payments shall be earned or made hereunder.

ATTACHMENT 1 – CBI Table						
CBI Program Measurement Components	**Available Points**	**Member Requirement**	**Performance Target/Relative Ranking**	**Measurement Period**	**Measurement Data Source**	**Methodology**
Health and Cost Management:	***40 total***					
Rate of Ambulatory Care Sensitive Admissions Number of ambulatory care sensitive admissions per 1,000 Linked Members per Fiscal Year.	30	≥ 100 Linked Members as of 12/31/12.	Relative Ranking[3]	FY 2012	Claims	AHRQ[1]
Rate of Generic Prescriptions Percent of Generic prescriptions among all prescriptions, regardless of prescriber.	10	None.	Relative Ranking[3]	FY 2012	Claims	IHA P4P[2]
Quality of Care (HEDIS):	**30 total**					
Well Child Visit 3-6 Years	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Well Adolescent Visit 12-21 Years	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Breast Cancer Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Cervical Cancer Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Diabetes LDL-C Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Diabetes HbA1c Screening	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Diabetes Medical Attention for Nephropathy	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
BMI Percentile Calculated	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	HEDIS
Asthma Medication Ratio	Per §4.1	≥ 5 continuously Linked Members[4]	Relative Ranking[3]	FY 2012	Claims	IHA P4P[2]

ATTACHMENT 1 – CBI Table						
Appropriate Access to Care	***25 total***					
Rate of Preventable Emergency Department Visits Number of preventable emergency department visits per 1,000 Linked Members per Fiscal Year.	20	≥ 100 Linked Members as of 12/31/12	Relative Ranking[3]	FY 2012	Claims	Medi-Cal ER Collaborative definition based on NYU study
Rate of Primary Care Visits Greater than three (3) Primary Care visits provided by Provider to Linked Members per Fiscal Year. Partial points will be awarded for 2.25 to 3 visits PMPY.	5	None	>3.0 PMPY Performance Target	FY 2012	Claims	Plan developed
Information Technology	***5 total***					
Electronic Claims/Encounter Data Submittal 95% of eligible claims/encounter data submitted electronically to the Alliance.	3	None	95% Performance Target	FY 2012	Claims	# eligible electronic claims All eligible claims
Referral Submittal 75% of eligible referrals submitted through Alliance web portal.	2	None	75% Performance Target	FY 2012	Referrals	# eligible referrals All eligible referrals

CBI FFS Incentive Measurement Component	**Amount (All paid quarterly)**	**Member Requirement**	**Measurement Period**	**Measurement Data Source**
Extended Office Hours Provider available to provide services to Linked Members for 8 hours per week beyond Monday through Friday, 8:00 a.m. to 5:00 p.m. Additional payment is to be paid per PCP covered by the Provider's agreement within a 5 mile radius if Linked Members may access care during the extended hours at the extended hours location.	5% of Capitation or Case Management Fee-for-Service	None	FY 2012	Administrative Data
Diabetes Services Provider to ensure provision of all of the following services for Linked Members with diabetes: HbA1c, LDL-C, retinal exam, diabetes medical attention for nephropathy[5] during the Fiscal Year. The Member must be linked to the Provider on the date(s) all such services are provided for Provider to receive payment.	$100 PM/PY	Members ages 21 and older, linked to Provider at date of service for each service.	FY 2012	Claims
Healthy Weight for Life (HWL) Program Referral Provider to refer Member aged 2 – 18 y/o with BMI at or above the 85th percentile to Plan's HWL by Plan's referral form. Incentive paid to the PCP who first notifies the Plan in Fiscal Year and who has counseled Member about nutrition, physical activity and Plan's HWL.	$15 PM/PY	Members aged 2 to 18	FY 2012	HWL Referral Form

ATTACHMENT 1 – CBI Table				
Healthy Weight for Life Program Follow Up Visit Provider to notify Plan by follow up form of the first six month follow up visit and further BMI percentile determination for a member previously referred for the HWL.	$15 PM/PY	Members aged 2 to 18	FY 2012	HWL Follow Up Form
Asthma Action Plans (AAP) Provider to submit AAP to Plan for Members with Asthma. Incentive paid to the PCP who first submits the AAP in the Fiscal Year and is paid only once per Fiscal Year.	$35 PM/PY	Members ages 3 to 56	FY 2012	Plans Submitted by Providers
Medication Management Agreements (MMA) Provider to submit MMA for members to Plan. Incentive paid to the PCP who first submits the MMA to the Plan in the Fiscal Year and is paid only once per Fiscal Year.	$50 PM/PY	None	FY 2012	Plans Submitted by Providers

[1] http://www.ahrq.gov/data/safetynet/billappb.htm
[2] http://www.iha.org/pdfs_documents/p4p_california/MY%202010%20Proposed%20Measure%20Set%2012%2009.pdf
[3] For relative ranking measures, PCPs ranked at 100th to 76th percentile amongst peers earn maximum available points, ranked at 75th to 51st percentile earn one-half available points, ranked below 50th percentile earn no points for the measure.
[4] For HEDIS Measures, the continuously Linked Members must be qualified per HEDIS specifications.
[5] Diabetes medical attention for nephropathy includes: claim/encounter data with relevant CPT or ICD-9 code evidencing treatment of nephropathy, claim submitted by a nephrologist, positive urine macroalbumin test documented by claim/encounter data, evidence of ACE inhibitor/ARB therapy during measurement year.

Note: If a Provider has 100 or more Linked Members, and the Provider's rate of member reassignment per 1,000 Linked Members exceeds the Plan mean of member reassignment rate per 1,000 Linked Members by more than two standard deviations, the points awarded to Provider for the Relative Ranking and Target Measures will be reduced by 50%.

EXHIBIT B

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH	**POLICIES AND PROCEDURES**
Policy #: 300-4030	**Lead Department:** Provider Services
Title: Credentialing Criteria and Identified Issues	
Original Date: 10/01/2007	**Last Revision Date:** 12/12/2012
Approved by: Peer Review and Credentialing Committee	
Effective Date: 12/12/2012	

Purpose:
To establish criteria for the review and approval of provider credentials based on verified credentialing information and identified issues.

Policy:
The Peer Review and Credentialing Committee (PRCC) is responsible for reviewing and approving, deferring, or denying Central California Alliance for Health (the Alliance) provider network participation based on established credentialing criteria and adverse findings.

Definitions:
Attestation: A signed statement indicating that a provider personally confirms the validity, correctness and completeness of the credentialing applications at the time of application to the Plan.

Conditional Credentialing: Network approval by the PRCC with special conditions of participation rendered as a result of recommended focused monitoring, typically resulting from identified issues during the credentialing or ongoing monitoring processes.

Provisional Credentialing: A process by which a new practitioner, who meets credentialing criteria, is approved to participate in the network in advance of a PRCC meeting to meet a specific access need.

Service Area: Santa Cruz, Monterey, and Merced Counties.

Procedures:
1. Verified Credentialing Criteria

1.a. Provider credentials are collected, verified, and reviewed in line with parameters set in Policies 300-4040 – Professional Providers Credentialing Guidelines, 300-4110 – Organizational Providers Credentialing Guidelines, and 300-4090 – Ongoing Monitoring of Provider Credentials and Issues.

1.b. The PRCC approves, defers, or denies providers' network participation status, based on established credentialing criteria for network providers.

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1.c. The PRCC renders non-discriminatory, confidential credentialing decisions and/or recommendations, as defined in Policy 300-4020 – Peer Review and Credentialing Committee – Authority, Roles and Responsibilities, based on review of providers' verified credentialing file obtained during initial credentialing, recredentialing and ongoing monitoring processes.

1.d. Credentialing decisions and/or recommendations are signed off by each PRCC member and reflected in the meeting minutes.

1.e. Notification of PRCC decision will be sent to the provider in writing within sixty (60) calendar days of the PRCC decision.

1.f. After final approval by the PRCC, provider qualification information is listed in the Alliance provider directory consistent with information gathered and verified during the credentialing process.

2. Clean Credentialing Status
Clean Credentialing refers to files that meet the established credentialing criteria with no issues identified that would require PRCC review. Clean files are reviewed, signed and dated by the Medical Director, or designee, prior to presentation to the PRCC for final approval.

2.a. Provisional Credentialing

i. Providers applying for participation in the Alliance network for the first time who meet all of the credentialing criteria standards and having "clean" credentialing files may be recommended by the Provider Services Network Manager or Provider Services Director for Provisional credentialing approval.

ii. The Medical Director will review and may approve such "clean" credentialing files for new providers on a provisional basis, pending final PRCC approval, as needed to meet specific access needs within the network between quarterly PRCC meetings.

iii. Provisional status will not exceed sixty (60) calendar days.

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3. Identified Issues
Provider files not meeting established credentialing criteria resulting from verified or potential issues, are reviewed by the PRCC.

3.a. Conditional Credentialing

i. When appropriate, the PRCC members may approve a provider's credentials conditionally pending possible follow-up and further review. A timeframe is set by the PRCC to allow for the conditions of approval to be met. Upon fulfillment of the conditions, a provider may be approved for active network participation.

ii. Notification is sent to the provider to inform them of the Committee's decision and the special condition(s) attached to the approval as recommended by the PRCC.

3.b. Unfavorable recommendations and decisions are made in accordance with Policy 300-4102 – Reporting to the Medical Board of California and National Practitioner Data Bank.

3.c. Notice of the PRCC's final decision does not entitle the provider to any procedural hearing rights, except for specific providers, as defined in Policy 300-4103 - Fair Hearing Process for Adverse Decisions.

3.d. Identified issues, issues not meeting credentialing criteria and requiring PRCC review include:

i. Attestation
Attestation information disclosing health status and any history or limitations of licensure or privileges that could adversely affect the provider's ability to deliver care to members.

ii. Sanctions and Limitations
Any denial, limitation, restriction, suspension, revocation, forfeiture, subjection to probationary conditions, disciplinary action, or voluntary relinquishment as applicable to the provider of the following:

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- Professional state license
- Drug Enforcement Agency (DEA) registration
- Hospital clinical privileges
- Professional organization membership

iii. Professional Liability Claims History
- Two or more malpractice cases of any amount that have settlement dates within the past seven (7) consecutive years, and not reviewed during a previous credentialing cycle.
- Malpractice case(s) settled for an amount greater than $30,000 within the last seven (7) years, and not reviewed during a previous credentialing cycle.
- Any reports that do not meet established criteria through the National Practitioner Data Bank/Health Integrity Data Bank (NPDB/HIPDB) query, and not reviewed during a previous credentialing cycle.

iv. Medicare/Medicaid Program Participation and Eligibility
- Provider must not be ineligible, excluded or debarred from participation in the Medicare/Medicaid program and related state and federal programs; and
- Provider must be free from restrictions or sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or disciplinary action by other federal or state entities.

v. Member Complaints and Grievances
- Any pattern of member complaints or grievances, including 24 hour complaints as well as 30 day complaints, filed against a provider according to the following schedule:
  - Primary care practices with between 0 and 1,000 linked members and all specialist physicians: Two (2) or more complaints filed in any given quarter, four (4) or more in any given year; and six (6) or more during the three-year period since the prior credentialing review.

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- Primary care practices with >1000 linked members: Three or more complaints filed in any given quarter; six (6) or more in any given year; and nine (9) or more during the three-year period since the prior credentialing review.

vi. Quality Issues
- Any one (1) Verified Quality Issue (VQI) or three (3) or more Potential Quality Issues (PQI), as defined in Health Services Policy 401-1301 - Potential Quality Issue Review – General, since the last credentialing cycle, will be reviewed during recredentialing, or sooner if indicated.

vii. Site Review
- Any facility site or medical record review issues, based on Quality Improvement reports, including unresolved Critical Element Corrective Action Plans (CAP) since the last site review cycle.
- Site review must be current at time of PRCC review.

viii. Criminal Charges
- The following criteria will be reviewed as part of the provider's file:
  - Providers with a pending felony charge;
  - Providers with a pending criminal charge involving any criminal activity related to the professional practice of medicine;
  - Providers involved in any open civil suit related to the practice of medicine;
  - Providers registered as a sex offender, if pertinent.

References:

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Alliance Policies: 300-4020 –PRCC Authority, Roles and Responsibilities; 300-4040 – Professional Provider Credentialing Guidelines, 300-4110 – Organizational Providers Credentialing Guidelines; 401-1301 – Potential Quality Issue Review – General; Policy 300-4102 – Reporting to the MBC and NPDB; 300-4103 – Fair Hearing Process for Adverse Decisions
Regulatory: NA
Contractual: Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12; Exhibit E, Attachment 2, Provision 24.B.2
Legislative: NA
MMCD: Policy Letter 02-03
Supersedes: 300-4022 - Peer Review and Credentialing Committee – Review of Credentials and Issues (retired)

Lines of Business This Policy Applies To:

☒ Medi-Cal
☒ Healthy Families
☒ Healthy Kids Santa Cruz
☒ Healthy Kids Merced
☒ Alliance Care IHSS
☒ Access for Infants and Mothers
☒ Individual Conversion Form
☒ Santa Cruz County LIHP
☒ Monterey County LIHP

Revision History:

Review Date	Revised Date	Changes Made By	Approved By
12/12/2007			PRCC
12/10/2008	12/10/2008		PRCC
03/10/2010	02/24/2010		PRCC
12/14/2011	12/06/2011	Sierra Brode	PRCC
12/12/2012	12/12/2012	Sitara Cavanagh	PRCC